December 15, 2023

U.S. Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

The patients of Saint Vincent Hospital in Worcester, MA continue to be at risk for harm despite a July 2023 site visit by The Joint Commission inspectors. The hospital management has failed to address the very basic requirements of healthcare delivery despite frequent requests from the registered nurses at the bedside. The hospital has consistently failed the patients it serves.

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. The hospital repeatedly violates 105 CMR 130.311: Registered Nurse Coverage There shall be a sufficient number of registered nurses on duty at all times to plan, supervise and evaluate nursing care, as well as to give patients the nursing care that requires the judgment and specialized skills of a registered nurse and 105 CMR 130.312: Registered Nurses, Licensed Practical Nurses, and Ancillary Staff Coverage The number of registered nurses, licensed practical nurses and unlicensed nursing personnel assigned to each nursing unit shall be consistent with the types of nursing care needed by the patients and the capabilities of the staff.

We ask for your further investigation and intervention at the hospital to protect the patients of Worcester County.

Emergency Department and Emergency Department Behavioral Health

The Emergency Department, particularly its triage area and the Behavioral Health unit have been consistently unstaffed or understaffed. The Behavioral Health unit has been repeatedly staffed with unlicensed personnel only- with no registered nurse, particularly on the overnight shift. This is a blatant violation of 105 CMR 130.313: Licensed Mental Health Professionals in Emergency Departments or Satellite Emergency Facilities (A) A hospital shall ensure that a sufficient number of licensed mental health professionals are available at all times in an emergency department or a satellite emergency facility to assess, evaluate and stabilize, either in person or via telehealth, or electronic or telephonic consultation, a person who presents with a

Massachusetts Nurses Association ■ 340 Turnpike Street ■ Canton, Massachusetts 02021-2711
781-821-4625 ■ Fax: 781-821-4445 ■ www.massnurses.org

primary mental health concern, and, if appropriate, to refer such person for appropriate follow up, treatment or inpatient admission. Individuals with a master's degree in a clinical behavioral health practice pursuing licensure post master's under the supervision of an appropriately licensed and credentialed clinician may be considered a "licensed mental health professional" for purposes of 130.313.

Multiple ED assignments have no nurse assigned. Management has told the staff to "put all the boarders in the annex (8 beds) and put a PCA with them to take vitals and babysit them. No nurse is to be assigned." The hospital repeatedly has violated TJC standards LD.03.01.01, "*Leaders create and maintain a culture of safety and quality throughout the hospital*"; TJC standard LD 04.01.11 "*The hospital makes space and equipment available as needed for the provision of care, treatment, and services*"; and TJC Standard PC02.02.01, "*The hospital coordinates the patient's care, treatment, and services based on the patient's needs.*"

St. Vincent Hospital has been designated as a Primary Stroke Service by the Massachusetts Department of Public Health which requires a readiness to provide timely acute stroke evaluation and treatment (Commonwealth of Massachusetts, 2023). However, St. Vincent Hospital has been consistently without a triage nurse to assess patients on arrival and adequate staff to assess and treat patients in a timely manner which directly contradicts the commitment made in obtaining that designation.

September 21, 2023- A behavioral health RN was floated to the ED without orientation to the unit or the patient population violating both TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff*" and TJC Standard HR01.06.01, "S*taff are competent to perform their responsibilities.*"

There was no triage RN with 26 patients in the waiting room, unmonitored. The resource RN had a full assignment in addition to triaging patients who arrived. Antibiotic orders were placed but not carried out for more than 4 hours, a delay in care.

October 11, 2023- 1-2 RNs in triage with 40 patients in the waiting room, at least part of the day there was no critical care technician to assist. Multiple patients had antibiotic orders pending for more than 3 hours, with treatment delivery delayed.

October 16, 2023- No nurse in triage with 10 patients in the waiting room, unmonitored. Resource nurse had a full patient assignment in addition to triaging patients on arrival. The Behavioral Health unit of the ED had 8 admitted patients, some hostile, some requiring sedation. The unit was staffed with one RN and one sitter.

