Legacy Mt. Hood Bargaining Update #3

At our bargaining session yesterday, we decided to put aside the normal routine of proposal and counterproposal and use the opportunity of being at the table with Legacy leadership to talk about how badly they handled the recent ice storm. Lille Charon and Jenni Saurez read strong statements sharing their experiences during the emergency. These are included below at the end of this email. Annie Davidson shared her story of seeing the hospital once again devolve into chaos during a crisis. The rest of the team added their thoughts and suggestions for how Legacy leadership failed over the course of the last two weeks.

We tried to reflect what we'd heard from nurses over the course of crisis. Our main points were frustration with the lack of preparation for a forecasted weather event, the quickness and blatancy of the violations of safe staffing ratios, the danger to patients, and the apparent lack of urgency on the part of senior leadership to incentivize staff to come in.

After hearing our remarks, the Legacy team called in CNO Allea Thomas-Putnam to continue the conversation. She immediately acknowledged that things went poorly. She offered some context to how the situation got as bad as it did and some of the things that the hospital had done to try to alleviate the situation. In response to further remarks from our team, she acknowledged that having nurses voices heard before and during the crisis would have been helpful, and that nurses should be part of the planning for future challenging events.

While it was good to hear the Legacy team and leadership acknowledge that things went poorly and that they are open to our ideas to address future events, these are just words. We hope they maintain this spirit when we bring proposals that address the shortcomings and that it will translate into staffing above core when severe weather events are predicted, nurse involvement in emergency planning, local – not corporate – control over incentives during an emergency, and, of course, hazard pay for nurses who are risking their lives and their licenses to care for patients during impossible times.

If you have any ideas for how we can better prepare for and operate during emergencies, please contact any of us on the bargaining team or our ONA rep, Dave Cecil.

In solidarity,
Your Bargaining Team
Chair: Jenni Suarez (ED)
Vice-Chair: Lilli Charron (ICU)
Secretary: Christie Mikrut (ICU)
Treasurer: Ranae Johnson (PACU)
Grievance Chair: Annie Davidson (Endoscopy)
Membership Chair: Marissa Taplin (Case Management)
Unit Representative/Steward Chair: Peter Reitan (Medical)
PNCC Chair: Sunshine Keenan (OR)
Staffing Committee Chair: Patrick Blankeship (ICU)
Member-At-Large: Austin Teune (ED)
Member-At-Large: John Pfender (ED)

Statement from Lillie Charon:
I am Lillie Charron, and I'm a nurse in the ICU. I have worked for Legacy for 22 years, 14 of

those as a nurse in the Mount Hood ICU. I perform a variety of roles, including relief charge, critical response nurse and preceptor. I want to tell you about a situation that happened on Monday, January 15, when I was called up to the Surgical unit because they were preparing to stretch to 6 patients. When I got there, we were able to determine that stretching to unsafe levels seemed unnecessary and worked with the nurses and the CNO to find a better solution. On Monday night 1/15, as the Critical Response Nurse, I was called by the surgical specialties charge nurse, asking me to come to the floor because they were being told to “stretch” to 6 patients. The nurses normally care for up to 5 patients on night shift, and 4 on day shift.

The hospital was relatively full, it had snowed and the ER was busy at the beginning of the shift. When I arrived she was on the phone with the manager, and stated that the house supervisor wanted the charge RN to take 5 patients to send a RN to ED to board patients but we still had a few open beds in the hospital. The charge nurse, per the staffing plan, does not have a patient assignment. She also had never been contacted by the house supervisor. She had many suggestions to avoid going out of ratio, which were reasonable but unexplored.

Important to note that no weather emergency had been called, staff call-outs were minimal and ER had enough staff to board, plus a boarder nurse who had already had to refuse an unsafe assignment. This was days prior to the ice storm and emergency declaration by the governor of Oregon that followed.

