Massachusetts Nurses Association

May 23, 2024

Division of Health Care Facility Licensure and Certification
Complaint Intake Unit
67 Forest Street
Marlborough, MA 01752

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

On behalf of the Worcester area community and the RNs and other staff at St. Vincent hospital, I am submitting another official complaint with the Joint Commission, MA Department of Public Health Division of Health Care Facility Licensure and Certification, Centers for Medicare and Medicaid and Kepro BFCC-QIO-MA regarding an ongoing and dire crisis in the safety of care for patients admitted to St. Vincent Hospital. This is the **fifth** such complaint we have filed in an attempt to address an ongoing patient safety crisis at this facility. As we have stated in previous complaints, every patient and every nurse on every shift is subjected to abnormally dangerous conditions, with both patients and nurses at risk for imminent harm at the hands of an administration that fails to meet the most basic standards of patient care delivery. Despite multiple cries for help, the conditions at that facility have deteriorated even more, with a multitude of patients developing hospital acquired pressure ulcers, insufficient supplies to care for patients, and the appointment of staff to positions for which they do not hold the minimum qualifications needed. We have already reported to your agency and all other applicable agencies specific deficiencies in staffing, hospital policies, allocation of technology, and a deliberately punitive management culture that is resulting in dangerous delays in the administration of needed medications and treatments, preventable patient falls and other complications, including preventable sentinel events. Despite onsite investigation and monitoring by state and national agencies, the conditions have not improved and have in fact, gotten worse. Just last week, on 5/16/2024 at 1930h, a unit secretary found an unaccompanied patient wearing green paper scrubs (typically used for suicidal or at-risk mental health patients) in the south atrium elevator on the 2nd floor.

We issue this complaint as part of an ongoing effort to secure safe conditions for the patients in Worcester County who deserve to receive the healthcare they expect. This is yet another good faith effort to alert our administration of the dangers these conditions pose for their patients and themselves. Our nurses have carefully documented these conditions and concerns and have made repeated requests to engage in a meaningful process to address these conditions, only to be met with rancor and recrimination. In our role as legally mandated advocates for our patients we once again appeal to The Joint Commission, the Centers for Medicare and Medicaid, and the Massachusetts Department of Public Health to immediately intervene, and take whatever steps

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are necessary to prevent the further erosion of patient care conditions, and to protect our patients and our community from continued harm and unnecessary suffering.

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 on 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.

Patient Care Conditions Result in Unprecedented Increase Pressure Ulcers

The lack of staff, both licensed and unlicensed has allowed too many patients to go unmonitored and left unattended without the ability of staff to reposition patients as required under accepted patient care standards, which has resulted in an alarming number of patients suffering from documented **hospital acquired pressure ulcers**, including 25 in April alone. As you are aware, pressure ulcers are mandated by the Joint Commission and the DPH as serious reportable events that signal problems in care management that need to be addressed. Instead of addressing the systemic issue that prohibits the nurses from repositioning at-risk patients and minimizing the risk for soft tissue injury, nurses have been told that nursing leadership has threatened to fire every nurse who has cared for a particular patient whose ulcer advanced to a Stage IV wound while admitted to the hospital. **Lack of Safe Patient Handoff Protocols**

The nurses working on the inpatient units do not receive handoff communication from the Emergency Department when a patient is being admitted to their unit. Nurses report they have not received an SBAR report since the facility instituted the use of the Cerna electronic documentation system 10 months ago. There is reportedly a means to access the ED report in Cerna, but the staff have still not received education and training on it despite requests. Because of the lack of communication, the admitting nurse is unaware of medications given and sometimes has to investigate medications given by calling the pharmacy. Once patients are assigned to rooms, they are transported to the floor quickly, eliminating any time for the accepting floor nurses to assign the patient, prepare the room with necessary equipment (such as a telemetry box if needed). The accepting nurse has no time to ask questions or clarify information from the originating staff or to assess if the assignment is appropriate for that room.

Appointment of Staff Without Required Experience to Function in Role

The role of the Bed Manager who is "responsible for the coordination and management of personnel and assumes responsibility for hospital administration" for the off shifts, requires a registered nurse with "3-5 years of demonstrated leadership ability in an acute care setting" by the hospital's own job description. The hospital has violated its own policy and hired a Bed

Manager who graduated from community college and has an LPN license that was issued on 9/29/2023, just months prior to being hired in the role. The relief Bed Manager is not clinically trained, but rather the Director of Transportation. Neither of these employees meet the basic requirements of the hospital's own identified qualifications for skills and education to manage the flow of patients through the hospital and onto appropriate units.

