



Oregon Nurses Association  
Bargaining Unit Newsletter

Providence Milwaukie Hospital (PMH)

# Newsletter

May 15, 2020

## PMH Executive Committee

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## Welcome Back Paul Kylo!

Paul Kylo is back as our labor representative from ONA. Paul worked with us last summer and fall, and he is now back to work with us this spring and summer. Paul has worked as a labor representative in Oregon for over 20 years working with teachers and educational support staff. He can be contacted by phone at (503) 293-0011 ext. 1305 or by emailing [Kylo@OregonRN.org](mailto:Kylo@OregonRN.org).

## FAQ: Oregon Reopening Elective Procedures

*This FAQ was created by the ONA Office of Professional Services to assist with the reopening of units within hospitals in compliance with the Governor's order. See page 4 of this newsletter for a flow chart on non-urgent procedures concerns or actions.*

*Questions or concerns at your facility should be directed to the Professional Services Department at ONA*

Frequently Asked Questions and Answers regarding the Oregon Governor's "[Framework for Restarting Non-Emergent and Elective Procedures in Hospitals and Ambulatory Surgical Centers](#)"

### What sort of bed capacity must a facility have available before resuming elective procedures?

Bed availability must be at least 20% open in order to accommodate any potential surge of COVID-19 patients. There are 7 [regions](#) in Oregon and are defined by the Oregon Health Preparedness Program and align with the Oregon Area Trauma Advisory Board regions.

### Can a facility resume elective procedures while still operating under a facility disaster plan?

This answer isn't quite as clear cut, however there are criteria related to this. No facility can resume elective procedures if they are still having to utilize "crisis standards of care" for any patients requiring hospitalization. The 2018 [Oregon Crisis Care Guidance](#) standards include interventions such as utilizing triage principals to determine who should get care, closing non-essential nursing units and moving staff from their home unit on a planned basis to back-fill high acuity areas, changes in documentation requirements, and changes in nurse-patient ratios from pre-crisis standards. Please contact your [Nurse Practice Consultant](#) or Labor Representative if you are concerned about practices in your facility that may be out of alignment with these criteria.

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## FAQ: Oregon Reopening Elective Procedures *(continued from page 1)*

### How much PPE does my facility need to have in order to resume elective surgeries?

The first two criteria are that medium and large facilities (50 or more beds) must maintain a 30-day supply of PPE on-hand, and small facilities (less than 50 beds and not associated with a large health system) must maintain a 2-week supply of PPE on-hand. All facilities must also have an open and adequate supply chain.

The other criteria are related to PPE conservation measures. Firstly, the facility must be able to maintain recommended PPE use for staff without the need for [emergency PPE-conserving measures](#). Although ONA is in opposition to extended use and reuse when not in an emergency setting of extremely limited PPE, the guidance states that a facility may utilize extended or reuse of PPE, but it must follow [CDC guidance](#).

All hospitals must report all PPE supplies daily through the Oregon Health Authority's Hospital Capacity web system.

### What testing capacity does my facility need to have in place to resume elective procedures?

Large facilities (50 or more beds) must have COVID-19 testing capacity to ensure results within 2 days and small facilities (less than 50 beds and not associated with a large health system) must ensure results within 4 days.

### What policies does my facility need to have in place regarding infection control measures and visitation policies?

Facilities must comply with current OHA standards for infection control and visitation.

The [March 27, 2020 OHA guidelines](#) updated guidelines related to: extended use of masks and faceshields only with cohorted care of patients with COVID-19; implementation of rigorous testing for patients; strict monitoring of asymptomatic healthcare workers that have been exposed to COVID-19 patients; 72 hours of no symptoms before healthcare workers return to work.

The [April 23, 2020 OHA guidance](#) updated: essential workers who should be allowed entry to acute care facilities; screening criteria for essential workers and the limited class of visitors allowed; documentation requirements for screening.

### Will the surgical patients need to be able to receive all of the care that these patients received prior to the pandemic?

Yes, facilities must have all necessary peri-operative resources in place including: pre- and post-operative visits; laboratory, radiology, and pathological services; all other necessary ancillary services. If you are concerned that these resources are not in place and your facility is planning to or already resuming elective procedures, please contact you [Nurse Practice Consultant](#) or Labor Representative immediately.

