

# **PATIENT CARE ISSUES REPORT**

**St. John's Health Center, Santa Monica, CA  
Version 1, February 26, 2009**



# Introduction

---

This first Saint John's Patient Care Issues Report was compiled entirely from direct, first-hand written and oral reports of staff RNs currently employed in direct patient care at Saint John's Health Center in Santa Monica, CA. The report was compiled with assistance from registered nurses with California Nurses Association's Nursing Practice Department and Joint Nursing Practice Commission.

Where possible, RNs' written reports have been included, though they may have been edited. Initial and final drafts of this report were reviewed for accuracy by the reporting RNs. All incidents reported herein are believed to be not only accurate in their particulars, but also representative of common or typical assignments, practices, or policies. The report contains no personally identifiable patient information. All reporting is consistent with HIPAA guidelines.

All Saint John's staff RNs should be commended for their commitment to the safety of their patients and for having taken seriously the duty placed on them by California state law to affirmatively act on their concerns.

As stated in the accompanying cover letter, we ask St. John's' management to take this Report seriously, to contact us *immediately in writing* as to any and all specific portions management believes are or may be in any way inaccurate, and to communicate back to us within 10 days of receipt of the report the Hospital's responses to and planned corrective action to remediate problems identified in this Report.

## California Code of Regulations. §1443.5(6)

*An RN is expected to:*

---

**Act as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client...**

---



# Table of Contents

<b>Introduction</b> .....	3
California Code of Regulations. §1443.5(6) .....	3
<b>Postpartum/Couplet Care</b> .....	7
Support Staff Levels .....	7
Scope of Practice.....	8
Reference: AGOG Guidelines (required by Title 22, the Nursing Practice Act) .....	8
Reference: RN Scope of Practice.....	8
Charge Nurse Unavailability.....	9
Disruption in Care to Accommodate Wealthy So-Called “VIPs” .....	10
<b>GYN</b> .....	11
<b>Nursery</b> .....	12
Failure to Correct Previously-Cited Deficiencies.....	13
Competency Ignored.....	13
Reference: Current Competency, Statutory Requirement .....	13
<b>Labor and Delivery (L&amp;D)</b> .....	15
Staffing Ratios .....	15
Working Conditions Suffer from Neglect and Poor Workflow Design.....	16
Reference: Perinatal Equipment and Supplies .....	16
Competency Ignored.....	17
Reference: RN Competency .....	18
Reference: Competency in the Nursing Context .....	19
Inadequate Orientation .....	20
<b>Neonatal Intensive Care Unit (NICU)</b> .....	21
Insufficient Meal and Break Relief.....	21
Reference: CA Dept. of Public Health Summary Statement of Deficiencies.....	21
Reference: ACOG Staffing Requirements .....	23
<b>Intensive Care Unit (ICU)</b> .....	24
No Reported Deficiencies .....	24
<b>Emergency Room (ER)</b> .....	25
Staff Not Supported by Management.....	25

Fast Track .....	25
Staffing Ratios .....	25
Reference: ER Ratios .....	26
Reference: ED Guidelines.....	27
Working Conditions Suffer from Neglect and Poor Workflow Design.....	28
Reference: Availability of Supplies in ER.....	28
<b>Telemetry &amp; Step-Down</b> .....	29
Charge Nurse Should Not be Included in the Ratio .....	29
<b>Medical-Surgical (Med/Surg)</b> .....	31
Patient Acuity Ignored .....	31
<b>Orthopedics (Ortho)</b> .....	32
Acuity Ignored.....	32
Reference: Definition of Specialty Care Unit .....	33
<b>Oncology</b> .....	34
Late Compliance with Long-Standing Regulations.....	34
Insufficient Support Staff Levels .....	34
Scope of Practice.....	34
Reference: Scope of Practice .....	35
<b>Surgical Services</b> .....	36
<b>Operating Room</b> .....	37
<b>Post Anesthesia Care Unit</b> (PACU)      (Recovery Room) .....	38

# Postpartum/Couplet Care

---

## Support Staff Levels

Lack of adequate levels of support staff are a particular concern in Postpartum. While RN-to-patient staffing ratios demand attention, non-RN staff levels, including certified nurses aide staffing, are also important for patient safety.

RNs are concerned that these staffing levels are insufficient to provide the proper level of care.

Title 22 Section 70217 states, "Staffing for care not requiring a licensed nurse is not included within these ratios and shall be determined pursuant to the patient classification system."

The patient classification system should provide that patients who are not normal healthy mothers and normal healthy newborns require more care. Additional staff must be provided according to the patient classification system. This could be the addition of a secretary to answer the telephone and perform clerical duties, LVNs and/or nursing assistants or aides to provide comfort care to the mother and infant.

Examples of mothers who require more care and thus additional staffing are those who are recovering from a cesarean section. Post-operative patients require additional nursing care. New mothers, who are diabetic, asthmatic, have any chronic condition, have an infection, have additional teaching and/or psychosocial needs require additional staff.

In September, 2008 management began to cancel secretaries and aides for entire shifts. This tends to occur when census is low. Although there may be fewer patients, RNs are also sent home, meaning that the remaining RNs have the maximum number of patients allowed and are in no position to assume the roles of secretaries and aides (such as processing admissions or answering phones) in addition to nursing responsibilities. This practice amounts to a decrease in care provided to patients.

Only one nursing assistant is assigned to the unit regardless of the number of patients, or their needs. Some patients are physically heavy and require the assistance of two or more people to get out of bed.

Each nurse in Postpartum is generally assigned the maximum allowed, four couplets. This is eight patients: four mothers and four babies. Depending on the severity of coexisting conditions the RN may be assigned to fewer patients.

However, St. John's does not count the mother and baby as separate individuals for the purpose of the Evalysis (computerized patient classification system) tool. For eight patients

assigned to each nurse only four tools are used. There are no instructions for the use of an acuity tool for the baby. Because inaccuracy is a feature of the system, it is literally impossible to provide staffing by acuity (severity of illness) while following the system.