Patient Reviews Indicate Dissatisfaction with Care

The attached published patient reviews reveal the experience of patients at St. Vincent Hospital. Of the 73 reviews posted in the first quarter of the year, more than half (53%) are negative; 12% are neutral and 10.0% are mixed. Less than one quarter of the posted reviews indicate a positive experience at the hospital. This provides some indication of the patient experience under the current care conditions.

The next section of this complaint documents reported violations of patient care standards on a variety of units.

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. Nurses have been assigned multiple critical patients at one time, risking the lives and well-being of both. Despite contractual language that the charge nurse should not have a patient care assignment and therefore available to assist and mentor other staff, the resource RN is almost always responsible for a full patient assignment, and therefore, unable to respond to emergencies within other units in the hospitals when patients are critically ill and require the expertise of a critical care nurse, violating hospital policy.

March 4, 2024- Staffing was inadequate and patients suffered. The charge nurse had 2 critical patients assigned and was forced to take an admission from the cardiac catheterization lab. Part of the charge nurse's responsibility is to respond to rapid response calls in the hospital, but due to the untenable assignment no critical care nurse was able to assist at crisis calls that entire shift. The hospital violated TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 9, 2024- Because the unit is staffed with not fully competent newly licensed RNs, an experienced nurse assigned to an unstable septic patient with pulmonary hypertension on

multiple vasopressors, sedation, and in atrial fibrillation was forced to take a direct admission with an IABP from the cardiac catheterization lab who was planned for surgery and required multiple blood draws but the RN. That patient was transported to CT scan (which requires 4 staff members to maneuver the bed, IVs and balloon console). Neither patient should be part of a multi-patient assignment because of their acuity. The hospital violated TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 15, 2024- Resource nurse assigned a fresh post-operative CABG patient and therefore unable to mentor/assist other nurses in the unit. In addition, there was no secretary to answer phones and assist with necessary calls. The hospital violated TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 27, 2024- Charge nurse was responsible for a fresh post-operative CABG patient and therefore unable to assist the nurse who accepted an unstable admission from the cardiac catheterization lab who had cardiac arrested twice and had an IABP. That new admission required the focus of two RNs but the charge nurse was unavailable. The hospital violated TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 28, 2024- The charge nurse was assigned a new admission direct from the cardiac catheterization lab with an Intra-Aortic Balloon Pump (IABP). That patient was transferred to Boston which requires a great deal of coordination and paperwork to be prepared for transfer. Not only was the charge nurse responsible for the patient care and transfer logistics, but there was also no secretary to assist. The hospital violated TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 29, 2024- The charge nurse was responsible for the care of a fresh post-operative CABG patient and unable to respond to any raid response or code responses within the hospital. That patient required titration of 5 intravenous drips and extubation. A patient was transferred to Boston for a higher level of care. There was no secretary to assist with the paperwork and phone calls required to implement the transfer plan. The hospital violated 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 despite TJC onsite survey in July 2023. When a patient initially arrives to the unit, most of the documentation is completed in Cerner, but a portion of the documentation (OB specific content) is completed in Centricity. After a vaginal delivery, the patient is monitored for 2 hours and documentation completed in Centricity and date, time, mode of birth with interventions for shoulder dystocia is documented in Cerner. A delivery summary is documented in Centricity, but most of the infants records are held in Cerner. When the patient is admitted to the post-partum unit, documentation is then completed in Cerner. For a patient who undergoes a c-section, some intake documentation is completed in Centricity (e.g. OB history, previous or

current pregnancy complications, fetal monitoring strip documentation, prenatal lab work) then switched to Cerner during the intraoperative period. The initial 2-hour recovery documentation is completed in Centricity, with subsequent documentation being completed in Cerner. There is no continuous flow of the information from admission through the patient's hospital stay. This lack of information flow and access risks patient care. When the infant of a patient with gestational diabetes was admitted to the Level 2B nursery with respiratory depression, the infant's blood sugar was not checked because the receiving nurse did not have the information about the mom's diabetes diagnosis. When a post-partum readmit returns to the L+D suite for magnesium therapy, the patient's frequent vital signs (every 5-minute blood pressure and neuro checks) flow into Centricity from the monitor but the hospital documentation is required in Cerner. This risk transcription error when RNs are manually placing VS into Cerner from Centricity. This convoluted documentation plan clearly violates TJC standard IM.02.02.03, "The hospital retrieves, disseminates, and transmits health information in useful formats"; TJC standard LC.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 failing to meet the National Patient Safety Goal 2, "to improve the effectiveness of communication among caregivers."