### Can my facility return to levels of elective procedures similar to pre-pandemic levels?

No. Facilities must limit the volume of elective and non-emergent procedures to a maximum of 50 percent of pre-COVID-19 procedure levels. Facilities must also reassess capacity on a biweekly basis and maintain a plan to reduce or stop these procedures should a surge of COVID-19 cases occur in their region or if any of the other criteria can no longer be met.

### Is there any guidance regarding which types of procedures and populations can resume?

Yes. A medical committee or the medical director must review and prioritize cases based on urgency, with consideration of balancing risk vs. benefit for higher risk groups, and should consider ongoing postponement of non-emergent and elective procedures that are expected to require blood transfusion, pharmaceuticals in short supply, ICU admission, or transfer to a skilled nursing facility or inpatient rehab.

Definitions from the Governor's Office and OHA regarding the "Framework for Restarting Non-Emergent and Elective Procedures in Hospitals and Ambulatory Surgical Centers":

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## FAQ: Oregon Reopening Elective Procedures *(continued from page 2)*

**Definitions:** For purposes of this guidance, the following definitions apply:

“Crisis standards of care” means standards of care for non-conventional conditions (i.e., contingent or crisis conditions) as established in [Oregon’s Crisis Care Guidance](#).

“Elective and non-urgent procedures” means procedures that require PPE and that will not result in irreversible harm to the patient if delayed for up to 90 days.

“Emergency PPE-conserving measures” means a set of strategies used by facilities in face of PPE shortages, also referred to as “[crisis capacity strategies](#)” by the Centers for Disease Control.

“Hospital bed availability” means the availability of intensive care unit (ICU), step-down, and medical/surge beds.

“Large hospital” means a hospital, licensed under ORS 441.025 with 50 or more licensed beds.

“Open supply chain” means having a contract in place with a vendor that allows for sustained PPE supply with no reliance on local or state government to fulfill PPE requests.

“Personal protective equipment (PPE)” means gloves, gowns, face shields, surgical masks, and N-95 respirators or other reusable respirators (e.g.,

powered air purifying respirators) that is intended for use as a medical device.

[“Region” means Oregon’s existing Health Preparedness Program \(HPP\) regions which align with the Oregon Area Trauma Advisory Board \(ATAB\) regions as defined in OAR 333-200-0040.](#)

[“Regional resource hospital \(RRH\)” means a hospital that has entered into agreement with the Oregon Health Authority to serve as the regional hospital bed management and transfer center for one or more regions during the COVID-19 emergency.](#)

“Small hospital” means a hospital licensed under ORS 441.025 with fewer than 50 beds that is not part of a larger health system.

“Threat of irreversible harm” includes:

- Threat to the patient’s life;
- Threat of irreversible harm to the patient’s physical or mental health;
- Threat of permanent dysfunction of an extremity or organ;
- Risk of cancer metastasis or progression of staging; and
- Risk of rapidly worsening condition (i.e., need for the procedure is time-sensitive).

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## IMPORTANT REMINDERS

### CHECK YOUR PAY CHECK

If you received SOE pay you probably did not get your clinical ladder, certification pay, or shift differential. You can be reimbursed for this error by filling out a prior pay period exception sheet, have your manager sign it, and send to payroll. Please alert your labor representative if you are denied; Other nurses have already been reimbursed.