## **Scope of Practice**

All patients in an acute care setting must be assigned to a registered nurse. However, at Saint John's, a licensed vocational nurse (LVN) is given independent patient assignments of up to four couplets. While the LVN is described as an excellent, experienced LVN, the LVN license does not allow independent practice, and every LVN must be supervised by a registered nurse. There is no flexibility in the law for this kind of assignment, which puts patients and the LVN's license at risk.

RNs are required to "co-sign" the charting of the LVN, meaning that the "co-signing" RN assumes responsibility for charting that was done by another individual, and outside of that individual's scope of practice. There is no legal or clinical justification for this practice. The LVN is a licensed nurse and is responsible for her own charting. Unless the RN was side by side with the LVN the RN cannot "validate" the charting of the LVN.

## **Reference: AGOG Guidelines (required by Title 22, the Nursing Practice Act)**

*"A licensed practical nurse (LVN in California), supervised by a registered nurse, may provide support to the mother and attend to her personal comfort."*

*A suggestion would be to have the LVN assistive to an RN assigned to high acuity patients.*

*If no LVN is available to assist the RN, the RN would be assigned to fewer patients (two or three couplets, depending on patient acuity, in order to provide safe, effective, therapeutic care to patients with increased nursing care needs).*

---

## **Reference: RN Scope of Practice**

*Title 22, which licenses the hospital states in Section 70215, Planning and Implementing Patient Care:*

---

(a) A registered nurse shall directly provide:

(1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings

documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.

(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.

(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.

(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.

---

## **Charge Nurse Unavailability**

The Postpartum charge nurse is often also the break nurse, which may divert the charge nurse from other duties for at least three hours. The charge nurse might also go to the first floor to break a GYN nurse thereby leaving the Maternal Child Health floor (4<sup>th</sup> floor). Nurses are frequently out of ratio while “covering” other nurses for breaks, deliveries, epidurals and procedures.

Frequently the charge nurse is providing break relief while attempting to perform charge nurse duties such as scheduling and staffing. According to Title 22 Section 70217, Nursing Service Staff, when a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio.

Charge nurses are frequently away from the unit and unavailable by phone while attending administrative meetings. These charge nurse meetings are often in locations that are not announced to the staff. Charge nurse absences from the unit have increased during recent months.

Continuous patient safety requires that the charge nurse is available for clinical supervision and coordination to the unit.

This chronic understaffing is unsafe and interferes with the RNs' responsibility to provide ongoing assessment, evaluation and timely therapeutic intervention resulting in potentially dangerous delays in treatment and poor patient outcomes.

### **Disruption in Care to Accommodate Wealthy So-Called "VIPs"**

On more than one occasion, management has shown a willingness to disrupt patient care, even going so far as to transfer patients into unsafe environments, in order to please a single, wealthy patient.

Management cleared seven rooms that are used for Postpartum patients to accommodate a single patient and entourage. Mothers and their newborn babies were then housed in the ICU, despite serious infectious disease issues and other concerns. ICU patients were in turn cared for in the ER.

There is no clinical justification for playing musical chairs with patients in this fashion.

Staff RNs tried to object but were thwarted by management.

Supervisors with RN licenses who abetted this scheme violated their duty to object:

According to the Standards of Competent Performance, Title 16 Section 1443.5(6), a competent registered nurse:

Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client.

# GYN

---

The GYN unit, which houses women Oncology patients, is staffed primarily by a group of Postpartum RNs, and occasionally by CSS1 (Oncology) and registry RNs. The RNs do not complain that they have not been properly oriented to the unit, or that they lack current competency, given the consistency and frequency of their assignments there.

The RNs do, however, object to the consistent failure to staff by acuity and the isolation and lack of support in the GYN unit.

Providing additional staff for the acuity is very important for GYN patients, who are particularly high-acuity patients due to the nature of their surgeries. For example, “flap” patients have undergone massive reconstructive surgery following breast removal to treat cancer. Fat, muscle and skin are removed from the abdomen and attached to the chest wall to create a new breast. The tissue is highly susceptible to infection, and requires frequent monitoring of the temperature and other data. Highly attentive, specialist nursing care is needed to ensure flap survival.

Very frequent ongoing assessment is required to ensure the tissue doesn’t die. The appearance, temperature, and cleanliness of the area are imperative. A change in coloration or temperature of the flap can indicate decreased circulation. Drainage or redness can indicate infection.

If either is discovered in a timely manner the RN can intervene or notify the surgeon to prevent the tissue from dying. This can lead to painful necrosis, gangrene, draining wound, and bleeding. The patient is left with an unsightly scar after much pain and suffering.

RNs have not reported incidents resulting from failure to staff by acuity – yet. But they have reported close calls, when RNs have not had time to perform all the necessary checks on five patients. Luckily patients did not suffer tissue death.

Management has been notified, and is therefore accountable for any adverse consequences resulting from the failure to staff by acuity.

# Nursery

---

When the Nursery is not staffed according to safety guidelines, newborn babies are put at risk.

In 2008, RNs reported multiple incidents of unsafe staffing that caused them to be concerned.

During one incident, one RN was the only person assigned to the Nursery. By law, at least two nursing staff must be present in the Nursery, at least one of whom is a registered nurse who has had training and experience in neonatal nursing.

At the start of the shift the census consisted of two babies undergoing phototherapy (bili light).

Three babies were admitted to the Nursery immediately after birth. No additional assistance was provided. No secretary was assigned, resulting in the RN being forced to assume additional duties in addition to the direct patient care assignment.

Direct assessment and newborn care needs precluded timely documentation and computer admitting work. The telephone rang constantly, and the RN had to stop and answer the phone in case of test results or other clinical necessities.

Phototherapy babies could not be fed on time due to the immediate needs of the recently born infants.

The RN was assigned to five patients without assistance. By law, the maximum patient assignment allowed for the most stable recently born infants and those requiring close observation is four patients. This assignment was illegal and unsafe. Unfortunately, it is not atypical.

During another incident, there was only one RN assigned to the Nursery, and no other staff. There were seven deliveries that night. The RN attempted to perform all initial assessments and baths, perform all admitting documentation and orders, and care for babies whose mothers wanted them in the Nursery.