October 19, 2023- Two patients admitted to behavioral health unit with no RN- assigned to a sitter only. There was no nurse in triage with 27 patients in the waiting room unmonitored. Multiple medications and orders were not carried out in a timely manner due to the lack of an RN assigned to the area.

October 30, 2023- Behavioral Health unit in the ED had 7 patients admitted and no RN assigned. A sitter and security staff were left to monitor the patients. Multiple suicidal patients in the ED

required but were not given a 1:1 sitter for safety. One patient was able to elope because they were not being monitored by a sitter.

November 6, 2023- No ancillary staff were present in the ED, therefore there was a delay in assisting patients to the restroom, providing patients with nutrition, and to transport patients. There was no RN in triage. The one RN in the behavioral health unit was assigned 8 patients

November 15, 2023- There was no nurse in triage to assess patients on arrival.

November 21, 2023- Behavioral Health Unit had no RN, leaving 5 patients to be monitored by a sitter only. There was no triage RN to assess patients on arrival.

November 22, 2023- There was no RN in triage. The resource nurse, a 3-week employee of the facility, had never been oriented to the resource role and was expected, in addition to being the resource, to triage new patients who arrived, monitor patients in the waiting room and care for a full patient assignment including a critical care admission. This violates TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff*" and TJC Standard PC02.02.01, "*The hospital coordinates the patient's care, treatment, and services based on the patient's needs.*"

November 29, 2023- No nurse in triage; resource nurse had a full patient assignment of 6 patients including at least one ICU admission boarding in the ER due to lack of beds.

December 1, 2023- Five (5) mental health patients were left with a sitter and security only on the 11p-7am shift. There was no RN in either the behavioral health section of the department or triage to asses patients on arrival and monitor patients in the waiting room. An ICU patient was cared for in the hallway, without the benefit of privacy, wall suction, wall oxygen, hard wired cardiac monitoring in violation of TJC Standard LD 04.01.11 "*The hospital makes space and equipment available as needed for the provision of care, treatment, and services.*"

December 15, 2023- All inpatient boarders have been cohorted in the annex seated in chairs because there is not room for stretchers. The only nurse assigned to that area, with 14 patients, is a new graduate nurse, recently off orientation. This violates TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff*" and TJC Standard PC02.02.01, "*The hospital coordinates the patient's care, treatment, and services based on the patient's needs.*"

Intensive Care Unit

The hospital consistently understaffs the ICU, directly violating MGL 111 Section 231, Limitation on patient assignments per nurse in intensive care units; development and certification of acuity tool. This violates TJC standard LD.04.01.01 *"The hospital complies with law and regulation,"* and TJC Standard PC02.01.03 *"The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation."* The law states "Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed to resolve a disagreement." However, the nurses are routinely assigned more than one patient regardless of the RNs assessment of the acuity of the patient, the experience of the nurse and other relevant factors identified by the Health Policy Commission in Massachusetts.

September 6, 2023- Bed manager instructed the resource nurse to encourage an orientee to come off orientation early to take an assignment independently or to respond to a rapid response call without full orientation to the role. This would violate both TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff*" and TJC Standard HR01.06.01, "S*taff are competent to perform their responsibilities.*"

September 8, 2023- Patient in DKA arrived to the ICU from the ED without full report. Patient was combative. Multiple patients on the unit were attempting to climb out of bed, at risk for falls and harm violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

September 23, 2023- Charge nurse with two-patient assignment; unable to mentor new graduate nurse recently off orientation, unable to respond to rapid response calls in the hospital in violation of ICU Resource role as assigned by hospital. Only one cardiothoracic trained RN scheduled for shift- therefore, the nurse caring for new CT surgery patient had no back up and was unable to safely take a meal break.

October 19, 2023- An unstable patient on four vasopressors and receiving multiple blood products assessed by RN as needing 1:1 care was assigned with a second patient, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

October 28, 2023- RN was required to accept an unsafe assignment pairing a second patient with an unstable patient who was intubated, paralyzed and sedated and required frequent monitoring, repositioning, suctioning.

