Low Census Concerns Grow Throughout the Hospital

We have been hearing from some units that are experiencing increased low census (LC) hours these past few weeks since the labor pool closed. Your Oregon Nurses Association (ONA) team reviews the LC data for each unit at the end of each cycle – see chart in adjacent column.

The contract does have limits for how much mandatory low census you can receive and processes for addressing excess low census as well. See Article 14.2.5 and 14.2.6 below. It is important that you are familiar with the order of low census in Article 14.2 and that you review your low census data for accuracy. Your charge nurse can help you review this data and make corrections if necessary. Please make sure that your low census is recorded accurately: voluntary vs mandatory. If you signed up or volunteered to take the low census day then it’s voluntary (voluntary hours don’t count toward your maximum). If you have question about this contract language reach out to your unit steward or one of your labor reps. You can find their contact information on the Sacred Heart Medical Center (SHMC) webpage: www.oregonrn.org/page/86.

SHMC Contract Language:

Article 14.2.5 Mandatory low census maximum. The Medical Center will limit assignment of mandatory low census to regular nurses to a maximum of twelve percent (12%) of a nurse’s regularly scheduled hours over six (6) consecutive work cycles.

a. Hours count toward the mandatory low census maximum (“Maximum”) only when low census is assigned pursuant to clause 14.2 (7) above in the order of low census.

b. Low census hours will be considered voluntary and will not count toward the Maximum if a nurse declines an opportunity to work during the scheduled shift.

c. Hours shall not count toward the Maximum to the extent that the Medical Center offers the nurse who is assigned low census an opportunity, at least 48 hours in advance of such opportunity, to work additional hours on the same shift during the same work cycle.

d. In determining whether the...
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Maximum is reached at any point during six consecutive cycles, all hours worked in excess of a nurse’s assigned FTE will be deemed to offset the equivalent number of mandatory low census hours.

e. In the event that one or more nurses on a unit and shift approach the Maximum, the Medical Center may, notwithstanding clause 14.2 (7) above, assign low census to assure equitable distribution among all nurses on the unit and shift.

Only Mandatory Low Census hours will be counted in determining whether a nurse has exceeded the maximum low census hours. A nurse’s use of PTO (scheduled or unscheduled) or Voluntary Low Census shall not be taken into account for purpose of determining whether the nurse has exceeded the maximum low census hours. Nurses’ maximum mandatory low census hours shall be calculated as follows for six consecutive cycles:

- 36 hr/week, .9 FTE nurses = 36 x 24 weeks x .12 = 103.68 hours
- 32 hr/week, .8 FTE nurses = 32 x 24 weeks x .12 = 92.16 hours
- 30 hr/week, .75 FTE nurses = 30 x 24 weeks x .12 = 86.4 hours
- 28 hr/week, .7 FTE nurses = 28 x 24 weeks x .12 = 80.64 hours
- 24 hr/week, .6 FTE nurses = 24 x 24 weeks x .12 = 69.12 hours
- 20 hr/week, .5 FTE nurses = 20 x 24 weeks x .12 = 57.6 hours

Article 14.2.6 Protocol for addressing excess low census. The Medical Center will provide to the Association low census data for each nursing unit within fourteen (14) days after the end of each work cycle. If the Association desires to discuss with the Medical Center its concerns regarding excess low census on any unit, it will arrange for a meeting with the Medical Center to be held within fourteen (14) days after having received the end-of-cycle low census data. Excess low census is defined as a reduction of at least 10% of the core scheduled hours in a nursing unit over a span of two (2) consecutive cycles. When they meet, representatives of the Medical Center and the Association shall consider actions to remedy the situation, including:

- allowing nurses to voluntarily reduce scheduled hours with continued benefit level and guaranteed return to scheduled hours for a specific number or cycles;
- allowing nurses to voluntarily be removed from the schedule for a specific period of time without utilizing PTO;
- potential reorganization and/or implementation of layoffs as provided in this article.

The parties will strive to mutually agree upon appropriate remedial actions at such meeting or within fourteen (14) days thereafter.

a. All time that a nurse is prevented from working his/her scheduled hours because of low census will be included in calculating these percentages, regardless of whether the nurse uses PTO for any of the low census hours.

b. Furthermore, whenever a nurse’s scheduled work hours are reduced by more than 25% in a given cycle because of low census, the Medical Center will seek to provide that nurse, upon written request from the nurse, any available work on the nurse’s regular shift that the nurse is qualified and able to perform.