Title 22 of the California Code of Regulations contains the regulations the hospital must comply with as a condition of licensure. Title 22 Section 70547, Perinatal Unit General Requirements, states that there must be written policies and procedures developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. These policies and procedures shall reflect the standards and recommendations of the American College of Obstetricians and

Gynecologists (ACOG) "Standard for Obstetric-Gynecologic Hospital Services," and the American Academy of Pediatrics "Hospital Care of Newborn Infants."

Newborn babies must be staffed as one RN to four or fewer recently born infants (transition babies) and those requiring close observation. This includes any infant requiring a bili light, babies with a fever, respiratory issues, feeding, or other signs and symptoms requiring closer observation than a normal healthy infant. The assessment of the registered nurse determines when a recently born infant no longer requires close observation.

These situations have been reported to nursing management. The RNs suggested that additional staff needs to be planned when patients are in labor and when babies are cared for in the Nursery.

### **Failure to Correct Previously-Cited Deficiencies**

Staffing problems in the Nursery are not new. In 2004, Saint John's was cited by the California Department of Public Health for failing to maintain and implement required policies and procedures. The "Statement of Deficiency" included that Nursery staff RNs had to relieve each other for breaks, further exceeding their nurse-to-patient ratio requirement.

### **Competency Ignored**

Recently a nurse on light duty was assigned to the Nursery despite the fact that the Nursery was not her specialty. Although the nurse had current competency in her particular specialty, she was neither educated in nursery nursing, nor was she oriented to the department, nor did she have experience in the assessment and nursing care of newborn babies, nor had she taken neonatal resuscitation, as is required for a nursery nurse.

Concerned for patient safety, the charge nurse objected to the manager that this particular nurse lacked the proper competency validation. The manager replied, "She's a body."

While management may prefer to treat RNs as interchangeable regardless of specialty, experience and competencies, this practice is illegal and unsafe, and potentially jeopardizes not only patient care, but also the licensure of RNs whom management assigns outside of the RNs' competency.

### **Reference: Current Competency, Statutory Requirement**

*Title 22 Section 70217 states in the second paragraph, "No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and*

***procedures of the hospital shall contain the hospital's criteria for making this determination.”***

---

Babies are routinely at risk due to Saint John's failure to comply with applicable laws and regulations. It is likely that these practices also violate Saint John's own policies and procedures, given that as recently as August, 2004, the policy and procedures manual for Newborn Nursery stated that RNs will not be assigned to more than seven patients at a time. This is according to a Department of Public Health Statement of Deficiencies and Plan of Correction faulting Saint John's for violating this very policy.

# Labor and Delivery (L&D)

---

## Staffing Ratios

Safe staffing ratios are ignored as a matter of routine practice in L&D.

The American College of Obstetricians and Gynecologists (ACOG) requirement to staff patients in the second stage of labor or initiation of epidural anesthesia as 1:1 is not met. This failure to provide safe staffing could lead to a “failure to rescue”. The mother and/or baby could suffer complications, including disability or even death, which is why California regulations require a competent registered nurse to be present at all times.

Clearly, patients in the second stage of labor **must** be staffed as one RN for one patient (1:1). A second RN must be available for the assessment and stabilization of the newborn baby.

Registered nurses have reported that when they call the supervisor to request meal and break relief, she tells them to “take a break and find someone to cover you.” The term “cover” indicates that RNs are expected to take responsibility for two nursing assignments at once. However, these “double” assignments almost invariably cause the “covering” nurse to take responsibility for an assignment that exceeds the maximum allowable patient ratio.

An RN informed the supervisor that she had four patients on Pitocin drips (the maximum legal assignment for a woman in active labor is two patients per RN) and that the RN cannot abandon her patients because they require continuous monitoring with ongoing assessments. Abandoning the patients would have placed mothers and their babies at risk of suffering preventable complications.

St. John’s allows a registered nurse to be assigned to twice the number of patients allowed by law and expects RNs to leave their patients with already-overburdened colleagues in order to take a break.

L&D nurses report that when one of their patients has to be transported to the operating room for an emergency Cesarean section, an unqualified, non-L&D-competent charge nurse is placed in a position of having to assume responsibility for the transporting RN’s other laboring patients. This includes ongoing assessment, including fetal monitoring, and interventions. The charge nurse on nights in the Labor and Delivery unit is often a Postpartum nurse who, although she is a caring and competent Postpartum nurse, does not have the **current** clinical competencies and certifications required of Labor and Delivery RNs. These competencies and certifications include Advanced Fetal Monitoring, NRP, PALS, and ACLS.

This is a dangerous and unsafe practice and places patients at risk, and may subject the license of the registered nurse to discipline.

## **Working Conditions Suffer from Neglect and Poor Workflow Design**

Staff nurses report that mothers who are in labor are exposed to unsafe conditions when the hospital Labor and Delivery unit is full. Rather than divert patients, women in active labor have been placed on labor beds in small, inadequately stocked rooms. These rooms are called “labor rooms,” although they are significantly smaller than the standard labor rooms, and are not set up to adequately deliver care because they lack neonatal resuscitation. The delivery cubicles also lack basic equipment, including warmers, readily available IV fluids, linen, privacy curtain, emergency phone and trash can. Moreover, there is inadequate room for a team to handle an obstetrical emergency.