October 29, 2023-Two patients assessed by the RN as high acuity and requiring 1:1 nursing care were assigned to one nurse: An intubated, paralyzed and sedated patient doubled with a patient with new EKOS Endovascular System catheter. Per hospital policy, EKOS patients require vital signs, pulse checks, dressing checks, capillary refill assessment, vascular sheath assessment and neurological assessment every 15 minutes x4, followed by every 60 minutes x4. Having this

patient assigned with a second patient is a clear violation of MGL 111 Section 231 placing both ICU patients directly at risk.

October 31, 2023- Resource nurse unable to response to rapid response calls due to staffing in violation of ICU Resource Role per hospital.

November 3, 2023- One RN was assigned 2 unstable patients- 1intubated and vented patient on 3 titrating sedation medications intravenously; the second patient was on 2 continuous infusion vasopressors and 2 sedation intravenous medications and required multiple lab draws and arterial blood gases. Having these patient assigned to one nurse is a clear violation of MGL 111 Section 231 placing both ICU patients directly at risk.

November 17, 2023- Resource nurse had a two-patient assignment; was unable to attend to rapid response calls in violation of ICU Resource Role per hospital.

November 19, 2023- Resource nurse had a two-patient assignment; was unable to attend to rapid response calls in violation of ICU Resource Role per hospital.

November 21, 2023- RN newly off orientation assigned a patient with a Swan-Ganz catheter. Nurse was not fully competent in care of the SG catheter. This violates TJC Standard HR.01.04.01 "*The hospital provides orientation to the staff.*" The resource RN had a two-patient assignment and was unable to assist a newly oriented nurse, unable to respond to rapid response in the hospital in violation of ICU Resource Role per hospital. Due to the acuity of patients in the ICU that night, patients were not turned as ordered to protect their skin and prevent pressure injury because of staff availability.

November 23, 2023- ICU staff was unable to respond to rapid response emergencies within the hospital, limiting the resources available to a critical patient and violating hospital policy that the ICU Resource nurse responds to all in-house emergencies.

November 24, 2023- RN assigned charge while also responsible for an identified organ donor patient who required close hemodynamic monitoring, frequent labs and ongoing communication with the family and New England Donor Services. This nurse was unable to fulfill the charge role or to assist another nurse who required help with a patient on four vasopressors for hemodynamic instability, in violation of the ICU Resource Nurse role as written by the hospital.

November 26, 2023- ICU census included multiple confused patients and patients requiring 1:1 nurse staffing who were in fact "doubled" with another patient. One patient fell out of bed while in restraints. Staffing in the ICU was in clear violation of MGL 111 Section 231 placing all ICU patients directly at risk.

November 27, 2023- Patient ordered for 1:1 monitoring as high fall risk. Because of inadequate staffing, the order was not followed, placing the patient at risk for harm.

November 28, 2023-Resource RN told to accept 2 post operative patients on her assignment-patients required hourly pulse checks, neuro checks. Resource RN unable to perform resource role , respond to rapid responses on the floors, conduct hourly rounds to assist with care, admissions, transfers as needed per the ICU Resource Role assigned by the hospital.

December 3, 2023- Nurse was forced to take an unsafe two patient assignment that included a patient status cardiac catheterization, had an intraaortic balloon pump and a TR band, used to compress an artery to prevent bleeding but requires release every 15 minutes and frequent peripheral pulse assessment to maintain perfusion to the extremity used for the procedure and with the IABP.

December 4, 2023- Nurse was forced to take an unsafe two patient assignment that included a patient status post coronary artery bypass graft (CABG) who remained intubated, on four intravenous drips for hemodynamics, sedation and blood sugar control and had an intraaortic balloon pump (IABP). This patient meets the criteria to be singled and deserved the focus of the RN.

December 8, 2023- Despite the high acuity of the patients, one nurse was assigned 2 patients, one of whom sustained a perforated pericardium during a procedure and was actively bleeding, required multiple blood products, intravenous fluids and vasopressors to maintain hemodynamics until the patient was brought emergently to the operating room.

