CMS Investigation validates staff concerns

From November 2022 through January 2023, we all witnessed CMS surveyors conducting an investigation into the hospital. The investigation was the result of NUHW members shinning a light on issues that ranged from short staffing, lack of supplies, unsafe protocols and inadequate equipment.

During the course of the investigation, CMS required FVRMC to address these issues. The report cited **"the cumulative effect of these systemic failures resulted in the hospital's inability to provide quality healthcare in a safe environment"** and that "**these failures had the increased potential of patient care being compromised, adverse effects, inferior clinical outcomes, inpatient deaths and poorer patient experience of care."**

This is a summary of the report that was issued by the highest ranking regulatory agency about the issues at FVRMC.

Under our contract, we have Patient Care Committees that meet on a monthly basis with management to address issues impacting patient care. We must continue to speak out, raise our voice and shine the light on these issues.

WE SHINE THE LIGHT ON PATIENT CARE

Throughout the Covid-19 pandemic, National Union of Healthcare Workers (NUHW) members at Fountain Valley Regional Hospital and Medical Center (FVRMC) documented hundreds of instances of noncompliance with hospital regulations and reported these violations to the California Department of Public Health (CDPH).

In July 2020, one complaint to CDPH led to a multi-day investigation on behalf of the Centers for Medicare and Medicaid Services (CMS), which found multiple lapses in Covid-19 infection control that put patients and staff at risk. In response, the hospital made some improvements, but did not address widespread understaffing.

NUHW members—whose ranks expanded to include the hospital's 850 nurses in March 2022—have continued advocating for safe patient care. In 2022 they filed 248 complaints with CDPH spanning violations of nurse-to-patient ratios to breakdowns in hospital policy and procedure, to unsanitary conditions. These complaints to CDPH resulted in another investigation, which began in October 2022 and three months of ongoing site visits which illustrates the hospital administration's continued disregard for the health and safety of patients and staff.

FAILURE OF FVRMC LEADERSHIP

CDPH surveyors found that "the hospital did not have an effective GB [governing body] to provide a safe and secure environment for the patients."

Hospital leadership failed to:

- Institute an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program;
- Ensure the medical staff completed medical records including timely and complete history and physical exam notes, progress notes, and proper documentation for pressure ulcers, the use of patient restraints, and informed consent for procedures;
- Maintain a well-organized or well-staffed nursing service to meet the needs of patients; and
- Keep the hospital safe and sanitary.

UNDERSTAFFING AND DELIVERY OF CARE

The CDPH report demonstrates that understaffing of nurses and other healthcare workers, as well as lapses in care delivery, were widespread. The report notes that, "the cumulative effect of these systemic failures resulted in the hospital's inability to provide quality healthcare in a safe environment" and that, "these failures had the increased potential of patient care being compromised, adverse events, inferior clinical outcomes, inpatient deaths, and poorer patient experience of care."

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Some examples of understaffing and care delivery failings include:

- During day and night-time shifts, nurse-to-patient ratios (established by California law to ensure safe care of patients) were not maintained in eleven units/departments;
  - ° pediatric intensive care unit,
  - ° neonatal intensive care unit,
  - ° definitive observation unit (aka "step down" unit),
  - ° telemetry unit,
  - ° oncology unit,
  - ° pediatric care unit,
  - ° mother-baby care unit,
  - ° surgery and orthopedics unit,
  - ° pulmonary medical unit,
  - ° emergency department
- A charge nurse (who plays a critical role in ensuring the smooth operations of each hospital unit) was not assigned to units throughout the hospital.
- Break nurses were frequently unavailable to cover for nurses who needed to take meals or breaks.
- No support staff person in the intensive care and definitive observation units to assist with lifting and repositioning patients on the night shift.
- Patients on cardiac telemetry did not have appropriate monitoring and routine verification of the functioning of telemetry alarms, which notify caregivers of dangerous changes in cardiac activity.
- Crash carts (for patient resuscitation) on multiple units, including on the adult and pediatric intensive care units and ED, were not checked daily.
- Numerous failures to follow hospital policy on skin and wound care (including missing scheduled repositioning of patients with pressure ulcers) and the use of patient restraints (multiple patients in restraints were not checked on and reassessed according to the required schedule.)
- Lapses in protocols for the administration of IV medications and blood transfusions including one instance of a patient with anemia and thrombocytopenia (insufficient platelets for effective blood clotting) waiting 8 hours for a blood transfusion which a physician had ordered be given immediately.

Moreover, according to the CDPH report, hospital leadership was aware of the staffing crisis but failed to act, which put patients at risk.

The Chief Nursing Officer stated that staffing issues were reported to leadership but there was no documentation in minutes from leadership meetings of "any recommendations regarding the multiple staffing issues or the environment of care issues. As a result, there was no documented evidence the GB was ensuring that adequate resources were provided for the hospital's operation and care of patients, which had the potential to negatively affect patient care." Indeed, minutes from an August 25, 2022 Governing Board meeting, which were reviewed by CDPH surveyors, showed that the Board did not feel that Tenet Healthcare "was investing the money that was needed at this hospital causing huge amounts of frustration," and "nurses were being paid significantly lower than all other facilities in the area."

LACK OF SAFE AND SANITARY ENVIRONMENT

CDPH found that FVRMC failed to maintain a safe and sanitary environment putting patients at risk. Some examples included:

- Dirty, dusty, rusting, damaged and/or stained cabinets, counters, floors, ceiling tiles, refrigerators, and sinks as well as moldy patient bathroom showers.
- Overflowing sharps containers.
- Dirty staff break rooms/lounges.
- A broken freezer in which patient food was being stored.
- Propped open fire doors and doors to areas for authorized personnel only.
- Expired supplies including sterile gloves and filter needles in the bronchoscopy supply kit.
- A red biohazard bag that was opened and tied to the toilet handrail in the restroom for multiple patients in an intensive care unit pod.
- Trash bins without trash bags and lids.
- Broken equipment.
- Faulty temperature and humidity control of patient care areas.
- A fly seen flying out from the staff's lounge out into the definitive observation unit.
- Newborn bassinets with torn and cracked mattresses in storage.

We must hold management accountable

NUHW members must work to hold FVRMC accountable to this plan to ensure its complete and permanent implementation.

Some key commitments include:

- **Nurse Staffing:** Clinical Directors or their designee will monitor nurse-to-patient ratios every shift and complete staffing forecasting based on patient volume and acuity twice daily to ensure compliance with nurse-to-patient ratios. If unable to maintain ratios, all efforts/attempts will be documented and reported to the CNO. Monitoring results will be reported to the Executive Nursing Council, Quality Patient Care Committee, Medical Executive Committee, and the Governing Board.
- **Retraining:** Retraining on multiple topics including telemetry monitoring, turning/repositioning, IV administration, restraints, and constant observation.
- **Audits:** Leadership will perform more frequent chart reviews to monitor compliance with hospital policies including monthly random chart audits by Nursing Directors to confirm compliance with the restraint, wound and skin care, and blood transfusion policies.
- **Improvements to the Physical Environment:** Daily exam room checks by engineering staff, cleaning of all showers, removal of expired supplies, emptying of all full sharps containers, and repairs to broken equipment, cabinets, and tiles. Doors will no longer be propped open and trash will be bagged and stored in closed bins with regular audits to comply with hospital policy.