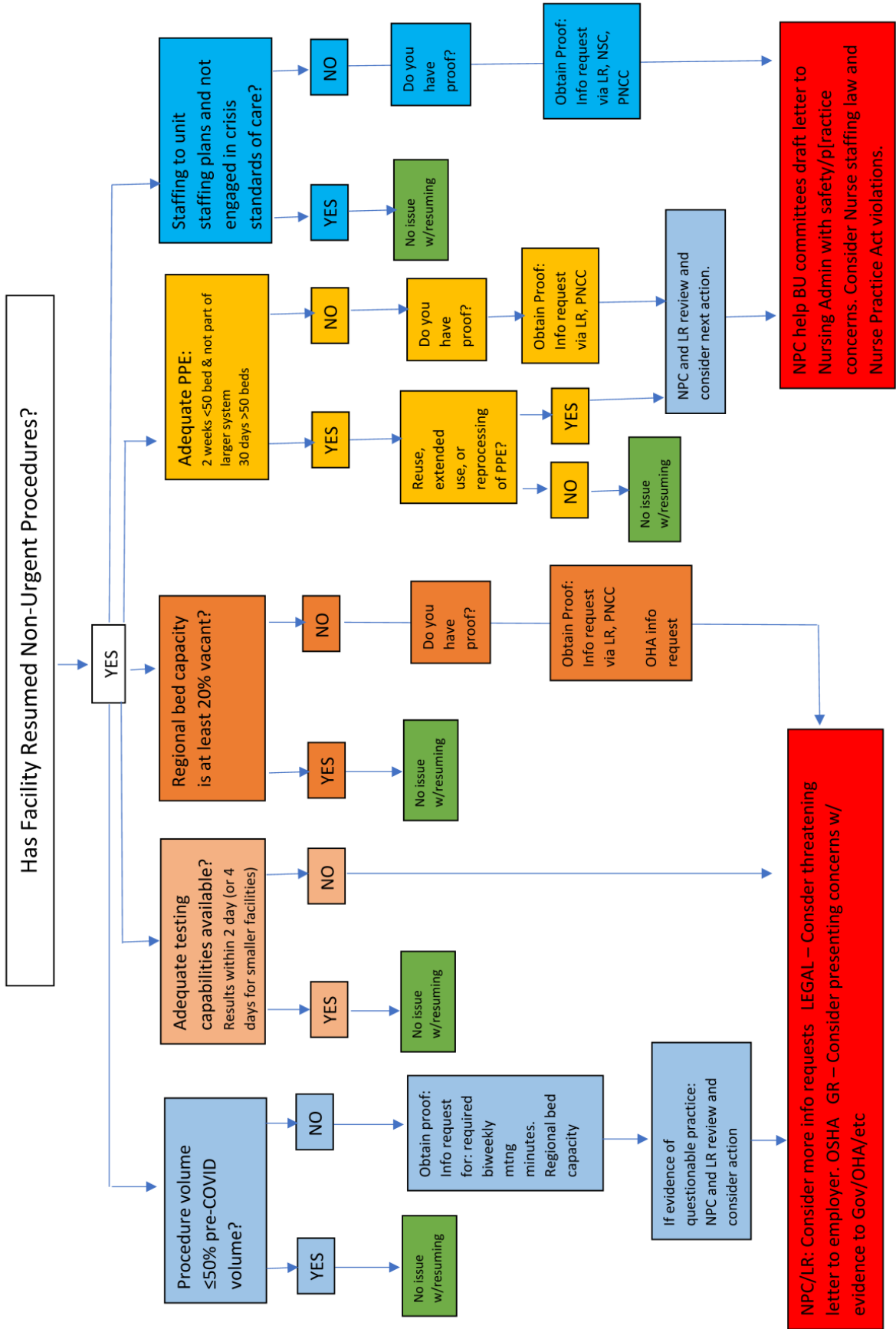
### MDOs ARE HITTING EVERY UNIT

Please pay attention to how your unit is MDOing nurses and alert your labor representative to any inequities you notice. You can find the MDO procedure in the ONA/PMH contract (Article 17, Section 3), found on the bargaining unit webpage at [www.OregonRN.org/408](http://www.OregonRN.org/408).

**If you have sought ADA accommodations or leave of absence related to COVID-19 and have not been satisfied with the response please let an ONA representative know.** Providence has been inconsistent about who qualifies and we want to advocate for you.

**FAQ: Oregon Reopening Elective Procedures** (continued from page 3)

**Non-Urgent Procedure Concerns and Actions**



## HAPPY NURSES WEEK!

Check out the following thank-you videos for all of the important work that nurses do:

- From: Oregon's Elected Officials, To: ONA Nurses, Thank you! (<https://youtu.be/ZrR1pvaMR2s>)
- Nurses' Week digital address from ONA President, Lynda Pond (<https://www.facebook.com/watch/OregonNursesAssociation/>)

## Guidelines for Taking Leave

*Following are guidelines from ONA General Counsel, Tom Doyle, regarding leaves that are available for nurses.*

On March 11, Providence waived the waiting period for accessing extended illness banks/time (EIB/EIT) “until the spread of COVID-19 has reduced in our community” for COVID-related symptoms. This did not expand that availability of EIT for non-symptomatic reasons for exclusion – i.e. for care of family members, self-exclusion because a nurse is a vulnerable individual.