22 South- short stay telemetry

October 29, 2023-- All care and medications were delivered with extensive delays. There was no secretary to answer phones creating a delay in obtaining critical lab results; physician follow up; communication with family. Nurses were unable to medicate for pain in a timely manner; all medications administered late and ultimately some doses were skipped to avoid dosing patients too close together; Unable to respond to IV pump alarms which triggered a new admission to sign out AMA because of incessant beeping.

November 1, 2023- - All care and medications including insulin were delivered with extensive delays. Two patients but required bladder scans and were only scanned one time in the shift. There was no secretary to answer phones creating a delay in obtaining critical lab results; physician follow up; communication with family.

November 13, 2023- Medication, including for pain management, administration delayed, antibiotics more than 2 hours late for 2 patients; some medication doses missed because the next dose was due too soon because medications were so late; Insulin given hours late after fasting blood glucose tested. 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.

November 18, 2023- Medication, including insulin administration delayed at least one hour; insulin doses missed; unable to assess and treat pain in a timely manner- patient found crying in pain because of extended time delay; unable to communicate with family and return family calls requesting update on patient status; blood transfusion delayed because nurse unable to follow hospital policy for monitoring; unable to provide 1:1 during meals for patient with intellectual disability at risk for choking. 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.

November 24, 25, and 26, 2023- All care and medications were delivered with extensive delays. There was no secretary to answer phones creating a delay in obtaining critical lab results; physician follow up; communication with family.

December 1, 2023- All care and medications were delivered with extensive delays. There was no secretary to answer phones creating a delay in physician follow up; communication with family obtaining critical lab results. When the lab called the floor to notify of an elevated creatinine level on a patient, the message did not get relayed to the nurse who unknowingly gave the patient their scheduled dose of vancomycin that should have been held to prevent further renal damage. TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it…" There was no phlebotomist to draw serum labs to assess coagulation on a patient with heparin infusing. Dressing changes were not completed as ordered because the nurse was unavailable.

December 6, 2023- Cardiac patients were admitted to the unit despite the hospital having no available telemetry boxes in order to monitor cardiac rhythms. Dressing changes and medication administration delayed significantly because of overwhelming patient assignments. These incidents violate TJC standard LD 04.01.11 *The hospital makes space and equipment available as needed for the provision of care, treatment, and services"*; and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

23 South

RNs have documented multiple days when inadequate staffing negatively impacted patient care. In addition, equipment issues raise concern for patient safety.

October 14, 2023- Multiple patients were incontinent of urine and remained in soiled linens for extended periods of time due to unavailability of staff. 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. Patients were not repositioned with skin assessments performed as ordered placing the patients at risk for pressure injury.

October 19, 2023- Multiple patients were incontinent of urine and remained in soiled linens for extended periods of time due to unavailability of staff. 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. Patients were not repositioned with skin assessments performed as ordered placing the patients at risk for pressure injury.

October 27, 2023- A patient who had no IV access was not given an IV push medication. There was a four (4) hour delay in medication administration. Ordered dressing changes were not done because of unsafe patient assignments.

October 30, 2023- Multiple patients were incontinent of urine and remained in soiled linens for extended periods of time due to unavailability of staff. Patients were not repositioned with skin assessments performed as ordered placing the patients at risk for pressure injury.

November 4, 2023- Telemetry monitory not functioning, therefore patients who required cardiac monitoring were unmonitored, violating TJC standard LD 04.01.11 *"The hospital makes space and equipment available as needed for the provision of care, treatment, and services"*; and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 5, 2023- The order for 1:1 monitoring on a patient at safety risk was not staffed for at least 4 hours. TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 12, 2023- Medication administration was delayed. Point of care testing was delayed due to unsafe patient assignments. The order for 1:1 monitoring on a patient at safety risk was not staffed as such, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

32 South

October 20, 2023- Patient ordered for 1:1 not staffed for continuous monitoring violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

33 South

There are numerous examples of the hospital's failure to meet the needs of the patient, violating both TJC Standards and the patients' rights to quality care. 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.