### **Reference: Perinatal Equipment and Supplies**

*Title 22 Section 70551 requires the following equipment and supplies:*

---

- (a) General equipment shall include at least the following:**
  - (1) Amniocentesis tray.**
  - (2) DC defibrillator immediately available.**
  - (3) Blanket warmer.**
  - (4) Solutions and supplies for intravenous fluids, blood, plasma and blood substitutes or fractions.**
- (b) A fetal heart rate monitor should be available.**
- (c) Labor rooms shall contain at least the following equipment:**
  - (1) Oxygen and suction outlets.**
  - (2) A labor bed with adjustable side rails.**
  - (3) Foot stool.**
  - (4) One or more comfortable chairs.**
  - (5) Handwashing facilities.**
  - (6) Toilet and handwashing facilities shall be in or immediately adjacent to labor room and shall be shared by no more than two patients.**
  - (7) Adjustable examination light.**
  - (8) Sphygmomanometer.**
  - (9) Regular and fetal stethoscope.**
- (d) Delivery rooms shall have at least the following equipment:**
  - (1) Adjustable delivery table.**
  - (2) Surgical light.**
  - (3) Equipment for inhalation anesthesia and regional analgesia.**
  - (4) Clock with sweep second hand.**
  - (5) An elapsed time clock.**
  - (6) Emergency supplies such as packings, syringes, needles and drugs.**
  - (7) Emergency call button.**
  - (8) Provision for oxygen and suction for mother and infant.**

- (9) Thermostatically controlled incubator or radiant heating device.
  - (10) Sterile one percent silver nitrate and irrigating solutions for prophylactic Crede treatment of the eyes.
  - (11) Sterile clamps or ties for umbilical cord.
  - (12) Resuscitation equipment and supplies to include at least:
    - (A) Glass trap suction device with catheter.
    - (B) Pharyngeal airways, assorted sizes.
    - (C) Laryngoscope, including a blade for premature infants.
    - (D) Endotracheal catheters, assorted sizes with malleable stylets.
    - (E) Arterial catheters, assorted sizes.
    - (F) Ventilatory assistance bag and infant mask.
    - (G) Bulb syringe.
    - (H) Stethoscope.
    - (I) Syringes, needles and appropriate drugs.
- Title 22 Section 70553 requires that delivery rooms must be provided which are used for no other purpose.
- 

*Delivery rooms must have a minimum floor area of 30 square meters (324 square feet) with no dimension less than 5.5 meters (18 feet).*

---

## **Competency Ignored**

Two of the night shift charge RNs do not have current, validated competency in Labor and Delivery. This in and of itself is not necessarily a problem, provided that the RNs are not given a direct patient care assignment in L&D. The Department of Public Health has clearly established that RNs must have current, validated competency for all patient care assignments, including break relief.

Saint John's management, however, routinely expects these individuals to be assigned to direct patient care while other RNs are on break. This practice violates the legal requirement that RNs assigned to direct patient care for any length of time have current, validated competency in the nursing specialty to which they are assigned.

One night one of these charge nurses admitted a patient and placed the fetal monitor. She did not interpret the fetal heart rate (FHR), assess the patient or document. Oncoming day shift RNs report that this charge nurse informed them that the patient was occupying a bed in the unit, but that none of the admitting paperwork was done. No assessment of the patient was documented and no assessment and evaluation of the fetal monitor tracing was provided, although the patient has been in the hospital for up to an hour or more.

Management is informed and aware of these ongoing, unsafe practice concerns.

According to the nursing process standards, an RN shall directly provide the initial assessment, ongoing assessments and document ongoing care of a patient admitted to a patient care area as indicated by physician's orders or nursing standards.

An RN who acts as a clinical supervisor must have current, demonstrated, validated competencies for the provision of care to patients specific to the assigned unit.

The Board of Registered Nursing holds the individual registered nurse accountable for determining his or her competency when accepting a patient care assignment. A nurse who accepts an assignment for which he or she is not competent, places patients at risk of harm, and their license is subject to discipline and/or revocation for unprofessional conduct.

Management indifference to competency standards also extends to the practice of periodically staffing the maternity recovery room with RNs who are not ACLS certified. RNs who wish to object to the assignment are told they cannot refuse the assignment, and are essentially put in the impossible situation of choosing between their jobs and their licenses.

### **Reference: RN Competency**

*Title 22 Section 70217 states:*

---

**No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination.**

---

*Title 22 Section 70215 states:*

---

**A registered nurse shall directly provide:**

**Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.**

**(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.**

**(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any**

assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.

(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.

(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.

(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.

---

*Title 22 Section 70217 states:*

---

No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination.

---

*According to the Nursing Practice Act, Title 16, Section 1443.5 an RN can only assign, delegate, or transfer responsibility and accountability for the provision of patient care to other care givers based on their legal scope of practice, license, certification, and validated competency.*

---

## **Reference: Competency in the Nursing Context**

*Competence is typified by the nurse who has been on the job in the same or similar situations two or three years. This RN is able to analyze and synthesize observations and data to perform the nursing process as outlined in the "Standards of Competent Performance".*

*A competent Registered Nurse is accountable to the patient and shall directly provide, according to the Nursing Practice Act, Article 2, Section 2725 (b)(4):*

---

...[O]bservation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

---

*Only registered nurses with current, validated competency for the provision of care to patients in a specific clinical area may be counted for the purposes of calculating the hospital's adherence to mandated, minimum nurse-to-patient ratios.*

---

## **Inadequate Orientation**

Registered nurses report that they are concerned that management's failings impair Saint John's ability to recruit and retain new staff. RNs report that Saint John's does not provide adequate orientation or competency validation for new RNs, and that consistent preceptors are not provided. In addition, management neglects to provide sufficient numbers of present and available clinical back-up resource nurses to provide ongoing support for new hires, new graduates, and those new to the particular nursing specialty.

Nursing management has been notified. Therefore management, not the nursing staff, is accountable for any adverse effects on patient care due to the lack of required equipment or to unsafe staffing.

# Neonatal Intensive Care Unit (NICU)

---

## Insufficient Meal and Break Relief

NICU suffers from unsafe staffing, including an overall lack of a coherent plan for meal and break relief, punctuated by severe lapses in judgment by management that potentially jeopardize patients and staff.

Although the ratios law has been in place for years, it was only recently after several months of union organizing that management implemented a break nurse policy that is beginning to move the department towards ratios compliance.

NICU is not immune from support staff shortages in other units. Since the NICU and Postpartum secretary scheduling was cut recently, NICU and Postpartum have had to share a secretary. The secretary's workload has not decreased, but more responsibility has shifted to RNs who are already responsible for full patient assignments.

