September 16, 2024

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

Re: Framingham Union Hospital
115 Lincoln Street, Framingham MA 01702

On behalf of the Framingham area community and the RNs and other staff at Metro West Medical Center's Framingham campus, I am submitting this 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 this facility owned by Tenet Healthcare. As part of the Tenet system, Framingham Union Hospital patients and staff are experiencing the same or similar deficiencies that have been documented at St. Vincent Hospital in Worcester. Registered nurses have documented and reported to hospital management specific deficiencies in staffing, hospital policies, allocation of technology resulting in dangerous delays in the administration of needed medications and treatments, preventable patient falls and other complications, including preventable sentinel events. The issues cited here have been documented contemporaneously by the RN responsible for the patient. Those documents were provided to the MNA and the employer at the time of the incident and to the knowledge of the nurse, no resolution was provided by those managers responsible for ensuring safe patient care. If necessary, the nurses who filed the individual complaints could be made available to your agency for additional information.

We issue this complaint as part of an ongoing effort to secure safe conditions for the patients in Framingham 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 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 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

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

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.

In addition, the hospital wide telephone system has been malfunctioning intermittently for the past month. As a result, pages notifying critical care team members of a rapid response have not been audible so no ICU nurse, ED nurse, Physician reported to at least one critically ill patient. The HUGS system, used in the newborn nursery to track neonates, has not been functioning 24/7, placing neonates at risk. The phone system rings repeatedly before connecting to the desired number, causing a delay in communication.

Lack of Safe Patient Handoff Protocols

The nurses working on the inpatient units do not consistently receive handoff communication from the Emergency Department when a patient is being admitted to their unit. Patients are rushed from the ED to a bed upstairs in a haphazard manner, at times with no communication to the inpatient nurse that the patient has arrived to the floor. 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.

Emergency Department

April 22, 2024- While managing the required cooling of a post return of spontaneous circulation (ROSC) patient after a cardiac arrest, care that requires intensive monitoring and 1:1 care in an attempt to preserve neurological function, the RN assigned was also responsible for at least 2 other patients, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

June 6, 2024- A nurse carried a six-patient assignment including two with slow heart rates, one of whom required a pacemaker. Those six patients did not receive the care they required because of the volume of work to be done. One patient waited 90 minutes for new linens after being incontinent; a confused patient got up without assist to use the restroom and fell then passed stool which spread across the room; a patient with urinary retention waited until the next shift for an intervention to relieve the pain and risk to further harm, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

June 21, 2024- The charge nurse was responsible for patient flow in the unit, a seven patient assignment and triage, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

July 31, 2024- The charge nurse, responsible for patient flow in the unit, was also responsible for triage, the rapid medical evaluation (RME) patients and at least 7 behavioral health patients boarded in the unit, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

August 6, 2024- The charge nurse was responsible for patient flow in the unit, six behavioral health patients, two RME patients, triage and the ten patients in the waiting room, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

In the Emergency Department, the RN station for rooms 23-27 is not in sight line of the cardiac monitor and separated from that central monitor by a triage hallway and 2 other patient rooms diagonally located across from the RN. The central monitoring station is approximately 40-50 feet away from the RN work station. Audible alarms cannot be heard from the station. This area is used for patients who require close monitoring including those who have received moderate sedation or are admitted for cardiac complaints.

Ultrasound coverage varies and the hospital has been left up to 12 hour periods without ultrasound technologists. The posted schedule is at times inaccurate or posted with significant vacancies. During the time when ultrasound imaging is not available, patients being evaluated for ectopic pregnancy, testicular torsion, or pediatric appendicitis are transferred to a larger facility for imaging, delaying definitive diagnosis and care.

Cardiovascular Unit (CVU)

January 9, 2024- During a shift with high acuity and inadequate staffing, the unit was required to accept patients to fill all beds and nurses were assigned additional patients. During that time, a 35 year old died following a cardiac arrest.

February 18, 2024- A STAT troponin lab, drawn on a patient with cardiac rhythm and EKG changes, took over 90 minutes to result; brittle diabetics with critically high blood sugars received full sugar juice and desserts on the dietary trays; the new Arjo (specialty) bed was not functioning; intravenous medications including electrolyte repletion and specialty medications requiring pharmacy preparation were not in stock despite the patient having been inhouse for multiple days with the same medication orders; family members were toileting, feeding and cleaning patients because the hospital staff were not available to assist with basic care needs, 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- The supervisor instructed the CVU nurse to accept a patient without physician orders, violating hospital policy. An Emergency Department patient was transported to the CVU by an unlicensed staff member with no cardiac monitor and no RN, despite an admitting diagnosis of new onset bradycardia (abnormally low heart rate).

May 19, 2024- The supervisor flexed ED nurses down, minimizing the staff in the ED despite multiple boarders waiting for inpatient beds. An actively seizing patient who had displayed combative behavior in the ED, was admitted to the CVU from the ED despite short staffing and

risk of harm to patient and staff. The unit did not have any seizure pads to place on the patient's bed for protection. The RN attempted to use blankets on the siderails as cushion to protect the patient but the linen supply was inadequate. When blankets were requested, housekeeping informed the nursing staff that restocking happens on Monday (it was a weekend) and blankets were "rationed for the ED due to budgetary concerns". The patient was febrile with a temperature of 102.9 axillary and no temperature had been documented for 13 hours. Labs ordered for 12 noon had not been drawn and the patient's WBC rose from 5 to 22. The MRI that had been ordered that day was not done because MRI is not available on weekends. When the MRI was finally done, a stroke was identified. The neurological assessment was conducted via telehealth since inpatient neurologist positions have been eliminated. Stroke identification and care was delayed for days in a 37 year old because of lack of resources at the facility.