March 4, 2024- Patient was placed on hold for induction of labor due to inadequate staff on the unit. When a post-partum nurse offered to help, the offer was declined by management, leaving the patient on hold.

March 11, 2024- Because of low census, the required 24/7 scrub tech coverage was compromised. Management cancelled 2 RNs who were scheduled and placed 2 nurses on call. The onsite resource nurse was the only nurse who is competent to perform the duties of scrub in an operating room. There was no consideration of the qualifications required to perform an emergency C-section, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

April 3, 2024- a patient with a planned induction was "on hold" to due to staffing. A post-partum nurse offered to assist but the nursing supervisor declined the offer, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

May 16, 2024- Numerous procedures were placed on hold due to inadequate staffing violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Special Care Nursery

March 27, 2024- Only 2 RNs were scheduled to a unit and census that required at least 3 RNs. Four special care infants in addition to other neonates require the expertise of 3 RNs, especially in the event of a neonatal resuscitation effort, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Same Day Medicine

There have been multiple cases when there is no signed consent for the cardiac catheterization procedure being performed.

Suite 280- *non-invasive hallway*

Multiple patients have been delivered to the area and left unmonitored in the hallway, with no handoff communication. In addition to others, patients left unmonitored include those with Amiodarone and/or Levophed drips which require continuous cardiac monitoring per hospital policy and industry standards.

22 South- Short Stay Telemetry

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

March 4, 2024- All RNs were assigned an excessive number of patients. Two patients were transferred to another unit because of an acute change in condition requiring intravenous cardiac infusions; there was no resource RN to assist with transfers or patient care; all care, treatments and medication administration was delayed; patients were not repositioned as indicated by Braden score to protect the patient from soft tissue injury violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* With nobody at the desk, all phone calls into the unit were missed, so staff could not be notified of critical lab values, physicians could not reach a staff person to inquire about patient condition and family members were unable to get updates on their loved ones violating TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it…"

March 6, 2024- The unit was staffed without a secretary and with no resource nurse to manage patient flow. There were only 5 RNs responsible for all patients including 2 bariatric patients who required 4-6 staff to assist each with multiple transfers. All medication administration was late and all care was delayed, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 11, 2024- There was no resource RN to assist and mentor the staff. All care and documentation was late for patients including a CVA patient who was ordered for neurological assessment every 2 hours and a diabetic whose serum glucose plummeted from >400 to 23 after insulin.

March 12, 2024- Medications administration delayed; response to call lights delayed; RNs unable to provide education to patients and families; incontinence care delayed leaving patients to lie in urine and feces soiled linens for extended periods of time, violating 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.

March 13, 2024- The unit was staffed with only 5 RNs, responsible for all patients including 2 bariatric patients who require at least 4-6 staff members to assist with transfers. One nurse was

off the unit for nearly 2 hours when they accompanied a patient who required sedation for an MRI. A combative patient who had suffered a stroke required nearly constant incontinence care, requiring multiple staff to complete the assessment and care delivery. All medication administration and wound care was delayed.

March 20, 2024- Late morning vital signs were not assessed; some patients were not assisted out of bed; wound care was not delivered and photographic documentation of hospital acquired pressure injuries was not obtained per hospital policy at time of discharge. All medication administration was late.

March 21, 2024- Multiple times during the shift 3 RNs were responding to a critical patient for whom a rapid response was called. During that time, the RNs were responsible for 17 other patients they could not be with. When the most critical patient was transferred off the unit by one RN, her other 5 patients were left unattended with no RN to monitor them. All medications were delayed and call lights were not answered 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."*

March 22, 2024- One nurse was assigned 5 patients including one who had a myocardial infarction, awaiting cardiac catheterization; one with frequent diarrhea and nausea/ vomiting; one with altered mental status trying to out of bed without assistance; a transfer from another unit who was septic, tachycardic with leukocytosis and lethargy; one on CIWA protocol admitted for suicidal ideation. All medication was administered late, care was delayed, and call lights were not answered in a timely manner leaving patients without assistance. The hospital violated its own handout, *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 in addition to TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 24, 2024- Multiple phone calls missed at the desk and patient call bells left unanswered for extended periods of time.