Unsafe staffing is not a new phenomenon in the Saint John's NICU. In 2004 the California Department of Public Health issued a citation against Saint John's for a violation of its responsibility. The "Statement of Deficiency" stated, "The facility failed to ensure the staffing ratio was maintained in the newborn intensive care unit (NICU). See below:

## Reference: CA Dept. of Public Health Summary Statement of Deficiencies

NAME OF PROVIDER OR SUPPLIER	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DATE SURVEY COMPLETED
SAINT JOHN'S HEALTH CENTER	T22 DIV5 CH1 ART3-70217(a)(1) Nursing Service Staff	C 08/10/2004

(1) The licensed nurse-to-patient ratio in a critical care unit shall be 1:2 or fewer at all times. "Critical care unit" means a nursing unit of a general acute care hospital which provides one of the following services: an intensive care service, a burn center, a coronary care service, an acute respiratory service, or an intensive care newborn nursery service. In the intensive care newborn nursery service, the ratio shall be 1 registered nurse: 2 or fewer patients at all times.

This Statute is not met as evidenced by: Based on observation, interviews, and review of assignment sheets and administrative documents, the facility failed to ensure the staffing ratio was maintained in the Newborn Intensive Care Unit (NICU).

While unsafe staffing is not new in the NICU, it took a shocking turn during one 24-hour period in 2009.

Originally three RNs were scheduled, but management failed to secure coverage when approving a schedule change for one of the RNs. One of the remaining RNs called in sick. Management was reportedly “unable” to find additional staff or outside registry RNs to work the shift, so management required two RNs from the previous shift to work an additional 12 hours, causing them to work continuously for 24 hours. The RNs reported that they were scared of the long drive home without sleep, and their colleagues are glad that they got home safely, and that no serious incidents occurred during the extra shift.

Department policy, consistent with past practice, requires that Maternal Child Health Director Irina Zuanic provide explicit approval of overtime staffing. Therefore, it is inconceivable that Ms. Zuanic was not aware of the situation. Being a NICU RN, Ms. Zuanic could have come in and assisted the staff. However, during this incident, which happened to occur on a Saturday night, Ms. Zuanic chose not to come to work to assist the staff RNs who were required to work 24 hours straight.

Reference: ACOG Staffing Requirements

*Guidelines for*  
**Perinatal Care** Fourth Edition

American Academy  
of Pediatrics



The American College  
of Obstetricians  
and Gynecologists



**Table 2-1.** Recommended Nurse/Patient Ratios for Perinatal Care Services

Nurse/Patient Ratio	Care Provided
<b>Intrapartum</b>	
1:2	Patients in labor
1:1	Patients in second stage of labor
1:1	Patients with medical or obstetric complications
1:2	Oxytocin induction or augmentation of labor
1:1	Coverage for initiating epidural anesthesia
1:1	Circulation for cesarean delivery
<b>Antepartum/postpartum</b>	
1:6	Antepartum/postpartum patients without complications
1:2	Patients in postoperative recovery
1:3	Antepartum/postpartum patients with complications but in stable condition
1:4	Recently born infants and those requiring close observation
<b>Newborns</b>	
1:6-8*	Newborns requiring only routine care
1:3-4	Normal mother-newborn couplet care
1:3-4	Newborns requiring continuing care
1:2-3	Newborns requiring intermediate care
1:1-2	Newborns requiring intensive care
1:1	Newborns requiring multisystem support
1:1 or greater	Unstable newborns requiring complex critical care

\* This ratio reflects traditional newborn nursery care. If couplet care or rooming-in is used, a professional nurse who is responsible for the mother should coordinate and administer neonatal care. If direct assignment of the nurse is also made to the nursery to cover the newborn's care, there may be double assigning (one nurse for the mother-neonate couplet and one for just the neonate if returned to the nursery). A nurse should be available at all times, but only one may be necessary, as most neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by ancillary personnel under the nurse's direct supervision. Adequate staff are needed to respond to acute and emergency situations.

# Intensive Care Unit (ICU)

## No Reported Deficiencies

Expert critical care RNs at Saint John's report that there are no significant deficiencies that warrant reporting.

On some shifts, the unit is staffed with many registry RNs who, despite lacking staff positions at Saint John's, are scheduled at Saint John's consistently enough that they are competent and familiar with Saint John's policies and procedures. Because these RNs are excellent clinicians, Saint John's RNs would prefer that these shifts not be outsourced to registry agencies, but rather that the RNs be brought on staff.

# Emergency Room (ER)

---

As part of St. John's marketing strategy, they advertise and promote "Fast Track" Emergency Room care services. However, the Emergency Room staffing is unsafe. The workflow design, placement of supplies, availability of medications, IV solutions, and properly working monitors result in treatment delays that are potentially life threatening.

Although the ER is not a designated level one trauma center, it is a high volume, high acuity unit that treats a significant number of patients with chest pain, abdominal pain, traumatic accidents, injuries, and emergent MI (heart attack) and stroke patients.

## **Staff Not Supported by Management**

RNs report that they and some of their colleagues do not have current, validated competency in all of the specialties required of ER nurses. Management is not providing RNs with proper orientation or training to all specialties, forcing RNs to seek training elsewhere despite Saint John's having the resources and personnel to provide the training in-house.

## **Fast Track**

The concept of Fast Track is poorly implemented and the staff RNs report that the advertisement of such services is for marketing and is misleading and falsely reassuring to the public. Management does not maintain a uniform protocol for Fast Track implementation, or, if such a protocol exists, management has failed to orient staff to the protocol. Chronically ill patients from nursing homes are accepted as interfacility transfer patients for admission to inpatient beds, when there is not a ready bed yet available for them on the Medical/Surgical ward. These patients are then held in the ER on a gurney, at times for extended periods, in the so-called Fast Track bays until a bed becomes available. The policy of combining true emergencies with less severe cases results in the distraction and diversion of staff from true emergency cases in Fast Track.

## **Staffing Ratios**

There may be unavoidable emergencies from time to time that will impair compliance with staffing ratios in the ER. However, chronic unsafe staffing points to a failure to consistently anticipate staffing needs. In the Emergency Department, management must plan for emergencies.