Labor and Delivery

May 16, 2024- Staffing included only 2 RNs and a scrub tech. The RN assigned to the resource role was not oriented or trained for that role. There was no additional staff trained in caring for a laboring patient onsite, 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.*"

May 23, 2024- A patient who was scheduled to receive an iron infusion was sent home to return the next day because of inadequate staffing. The RNs were all assigned laboring patients (a 1:1 assignment) including one who was also the designated scrub nurse for any emergent surgical procedures. The scrub nurse's patient required an emergent C-section, and because the other patients required the undivided attention of their assigned nurse, the lactation nurse was called emergently to "catch" the baby in the OR, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* 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.

June 13, 2024- An RN was instructed to report to the maternal child unit at a different facility, St. Vincent Hospital (SVH), because of patient volume. The RN had not been oriented to the hospital, the unit or the equipment and was expected to function in the role of primary nurse. SVH uses different equipment that the RN was not familiar with and she was not oriented to the location of emergency equipment or the location of the OR should her patient require an emergency C-section, violating TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff.*"

Surgical Services

July 10, 2024- All staff were caring for surgical patients in three OR's when a general surgeon wanted to perform an emergent procedure that could not be done at that time 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."* 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.

July 23, 2024- Once again, there was no flexibility to meet an emergent surgical need as all scheduled staff were in four ORs that were booked with planned cases. During that time, the unit manager was called "urgently" to assist with a procedure in Labor and Delivery, again violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

2nd floor (Medical-surgical and telemetry unit)

April 17, 2024- The floor did not have a charge nurse because of inadequate staffing. A patient was sent to the unit from the ED despite the floor not being able to safely accept the patient at that time. 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.

April 20, 2024- There was no unit secretary despite a significant need for the secretary to assist with multiple admissions, transfers, discharges and phone calls. 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..."

April 21, 2024- There was no unit secretary despite a significant need for the secretary to assist with multiple admissions, transfers, discharges and phone calls. 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..."

April 22, 2024- The charge nurse was assigned six patients while trying to fulfill the role of charge and assist with patient care, mentor new staff; a newly licensed RN was assigned seven patients; an experienced RN was assigned seven patients and unable to assist and mentor the new nurse because of the demands of their own assignment again violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* 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.

April 29, 2024- A patient admitted to the unit from the ED arrived with dried vomit on his face.

April 30, 2024- A patient admitted to the unit from the ED arrived without handoff communication. He was experiencing chest pain/ tightness and had not been seen for 2 hours. The receiving nurse was not informed of the patient's arrival to the floor. Medications were given late violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*"

May 13, 2024- Intravenous pain management due every four hours was given late all night; two patients did not receive IV medications because of lack of IV access; patients did not receive personal care and skin care when needed; missed medications from the previous shift were identified violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*"

June 10, 2024- There was a failure to provide staffing for two patients ordered for 1:1 safety monitoring; one patient fell; medications were given late throughout the shift, violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*"

July 30, 2024- Blood cultures ordered were not drawn in a timely manner as ordered violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*"

5th floor (Medical-surgical and overflow telemetry unit)

April 14, 16, 29, May 8, 15, 2, 2024- Staffing was inadequate so there was no charge nurse to manage oversight of patient flow, mentor new staff, or serve as resource to staff, physicians, patients and families.

April 14, 2024- Six empty oxygen tanks were found on the unit; there were no full tanks located. The charge nurse was responsible for patient flow in the unit and other charge duties, a seven patient assignment and orientation of a new hire. An EKG was ordered but both EKG machines were broken.

April 16, 2024- The charge nurse was unable to fulfill that role because of a simultaneous full assignment. That nurse was needed to assist other nurses but was unable to do so because of the patient load she was given.

May 8, 2024- Despite 8 patients in the unit requiring telemetry monitoring, no nurses qualified and credentialed to interpret cardiac rhythms was working on the unit violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*" 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.

May 9, 2024- The safety of an impulsive patient without physical or chemical restraint was put at risk because the nurse responsible had four additional patients with limited ability to monitor that patient closely. A 1:1 staff monitor was not available to ensure the safety of the patient, violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*" 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.

May 15, 2024- Nurses report being unable to provide adequate pain management, unable to provide personal hygiene and skin care for patients who were incontinent of urine/ stool because of inadequate staffing. 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.

July 2, 2024- Medications administered late; blood glucose checks completed late. Five admissions were sent to this floor during the day despite known inadequate staffing planned for 1500h-0700h shifts, violating TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.*" 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.

Call for Immediate Intervention to Protect Patients

We want to be clear that this list is by no means exhaustive and be assured they represent a mere snapshot of what have become daily occurrences throughout the units at Framingham Union Hospital. These conditions are abhorrent by any medical or nursing standard and the nurses of Framingham Union Hospital are both outraged and overwhelmed by the suffering they have endured.

As an organization, the MNA represents nurses and health care professionals working in 70 percent of the state's acute care hospitals, and we can state without equivocation or hyperbole that the conditions at Tenet owned facilities 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. We would also request an opportunity for the DPH Commissioner to meet with some of the frontline nurses at both facilities to hear their reports first-hand, as we were concerned to see the Commissioner be quoted in communications authored by two legislators, engineered by Tenet's local lobbying firm, that indicated the care was safe at St. Vincent Hospital despite numerous past complaints and significant testimony contrary to that portrayal.
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,

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