Article 14.2.7 Low census data. Nurses will have the opportunity to view the low census system on their unit so that they can see their order in the low census rotation and alert their charge nurse of any potential errors in the calculation of their low census hours. The Medical Center will make available to nurses information regarding the designation of mandatory and voluntary low census hours each pay period, and nurses will alert the appropriate party of any errors in such designation.
Sacred Heart Advanced Practice Nurses Vote to Join ONA!

We have five new members who just voted to join the ONA - SHMC collective bargaining agreement!

Please welcome Nancy Austin, Sarah Barry, Andrea Childress, Samantha Loomis, and Elena Shinn. They are Advanced Practice RN’s who have been working alongside you for years without the benefit of union representation. They got tired of being left behind in terms of their wages and benefits, so they reached out to ONA and eventually took the next important step of voting to joining the union.

We will begin negotiating their wages, benefits and working conditions to bring them into the SHMC contract soon. If you see one of these new members around the hospital, please welcome them as one of your new union sisters.

Advanced Degree Differential Grievances Resolved!

ONA became aware back in 2017 that some nurses weren’t receiving their Advanced Degree differentials as they should have been. A number of individual grievances were filed and then an Association grievance was filed for other nurses that may have been impacted.

As part of the grievance resolution SHMC/SHHCS sent notices out to all nurses via U.S mail and work email to notify them of the potential issue. We have finally been able to resolve these grievances for all the impacted nurses that came forward! We were able to settle the grievances to the satisfaction of all parties, and we have an Memo of Understanding for the issue going forward. Thank you to all the nurses that brought this issue forward. We are happy that we were finally able to get this issue resolved for you!

Just a reminder that advanced education pay shows up as a separate line item on your paychecks. It is not included in your base pay. Remember when you receive your advanced degree to submit proof of your degree to the Human Resources Service Center right away!

Article 9.12 Advanced Education Pay. Nurses holding a baccalaureate degree in nursing (BSN or BAN) will be compensated four percent (4%) above their Appendix A rate and nurses holding a master’s degree in nursing (MSN or MAN) will be compensated five percent (5%) above their Appendix A rate.

Article 9.12.1 Eligibility. To be eligible for the commencement of Advanced Education pay, the nurse shall submit documentation in the form of a copy of their transcripts, which indicate the degree awarded, or a copy of their diploma from the accrediting program to the Human Resources Service Center. All new hires shall be informed of this requirement in writing including the specific documentation required and where to submit the documentation. Pay will commence the firth full pay period following the receipt of the documentation.

Nurses Week 2020 Raffle

Congratulations to the 165 raffle winners! Your gift certificate to a local business will be arriving in the mail this week. We look forward to being able to hold our usual day-long Nurses Day Celebration next year!
Professional Nursing Care Committee Update!

Professional nursing care committee (PNCC) funds and hours extended for nine months.

GOOD NEWS! The PNCC, working with the rest of the union bargaining team, has secured an agreement to roll over the use of the remaining education funds and 2,000 hours for nine months due to COVID-19.

We know a lot of you had to forgo conferences and education during the crisis and you need to get back on track! We are here to help you do that with $54,533 dollars left for the 2019-2020 year. The full fund will reset in July but with the backlog of demand we wanted to make sure no one got left behind. We also got some extensions for folks to get certifications that were not available during the crisis, but those extensions are not long.

Don’t delay – contact PNCC today to make sure you get the professional development you need.

ONA Offers Members Guidance for Hospital Re-Opening

As Sacred Heart take steps to "re-open" under the state of Oregon guidelines ONA has developed a Frequently Asked Questions (FAQ) and algorithm to assist members in understanding if the hospital is meeting the state’s criteria.

Please contact your labor reps or nurse practice consultants if you have questions about this information or how your unit is complying with the requirements of the state. Contact information for these ONA staff members is located in the sidebar on page one of this newsletter.

Oregon Re-opening Elective Procedures FAQ

Frequently Asked Questions and Answers regarding the Oregon Governor’s “Framework for Restarting Non-Emergent and Elective Procedures in Hospitals and Ambulatory Surgical Centers”

1. What sort of bed capacity must a facility have available before resuming elective procedures?
   a. Bed availability must be at least 20 percent open in order to accommodate any potential surge of COVID-19 patients. There are seven (7) regions in Oregon and are defined by the Oregon Health Preparedness Program and align with the Oregon Area Trauma Advisory Board regions.

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

3. How much personal protective equipment (PPE) does my facility need to have in order to resume elective surgeries?
   a. 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.
   b. 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

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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.

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

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

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

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

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

i. The March 27, 2020 OHA guidelines updated guidelines related to: extended use of masks and face shields 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.

ii. 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.

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

a. 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 your Nurse Practice Consultant or Labor Representative immediately.

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

a. a. 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.

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

a. 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”:

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...continued on page 6
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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.
- “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).