RNs report that it is not uncommon to be assigned to 4 high acuity patients at once without assistance, which has resulted in potentially preventable complications from delay of treatment.

The assignments have included two patients who were to be admitted to ICU, a patient awaiting emergency heart catheterization, a patient requiring immediate abdominal surgery, and a patient with classic symptoms of acute MI. The RN reported the "hot" (evolving) MI patient with crushing substernal chest pressure and pain that radiated to the back, had been brought back to a monitored gurney to wait, untreated for pain, while completing documentation. A physician was summoned from the "Fast Track" bay where the waiting room triage nurse had directed an ambulance crew to place a chronically ill, non-emergent patient.

An RN reported the MI patient was finally interviewed and being charted on by the physician after 30 minutes. The RN requested orders for morphine and IV but was called away to prep another patient for surgery. No IV was placed. The patient then went into ventricular fibrillation, a lethal arrhythmia, and a code blue was called and CPR was begun. The physician delivered an unsuccessful pre-cordial thump while awaiting someone to bring the defibrillator. The patient was then intubated; IV access was established and was successfully resuscitated. Approximately an hour and a half later the patient was able to be transported to the Cardiac Cath lab for an emergency stent placement.

A common phrase in emergency care regarding chest pain is, "time is muscle." When a patient is having a heart attack the pain means heart muscle is dying. The code blue was almost certainly preventable. There is a high probability that the delay caused permanent damage to the patient.

Inadequate staffing levels have led to repeated occurrences of delay in care for patients with impending respiratory arrest. Saint John's allows these conditions to persist, despite having been cited 4 ½ years ago by the U.S. Department of Health and Human Services for what appears to be delaying care for a patient with impending respiratory arrest.

According to publicly available records, on August 30, 2005, a patient who was diagnosed as "normal" in the Saint John's ER was transported to a second facility by EMTs "for indeterminate reasons." The DHHS investigation found that "there was no documentation or other direct evidence to confirm that [Saint John's] performed a screening examination as required by regulation."

## **Reference: ER Ratios**

*According to Title 22, section 70217, Nursing Service Staff:*

---

**(a) Hospitals shall provide staffing by licensed nurses, within the scope of their licensure in accordance with the following nurse-to-patient ratios.**

---

**(a)(8) ...When licensed nursing staff are attending critical care patients in the emergency department, the licensed nurse-to-patient ratio shall be 1:2 or fewer critical care patients at all times. A patient in the emergency department shall be considered a critical care patient when the patient meets the criteria for admission to a critical care service area within the hospital.**

**Only registered nurses shall be assigned to critical trauma patients in the emergency department and a minimum registered nurse-to-critical trauma patient ratio of 1:1 shall be maintained at all times. A critical trauma patient is a patient who has injuries to an anatomic area that: (1) require life saving interventions, or (2) in conjunction with unstable vital signs, pose an immediate threat to life or limb.**

---

Risky assignments like this can be avoided if management were to provide safe staffing, standing orders, adequate equipment and medicines, and a general, coherent plan for the ER, including inservices for staff and physicians.

## **Reference: ED Guidelines**

***The Agency for Healthcare Research and Quality (AHRQ) is a federal agency under the Department of Health and Human Services. AHRQ guidelines include:***

***Patients whose chest pain symptoms are suggestive of serious illness need immediate assessment in a monitored area of the emergency department (ED) and early therapy to include an intravenous (IV) line, oxygen, aspirin, nitroglycerin, and morphine.***

***Triage and management of patients with chest pain and unstable angina must be based on a validated risk assessment system (i.e., American College of Cardiology/American Heart Association [ACC/AHA] criteria).***

***Patients with high-risk features need to be identified quickly and treatment instituted in a timely fashion.***

***Thrombolysis should be instituted within 30 to 60 minutes of arrival, or angiogram/primary percutaneous coronary intervention (PCI) should be performed within 90 minutes of arrival with a target of less than 60 minutes. (Annotations #43, 45)***

***Use of medication: aspirin and clopidogrel (Plavix®) (or clopidogrel alone if aspirin allergic) at admission. (Avoid clopidogrel if cardiac surgery is anticipated.) Beta-blockers whenever possible and/or angiotensin-converting enzyme (ACE) inhibitors at 24 hours if stable, nitrates (when indicated), and statins whenever***

*possible. Once the issue of surgery is clarified, consider the early use of clopidogrel for those in whom PCI is planned.*

---

## **Working Conditions Suffer from Neglect and Poor Workflow Design**

Management has failed to ensure that the Pyxis supply of medications and IV fluids are optimally-stocked or located to facilitate rapid intervention, and this limited supply places patients at risk. The ER has 16 bays, four of which do not have cardiac monitoring capability. Most of the monitors are aged with faded, poorly visible oscilloscope tracings that preclude accurate EKG arrhythmia and ST segment monitoring and assessment. The automatic blood pressure function on the old monitors is unreliable. There is only a limited number of working manual blood pressure cuffs that are not always readily available.

The ER RNs report that common antibiotics for treatment of community acquired or hospital acquired pneumonia is not readily available in the ER Pyxis. Lactated Ringers IV solution, often used for fluid resuscitation of dehydrated patients or volume replacement for patients in shock, is not stocked in the ER. D10/W is not routinely stocked in the ER, a solution commonly used for hypoglycemic diabetic patients. RNs must make a copy of orders and send a copy by pneumatic tube to the pharmacy. Tube station is approximately 40 steps away from the patient care area, and this interferes with the RN responsibility to provide ongoing direct observation, assessment, and implementation of emergency treatment of patients. This is unacceptable and unsafe.

RNs report that the turn around time from order, to request, to receipt of needed antibiotic medication can be as long as one to one and one half hours routinely. Requests for additional registered nurse and ancillary staff, appropriate supplies of IV fluids and medications, and request for updated, properly working monitors and equipment have been reported to management.