March 26, 2024- Staff unable to respond to bed alarms, vital signs were taken late; medications- including insulin- were administered late; a patient ordered for 1:1 safety monitoring was not staffed with a monitor; staff unable to reposition patients at risk for soft tissue injury in a timely manner; wound care delayed. violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 28, 2024- Staff unable to respond to bed alarms, vital signs were taken late; medications- including insulin- were administered late; a patient ordered for 1:1 safety monitoring was not staffed with a monitor; patients arrived to the floor unattended; RN unable to apply bear hugger to a hypothermic patient, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 29, 2024- There was no resource RN on the unit. One RN was orienting a new employee while also responsible for multiple total care patients, a confused patient who frequently got out of bed without assist; a combative patient who pulled at anything within reach; unable to complete incontinence care and reposition patients in a timely manner, including a patient with a Stage II pressure injury, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

May 5, 2024- A patient in supraventricular tachycardia (SVT) required close cardiac monitoring but the RN was unable to provide the extent of monitoring indicated by the patient's condition. Two patients who required 1:1 monitoring but was not ordered because "we need to get them transferred to a facility." The need to move the patient out of that setting superseded the need to maintain safety for the patients who required close monitoring for safety violating 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.

March 7, 2024- Medications administration delayed; multiple patients on the unit required insulin coverage for elevated blood sugar levels but the RNs reported delays in administration of insulin because of difficulty locating a second RN to witness the dose per hospital protocol. Each of the 4 nurses was assigned 6 or more patients when the expected staffing for that unit is 7. Bedridden patients requiring frequent repositioning to prevent soft tissue injury were left in the same position for extended periods of time, violating hospital policy and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 29, 2024- While trying to orient a new employee, one RN was responsible for 5 patients. 4 of the 5 required total care, were incontinent of urine and feces, and required frequent hygiene and repositioning. One patient had developed a Stage II pressure injury and required meticulous skin care that the RN was unable to provide due to the demands of her assignment.

March 30, 2024- Patient with Stage III pressure injury requiring dressing changes and repositioning every 2 hours waiting extended periods of time, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs"* and placing the patient at an increased risk for further soft tissue injury.

March 31, 2024- Multiple patients on bedrest including those with Stage II and Stage III pressure injury were left in the same position for extended periods of time because the RN was assigned an excessive number of patients and unable to reposition those at risk for developing or worsening soft tissue injury in accordance with hospital policy.

April 20, 2024- Nurses assigned 5 patients each, one also responsible for resource role. The resource nurse also was given an assignment that included 3 of 5 patients with pressure ulcers one of which is a Stage IV, requiring extensive care and attention violating TJC Standard

PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs"* and placing the patient at an increased risk for further soft tissue injury.

April 21, 2024- Patients with significant pressure ulcers and incontinence were left in soiled linens for extended period of time violating hospital policy and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

24 North

March 9, 2024- Multiple patients with high Braden scores and high fall risk, and high-risk telemetry patterns (pauses on telemetry noted) could not be monitored as closely as indicated by patient assessment needs and hospital policy.

March 12, 2024- RN floated to a "hard" telemetry unit without appropriate training and orientation. RNs were unable to appropriately monitor cardiac rhythms according to hospital policy and standard of care. Computers and the interdepartmental "tube" system were down, eliminating timely access to medical records violating TJC standard LD 04.01.11 *The hospital makes space and equipment available as needed for the provision of care, treatment, and services."* Nurses report being unable to assess telemetry, neurological status and pain management for their patients violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* Patients experienced a significant delay in response to call lights, cardiac telemetry alarms and IV pump alarms; family phone calls were unanswered, violating the violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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.

April 12, 2024- Pain wa reassessed as indicated, cardiac rhythms on telemetry were not monitored as closely as indicated; patients discharged without proper discharge instructions and education; admission sent from Emergency without handoff communication.

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.

March 9, 2024- Multiple call lights not answered for extended 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. Nurses were unable to monitor hemodynamics, assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; Patients at risk for pressure injury were not turned and repositioned every

2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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. Nurse were 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."*

March 16, 2024- Nurses were unable to assess pain adequately and in a timely manner; all oral, and intravenous medications were delayed including insulin; unable to start and advance tube feeding on patient who was previously NPO; ADL care delayed; incontinence care was delayed and patients were left in urine and feces for extended periods of time; dressing changes were delayed, call lights were not responded to in a reasonable time; cardiac monitors were not monitored according to hospital policy; COVID (+) patient was sent to the floor without handoff communication from the Emergency Department violating TJC Standard PC02.02.01. *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 19, 2024- A patient with c-diff was admitted for cardiac monitoring was sent to the floor without handoff report from the Emergency Department – there were no telemetry boxes left on the unit for this patient and staff were not notified of the need for precautions; Staff 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; Hourly safety rounds were delayed; Personal hygiene and linen change delayed significantly for incontinent patients; 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."*