On or about March 26, bargaining units entered into agreements (interim memorandums of understanding [MOUs]) that created an 80-hour emergency leave backstop for COVID-related symptoms or self-exclusion to recover from COVID-related illness. This is available only once nurse has used all of their paid time off (PTO)/EIT/grandfathered sick leave.

Nurses who are not ill can use accruals for other reasons not related to outbreak. **I interpret this as including EIT**, but I don't know if that has been tested or been consistently applied. So, a vulnerable nurse (age, disability, pregnancy) should be able to use their EIT for that time off that is requested as an accommodation. **It is not clear if the nurse has to use PTO first** – the MOU is not clear as to its interaction with the elimination of the EIT waiting period. It is clear that if all PTO/EIT is used, (or arguably, is not available to be used), the nurse can use the 80-hour emergency leave for other reasons unrelated to their own illness (explicit examples are taking care of children, I would argue staying home because of vulnerable status would be another example).

The interim MOU also extended 65 percent income replacement pay (STDI) after *all* other leaves are used; This included PTO, EIT, and 80-hour emergency leave. I do not believe that this 65 percent wage replacement would be available for instances where the employee themselves are not ill. I am not aware of an elimination of the STDI waiting period.

SoE leave (for closed or partially closed units) expired on April 30. We have proposed extending and spent much of our call last with Providence making the case for extension. They have not responded, although they have been clear that they intended it to end. As you know, we can't make Providence agree to our proposals.

Finally, as for accommodations for pregnant caregivers, my understanding is that Providence has consistently said that requests for accommodation for vulnerable caregivers would be done on a case by case basis and that requests for reassignment to non-COVID areas (to the extent known) would be honored and should go to managers or human resources. We have raised this issue on multiple calls with Providence and received the same response. If the requests are denied, I assume a grievance would have been filed, but, since this is a disability accommodation issue, a BOLI complaint would make more sense.

# ONA Convention and House of Delegates Postponed

To ensure the health and safety of our members through the COVID-19 pandemic, ONA has made the decision to postpone the ONA Convention and House of Delegates. We took this decision very seriously and felt it is in the best interests of our members. The new dates will be **Sept. 21-22, 2020** in Portland. More details to come.

Important Information about Postponed Convention

**Those who have registered for the convention will have their event registrations canceled and will be refunded their registration fees.** We will open registration again at a later date and will ask everyone to register again at that point.

If you have reserved a hotel room, you must call to cancel your reservations as this will not be done automatically.

ONA constituent association delegates will not have to reapply to be delegates. However, everyone will have to register to attend the convention again once the schedule of events is finalized.

If you have any questions, please contact us at [News@OregonRN.org](mailto:News@OregonRN.org).



## Completing the Staffing Request & Documentation Form (SRDF) During COVID-19

### SRDFs & COVID-19

Many processes within hospitals have changed since COVID-19 came to Oregon. With the current state of emergency, it is not required that the hospital follow staffing plans or the [Oregon Hospital Nurse Staffing Law](#).

However, it continues to be crucial to collect staffing data from within our facilities. The SRDF collects many data points in addition to whether the staffing plan has been followed, and **we encourage all members to continue filling out SRDFs when an unsafely staffed shift occurs or patient care is impacted.**

To make filling out an SRDF as accessible as possible, the [online form](#) is mobile compatible, and a computer is not required to fill it out.

The information gathered in SRDFs allows ONA to track staffing data and provide information to hospital wide staffing committees. It also provides valuable information to labor representatives about how specific units are staffed, and can be used to assist with OHA complaints.

### HOW TO FILL OUT THE SRDF

If you work a shift with insufficient nurse staffing, you should complete the following steps:

1. Notify someone in the chain of command;
2. Ask for additional staff;
3. Ask for a response in a reasonable period of time, (e.g., minutes, hours) and;
4. Complete the SRDF as detailed below.

The nurse should complete the SRDF at the end of the shift or as soon as is possible. The SRDF can be found online at [OregonRN.org/SRDF](http://OregonRN.org/SRDF). This version is web and mobile compatible.

A PDF copy is automatically emailed to the nurse and to ONA, and it is the nurse's responsibility to forward a copy of the completed form to the nurse manager, PNCC chair, and staffing co-chair. The SRDF should be completed even if the problem is corrected quickly.

Questions about the SRDF process? Email [SRDF@OregonRN.org](mailto:SRDF@OregonRN.org)