### **Reference: Availability of Supplies in ER**

*Title 22 Section 70415, Basic Emergency Medical Service, Physician on Duty, Staff requires that equipment and supplies necessary for life support must be available, including but not limited to, airway control and ventilation equipment, suction devices, cardiac monitor defibrillator, pacemaker capability, apparatus to establish central venous pressure monitoring, intravenous fluids and administration devices.*

---

Unsafe staffing levels and other risky policies at St. John's Emergency Room continue to pose a risk to the health and safety of patients. Management has been notified, therefore hospital management, not the nursing staff, is responsible for any adverse effects on patient care.

# Telemetry & Step-Down

---

This unit generally staffs safely and according to Title 22 regulations.

"Telemetry unit" is defined in Title 22 as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals. The nurse-to-patient ratio in a telemetry unit must be 1:4 or fewer at all times. This unit is generally staffed appropriately.

A "step down unit" is defined as a unit which is organized, operated, and maintained to provide for the monitoring and care of patients with moderate or potentially severe physiologic instability requiring technical support but not necessarily artificial life support. Step-down patients are those patients who require less care than intensive care, but more than that which is available from medical/surgical care. "Artificial life support" is defined as a system that uses medical technology to aid, support, or replace a vital function of the body that has been seriously damaged. "Technical support" is defined as specialized equipment and/or personnel providing for invasive monitoring, telemetry, or mechanical ventilation, for the immediate amelioration or remediation of severe pathology.

On this unit patients requiring mechanical ventilation (respirators), post-operative patients requiring cardiac monitoring, and other patients not in a stable condition are usually staffed at 1:3.

## **Charge Nurse Should Not be Included in the Ratio**

However, when patients require a 1:3 ratio, this is often achieved by assigning a patient to the charge RN for a portion of the shift, and at times for the entire shift. This direct patient care assignment makes the charge nurse unavailable to provide support to the staff and makes it difficult for the charge RN to complete his or her charge nurse duties.

This is why, when a charge RN is assigned to direct patient care for the purposes of meeting staffing ratios, the law assumes that the charge RN will only perform direct patient care and will not engage in charge nurse activities.

Title 22 Section 70217 states:

Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses, and other licensed nurses shall be included in the calculation of the licensed nurse-to-patient ratio only when those licensed nurses are engaged in providing direct patient care.

When a Nurse Administrator, Nurse Supervisor, Nurse Manager, Charge Nurse or other licensed nurse is engaged in activities other than direct patient care, that nurse shall not be included in the ratio.

The unit usually has four nursing assistants on the day shift. They assist with eight patients each. Sometimes there are only three assistants. Commonly this occurs on the night shift. Many patients are physically heavy so require two or more nursing staff to pull them up in bed, to turn, for baths, and to use the bedpan. Also many patients require two or more nursing staff to safely get out of bed into a chair or to walk.

Recently a break relief RN was assigned, alleviating the problem of ratio violations during meal and rest breaks. Nurses are generally able to provide the care their patients need, though on some shifts they worry about being injured when there isn't a second or third person to assist.

# Medical-Surgical (Med/Surg)

---

## Patient Acuity Ignored

The hospital does not assign additional staff in accordance with a documented patient classification system to meet the needs of each individual patient as required as a condition of Saint John's licensure (Title 22, Section 70217).

Disregarding the needs of patients the hospital assigns five patients per nurse consistently, with no adjustments to take into account patient acuity. Sometimes the patient's severity of illness, incapability for self-care, and need for increased teaching make it impossible for one RN to provide all required care.

For example, a patient was to be admitted to the Oncology unit requiring an insulin drip. The charge nurse pointed out that an insulin drip is not within the scope of service for that unit, the RN who would be required to admit the patient already had four patients, and was an inexperienced recently graduated nurse.

Next, the Med/Surg unit was notified they would be admitting the patient.

The charge nurse persuaded the supervisor not to admit the patient to Med/Surg either.

The use of an insulin drip is considered a critical care function. Generally there is a "Standardized Procedure" or protocol to adjust the amount of insulin every 30 minutes to one hour according to the patient's glucose level. It is necessary to test the glucose at least every hour when a sick or injured patient is receiving continuous insulin intravenously. These units have no policy because it is not part of their scope of service. No patient on an insulin drip should have to share his or her nurse with four other patients. The risk of hypoglycemia is too great.

Charge nurses were told they would have to admit this patient to their unit although to do so would have violated St. John's own policy.

# Orthopedics (Ortho)

---

## Acuity Ignored

The orthopedic unit regularly assigns each RN to five patients. This is the maximum number of patients allowed for a medical surgical unit. However, Ortho is a specialty unit, not medical/surgical, and must be staffed to a maximum ratio of one RN to four patients.

Management attempts to justify exceeding the specialty unit ratio by assigning five patients at the start of the day shift (7:00 a.m.) when one patient is expected to be discharged by 11:00 am. However, neither the law nor the needs of high-acuity patients make exceptions for “temporary” excessive patient care assignments.

Needless to say, given the starting point of maximum staffing that exceeds legal limits, additional staff according to the needs of patients is not provided. The Ortho RNs’ main concern is the failure to staff according to patient acuity, as required by law. A typical 1:4 assignment includes multiple high-acuity, complex day 1 back surgery patients that should be staffed lower than the maximum ratio.

Patient care has been adversely affected by insufficient staffing on the orthopedic unit.

When the RN is admitting a patient from surgery others must answer call lights and assist with that nurse’s other patients. Because the assisting nurse has her own assignment shortcuts may be taken. For example the patient may be given a bedpan rather than helped to the bathroom. Repositioning, pain assessments, and comfort measures are sometimes delayed because the nurse cannot be in two places at once.

A newly admitted patient requires the undivided attention of a registered nurse for 30 minutes to one hour. The Nursing Practice Act states that the planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and must be initiated by a registered nurse at the time of admission. Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy must be permanently recorded in the patient's medical record by the assigned registered nurse.

Discharging a patient is a focused process that cannot be rushed. When nurses are rushed, patient and family teaching is often incomplete. Nearly 18 percent of Medicare patients are readmitted to a hospital within 30 days of discharge. Research on care transitions suggests that as many as 20 to 30 percent of adverse events following discharge are preventable, and another 30 percent are ameliorable.