March 30, 2024- Multiple call lights not answered for extended 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. Nurses were unable to monitor hemodynamics, assess pain adequately and in a timely manner; oral, intravenous medications (including insulin and antibiotics) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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. Nurse were 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."*

April 2, 2024- Nurse assigned to orient a new RN was assigned 6 patients; all medications and care delayed; nurse unable to administer intravenous blood pressure medication for a patient

booked for the OR with a b/p 180/80 violating 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 TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

April 13, 2024- nurses were unable to monitor hemodynamics, assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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. Nurse were 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."*

April 15, 2024- Nurses were unable to assess pain adequately and in a timely manner, oral, intravenous medications including antibiotics significantly delayed; unable to ambulate patients as needed and required by physician orders; unable to conduct hourly safety rounds including on patients in restraints; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; unable to provide incontinence care in a timely manner; Nurse unable to provide emotional support and education to patients and families; unable to monitor vital signs as frequently as required by hospital policy; violating TJC Standard PC02.02.01, *The hospital coordinates the patient's care, treatment, and services based on the patient's needs.*

April 21, 2024- There was no IV nurse available- an elderly patient was stuck 3 times and no RN was able to obtain IV access to required to administer fluids and medications ordered; nurses were unable to monitor hemodynamics, assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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. Nurse were 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."*

April 27, 2024- Nurses were unable to monitor hemodynamics, monitor cardiac rhythms on telemetry; assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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. Nurse were 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."*

34 North

March 12, 2024- Multiple call lights not answered for extended 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. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications (including antibiotics for this post-op population) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities,* which 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.

March 17, 2024- Float nurse from a specialty area (L+D) sent to the unit with no orientation violating both TJC Standard HR.01.04.01, *The hospital provides orientation to the staff* and TJC Standard HR01.06.01, *Staff are competent to perform their responsibilities.* Multiple confused patients repeatedly attempted to get out of bed without the required assistance for safety; call lights not answered for extended 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. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications (including antibiotics for this post-op population) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered;

March 19, 2024- Multiple call lights not answered for extended 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. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications (including antibiotics for this post-op population) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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.

March 22, 2024- Multiple continuous bladder irrigation orders were rushed and discontinued because of inadequate supplies.

April 27, 2024- 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. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous

medications (including antibiotics for this post-op population) significantly delayed; Hospital policy requires that insulin, narcotic wastes and TPN but there was inadequate staff to be able to safely administer these therapeutics in a timely manner; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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.

36 North – Cardiac Step down

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. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications (including antibiotics for this post-op population) significantly delayed violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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.

March 9, 2024- Multiple call lights not answered for extended 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. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which 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. Nurses were 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."*

March 24, 2024- Multiple call lights not answered for extended 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. A patient fell on the floor, unmonitored because nurses had only half the nurse required to provide care on that unit. Nurse were 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."*

April 13, 2024- Patients ordered for 1:1 continuous monitor for safety were not monitored as such because of staffing violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

April 15, 2024- A patient waited over an hour for incontinence care, placing that patient at significant risk for soft tissue injury and infection while violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* and violating 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. Bed alarms and call lights were not answered in a timely manner despite that 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.

Call for Immediate Intervention to Protect Patients*We want to be clear thatthis list is by no means exhaustive and be assured they represent a mere snapshot of what have become daily occurrences throughout the units at St. Vincent Hospital. These conditions are abhorrent by any medical or nursing standard and the nurses of St. Vincent Hospital are both outraged and overwhelmed by the suffering they have endured. As a result, dozens have left the facility unable to accept such lax and dangerous standards, as well as from the repeated abuse they have received from their administration.*

Despite multiple DPH and Joint Commission onsite inspections, hospital management continues to place patients at risk and has not resolved the issues that impact patient care and safety.

As an organization, the MNA represents nurses and health care professionals working in 70 percent of the state's acute care hospitals, including the hospitals currently owned by Steward Healthcare, and we can state without equivocation or hyperbole that the conditions at St. Vincent Hospital are the worst among all those providers – by far. As such, we believe the DPH, as they have done in the case of the Steward facilities, should immediately assign DPH inspectors on site on a daily basis to ensure that this administration fulfills its responsibility to provide the care these patients and this community deserve. As an agency responsible for holding providers accountable for the care they provide, we reiterate our call for your immediate intervention, as without proper oversight, we fully expect many more patients to be harmed, and tragically, a number of our patients will die.

Sincerely,

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Enc.