While I was there, I was contacted by the medical specialties nurse about their charge nurse also being told to take a patient assignment even though they were already 2 CHT’s short and had a heavy acuity on the unit. They were also asked to take a nurse resident off of orientation to care for a full patient load. On the medical floor, similar to surgical, the charge nurse is not given a patient assignment, and it is quite rare to take a nurse resident in training off of orientation to assume an assignment, for safety reasons. It was made known to me that leadership believed there were two resident nurses with two preceptors on staff, and a plan to only have one preceptor for both orientees was an option. This is also unsafe, and is outside of safe staffing standards agreed on by all staffing committee members, except in emergency situations.

I was able to speak with our CNO Allea to find other solutions, including open beds on ICU, IMCU and the ability to open up two surgical specialties beds, thanks to Family Birth for agreeing to take an uncomplicated post-op patient. These 4 open beds negated the need for any floor or nurse to go outside of safe staffing ratios.

Leadership was very quick to jump to stretching and violating the staffing plans without speaking to all charge nurses to determine alternate scenarios. We were able to avoid going outside of staff ratios that night, by using those available beds.

As a union representative I was heartened by all of the nurses’ resolve to reject unsafe assignments, but I was alarmed by the conversations nurses had with management that were relayed to me, and the disregard for existing safe staffing standards. Pulling nurses out of their home and cluster units and going outside of ratios when it is not an emergency should not be the first option. Why does it seem like we immediately throw out the staffing plan when we get busy? Why is that the first option, instead of the last option? I ask these questions because later in the week, the situation became far worse, and nearly every unit’s nurses had more patients than what the staffing committee deemed minimal safe staffing.

From my perspective, knowing that we had winter weather approaching and the census already surging, it feels like Legacy Mount Hood was vastly unprepared for even a minor surge, let alone a major one.

Statement from Jenni Suarez:
This past week was by far one of the most difficult and quite frankly scary of my 11-year career.

Wednesday the low temperatures and icy weather began. Thursday it took me nearly two and ½ hours to inch my way into work. When I arrived to work I was shocked to see many inches of ice covering the parking lot, sidewalks and entrances. This continued through Sunday morning when temperatures finally increased and the ice began to melt.

During the 5 days that staff risked their life to come to work I did not witness any attempts at salting, scraping or in anyway managing the ice in parking lots, sidewalks or entrances. As a result of this I am aware of several employees who slipped and fell on their way in or leaving the hospital. Two of which had to actually check into the ER to be seen as their injuries were so significant. I also am aware of an employee's car being struck by a facilities vehicle in the parking lot because the ice was so treacherous impairing people's abilities to drive, park or walk.
The inclement weather plan put in place fell very short in providing any real assistance to employees to get to work. Reimbursing for an Uber ride to work when chains or studded vehicles are the only way to safely travel is of no help to staff. If its unsafe for me to drive my sedan to work then its unsafe for an Uber driver to do the same.

The unsafe working conditions continued once inside the hospital. Departments were significantly understaffed and leadership leaned on unsafe nurse to patient ratios in order to account for the large volumes of admissions and ER arrivals. Nurses on the floor were asked to take up to 6 patients each and on multiple days in the ER I (the charge nurse) had 4 patients myself. The rest of the ER staff also took 5-6. 60 plus patients in the lobby and only 3 RN's out there to try and care of them. That's a 20:1 ratio. How is this ok?

We have a 28 bed Emergency Department. We had up to 30 inpatient boarders and 104 patients in our department alone. This went on for days! Patients in every nook and hallway. At one point I was pulling printer paper out and writing with a sharpie additional hallway signs. Hallway 31 through 45 and taping them on the walls any place I could find. That's FOURTEEN hallway beds. These beds were unmonitored, meaning no tele. Patients getting tube feedings in the hallway. Patients w/ recent heart surgeries having chest pain in the hallways. Bedbound cerebral palsy patients in the hallway. Patients on oxygen in the hallways with no way to monitor when the tank runs out. I could go on and on.

All this to say that NOT ONCE did Legacy approve or offer special incentive pay in order to bulk up staffing. NOT ONCE did Legacy attempt to staff over core.

Everyone I saw was working their tail off for days to make the situation the best if could be. How we made it through with no patient deaths, I do not know.

What I do know is that it cannot happen again.

We would like to work with you during these negotiations to find proactive solutions. Solutions that are best for the patients, nurses, and everyone at the hospital. I really do hope you will engage with us in the conversations.