Admission and discharge documentation is necessarily time consuming, and can occupy the RN for a period of time after the patient is discharged. For the purpose of staffing within safe and legal ratios, a patient is considered to be assigned to a nurse until all documentation is complete, not when the patient is discharged. Saint John's management requires RNs to be assigned to new patients while the RNs are completing paperwork for recently-discharged patients.

At a minimum, management should begin to implement the 1:4 ratio consistently. In addition, assignments must account for patient acuity. RNs who are assigned to high-acuity patients, such as complex back surgeries, should be assigned to fewer than the maximum four patients.

## **Reference: Definition of Specialty Care Unit**

*In its "Final Statement of Reasons," supporting the specific RN-to-patient ratios, the Department of Health Services stated:*

---

**Specialty care units are often found in large, urban hospitals and academic medical centers serving unique patient cohorts. While "specialty care unit" is not currently a supplemental service or a licensing term, this is the generally understood meaning of the term. The specific specialties served by these units run the gamut from orthopedics to HIV/AIDS to metabolic transplants, and require more specialized skills and comprehensive care than is normally available in medical/surgical units. Minimum staffing, of course, will vary according to the needs of the patients, and will increase in response to the PCS. The most commonly found specialty care unit in California's hospitals is the oncology unit, and, therefore, that is the unit type that was included in the DHS on-site study.**

---

*Title 22 Section 70217 states, "Commencing January 1, 2008, the licensed nurse-to-patient ratio in a specialty care unit shall be 1:4 or fewer at all times."*

---

# Oncology

---

## **Late Compliance with Long-Standing Regulations**

Management only recently began staffing Oncology to the appropriate 1:4 ratio after a long-time Saint John's RN and CNA activist confronted CEO Lou Lazatin in late 2008 to put her on notice that staffing was consistently in excess of safe and legal limits.

However, this improvement may be short-lived. There is a plan for cancer patients to be admitted to different units. The nurse to patient ratio would be different also. Patients receiving chemotherapy would be assigned to an RN who has four patients. Other patients, who have cancer but are not being receiving chemotherapy, will be staffed at five patients per nurse.

The hospital has stated their opinion that a patient admitted to St. John's for a radical cancer surgery, such as a Whipple Procedure or for colon cancer surgery, will not be considered to be a cancer patient for the purpose of assigning sufficient nursing staff.

Title 22 Section 70217 states that the ratios shall constitute the minimum number of nurses who must be assigned to direct patient care.

## **Insufficient Support Staff Levels**

Additional staff in excess of these prescribed ratios, including non-licensed staff, must be assigned in accordance with the hospital's documented patient classification system for determining nursing care requirements, considering factors that include the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan, the ability for self-care, and the licensure of the personnel required for care.

Patients receiving blood and blood products, those in pain, with unstable temperature or blood pressure, and for many other reasons require additional staff. This does not happen on the Oncology unit at St. John's. Each RN is assigned the maximum allowed by law, without taking into account acuity.

## **Scope of Practice**

Sometimes an LVN is given a primary assignment. The LVN license is dependent on RN supervision. Every patient in an acute care hospital must be assigned to a registered nurse. (See Scope of Practice discussion under Postpartum.)

## Reference: Scope of Practice

*Title 22 Section 70215, Planning and Implementing Care, states:*

---

**(a) A registered nurse shall directly provide:**

**(1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.**

**(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation.**

**(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.**

**(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.**

**(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.**

**(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record.**

---

# Surgical Services

---

Currently, four registered nurses ensure that all tests, history and physical, and information recommended or required before elective surgery are available to the surgical team. These RNs do routine teaching and answer questions and concerns.

An example is a complete account of all prescription and over the counter medications and supplements. Any allergies are documented. The patient is interviewed and instructed regarding which medications should be continued and which should be stopped before surgery.

Another example is the requirement for an electrocardiogram (EKG) to be done. If it is abnormal a cardiology clearance should be done prior to elective surgery.

On top of these and other duties, RNs are expected to take on secretarial responsibilities because secretaries are understaffed.

Chronic understaffing becomes more severe at the end of the year, when a predictable rise in elective surgeries results from the clock running out on patients' insurance deductibles. Despite this consistent pattern, management makes no attempt to adjust staffing levels to adapt to the increased patient load.

RNs have stated that it is sometimes not possible to ensure all pre-operative information is elicited. Teaching is sometimes incomplete. At least once, a patient with an abnormal EKG has been operated on without a cardiology consult.

Despite the current practice of often rushing into elective surgery without proper preparation, management plans to begin experimenting in March, 2009 with decreasing the number of RNs from four to two. The number of procedures is not expected to decrease.

# Operating Room

---

The hospital appears to comply with the requirement that the surgical service operating room must have at least one registered nurse assigned to the duties of the circulating nurse and a minimum of one additional person serving as scrub assistant for each patient-occupied operating room. The scrub assistant may be a licensed nurse, an operating room technician, or other person who has demonstrated current competence to the hospital as a scrub assistant, but shall not be a physician or other licensed health professional who is assisting in the performance of surgery.

RNs report being concerned that the number of RN mentors is decreasing, and feel that, for our patients' safety, we need to work to retain as well as recruit competent nurses.

# Post Anesthesia Care Unit (PACU) (Recovery Room)

---

The PACU tends to be staffed appropriately. Most patients are staffed at two patients per RN. For ICU patients, staffing is 1:1.

RNs often must work seven or more hours without a meal or rest break. They are told to go on break but no relief is provided to provide care for these vulnerable patients.

Title 22 Section 70217 states that nurse-to-patient ratios represent the maximum number of patients that shall be assigned to one licensed nurse at any one time.

The licensed nurse-to-patient ratio in a post anesthesia recovery unit of the anesthesia service shall be 1:2 or fewer at all times, regardless of the type of anesthesia the patient received.

A competent RN must take report and assume responsibility for the patients when a nurse goes on a break. RNs report that they are unable to take meal and rest breaks because management does not schedule sufficient staff. Fatigue and hunger can lead to accidents and errors, and the resulting stress has contributed to the high turnover in PACU.