October 14, 2023- - Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families; unable to initiate physician orders in a timely manner violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

October 24, 2023- Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

October 15, 2023- - Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families; unable to initiate physician orders in a timely manner violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 1, 2023- - Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 4, 2023- - Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 5, 2023- Unable to meet basic needs of patients; No non-rebreather oxygen delivery masks on unit; printer broken; no one available to answer phones delaying access to critical lab values, physician orders; family communication No respiratory therapist available despite patient requiring nebulizer treatments every 20 minutes x 3; Nurses unable to provide basic hygiene, emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 9, 2023- Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families; unable to initiate physician orders in a timely manner violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 20, 2023- Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families; unable to initiate physician orders in a timely manner violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 25, 2023- Multiple basic supplies missing; patient waited 2.5 hours for nurse to establish IV access for pain and blood pressure medication administration; Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly

delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families; Recently diagnosed COVID (+) patient waited multiple hours for care and medication administration; unable to initiate physician orders in a timely manner violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 26, 2023- (day shift)- Patient admitted to floor with orders for continuous telemetry monitoring despite management being aware no telemetry boxes were available. Unable to properly monitor patient for cardiac dysrhythmias as ordered; unable to initiate physician orders in a timely manner, violating TJC standard LD 04.01.11 *"The hospital makes space and equipment available as needed for the provision of care, treatment, and services"*; and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 26, 2023- (night shift) Staff unable to respond to patient call bell for patient lying in urine and feces for extended period of time, placing patient at risk for pressure injury and infection violating the hospital's own *Patient Rights and Responsibilities* which ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to assess pain adequately and in a timely manner, oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Nurse unable to provide emotional support and education to patients and families; unable to initiate physician orders in a timely manner violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

December 4, 2023- Nurses were unable to assess pain adequately and in a timely manner, oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

34 North

November 6, 2023- An agitated and confused patient was ordered to be monitored as 1:1 for safety and pulled out her own intravenous catheter and attempted to climb out of bed with fractured hip because there was no sitter with the patient, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 12, 2023- There was no unit secretary to answer phones, leading to delay in obtaining critical lab results, communication with families violating TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it..."

November 18, 2023- Floor patient became critically ill and hypotensive; treatment delayed for hours because critical care staff were not available to start vasopressor to treat hemodynamic

instability violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 24, 2023- Nurses unable to administer medications in a timely manner due to no available staff to verify correct medication, dose, patient on high risk medications such as insulin per hospital policy violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

November 26, 2023- Multiple call lights not answered for extended time; tube system not functioning requiring RN from understaffed floor to retrieve medications (oral glucose) from pharmacy. Vital signs ordered for 0700 and 1100h were not done due to inadequate staffing. The staff were unable to provide nourishment to patient because of an unstocked kitchen; there were no supplies available to care for incontinent patients on enteric precautions and a patient had to wait in feces for hours because it required 3 nurses and the one PCA to turn the patient and staff were busy with other patients. 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. A patient reported chest pain and no EKG technician was on duty to obtain a 12-lead tracing;, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Labor and Delivery

Documentation in the Labor and Delivery suite continues on 2 different systems.

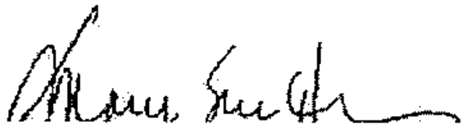
September 29, 2023- Three patients were unable to continue inductions because if inappropriate staffing levels violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Post-Anesthesia Care Area

October 26, 2023- Two RNs staffed the PACU- of the 3 patients they were responsible for, 2 were in Phase 1 post- anesthesia care. According the ASPAN, "Phase I is the level of care in which close monitoring is required, including airway and support for effective ventilation, progression toward hemodynamic stability, pain control, fluid management, and other acute aspects of patient care" (July 2019). The third patient required transport to the floor. One patient needed an EKG but there was no EKG technician in-house and no EKG machine on the unit, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

December 12, 2023- An RSV positive patient was sent the PACU from the Emergency Department for a procedure without the staff being aware of the infection. The patient was not isolated and placed in the PACU in a curtained area, potentially exposing other patients to the respiratory illness, violating 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."

Sincerely,



Mary Sue Howlett, PhD, RN/FNP-BC, CEN
Association Director, Division of Nursing
mhowlett@mnarn.org
781-363-3010