The Consequences of Short Staffing at Legacy Unity Center for Behavioral Health

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Compiled and Written by
Professional Services Department, Oregon Nurses Association
EXECUTIVE SUMMARY

Legacy Unity Center for Behavioral Health (Unity) is Portland’s only behavioral health hospital with psychiatric emergency services. Since its founding in 2017, Unity has been under state and federal investigation for safety issues. Because of staffing reorganizations, turnover, and staffing levels that do not meet the acuity needs of the psychiatric patient community, staff are under increasing pressure to provide more care with fewer and inadequate resources. To address these working conditions and staffing concerns, Oregon Nurses Association (ONA) nurses who work at Unity are in active union contract negotiations. This report provides an overview of some of nurses’ staffing and safety concerns, which impact the health care professionals at Unity, patients and our community.

Between November 2020 and January 2021, ONA nurses at Unity completed more than 50 Staffing Request and Documentation Forms (SRDFs). This patient care report summarizes those reported unsafe situations. These include:

1) Compromised patient and nurse safety,
2) Risk of nurse fatigue due to missed breaks and overtime,
3) Failure to deliver basic human care, including hygiene and psychosocial support
4) Late medications and medical orders/treatments, and
5) Delays in critical safety observation, assessment, and monitoring.

In their SRDFs, nurses reported incidences where a nurse was assaulted, a patient broke a window to the outside, patient rooms and main milieu went unmonitored, an open nurse station was left unstaffed, and an overall inability to provide basic standards of care.

Unity nurses have repeatedly notified hospital management and attempted to work on these issues through contract negotiations, the Housewide Nurse Staffing Committee (HNSC), and other unit and nurse practice committees. In all of these instances, hospital management consistently declined to address nurses’ safety concerns.

Because Unity management has refused to address these serious concerns, ONA nurses at Unity are providing this data to the public. The nurses welcome community support to ensure they can provide the highest quality care to their patients and our community.
INTRODUCTION

Unity is a 110-bed behavioral and mental health hospital for adolescents and adults. It was founded in 2017 as a joint venture of Oregon Health and Sciences University, Adventist Health, Kaiser Permanente, and Legacy Health to meet our vital community need for psychiatric emergency services.

History of Unsafe Staffing

After a near loss of federal funding in 2018 and another state and federal investigation initiated in 2019, Legacy's vow to fix the problems at Unity still falls short. Unity continues to be managed in a manner that jeopardizes nurse and patient safety and is harmful to the Portland metro community. Despite regulatory scrutiny and consistent reporting by nurses since Unity's founding, unsafe staffing conditions persist.

Direct Care Nurses Demand Change

Nurses voted to form their union and join with ONA in June 2019. They came together to work for proper staffing levels to ensure the highest standard of care for patients. Nurses are now negotiating their first contract, which includes working conditions such as sufficient staffing levels.

On 39 separate dates between Nov. 2020 and Jan. 2021, nurses at Unity filed 52 Staffing Request and Documentation Forms (SRDFs) to report inadequate staffing across multiple nursing units at Unity. Direct care nurses complete ONA's SRDFs when, in their professional nursing judgement, they believe: 1) the configuration or number of staff assigned to a unit on any shift is inadequate for patient care needs and/or 2) when staffing is not in line with the unit’s staffing plan as approved by the HNSC as a component of Oregon’s nurse staffing law. According to the Oregon Hospital Nurse Staffing Law, the HNSC should ensure the hospital is staffed to meet the health and safety needs of its patients and if not, to modify its plan accordingly. This has not been the case for the nurses at Unity.

Because Unity management continues to ignore the voices of frontline staff, along with regulatory agencies, ONA is presenting its findings to the public.
THE PROBLEM: UNSAFE STAFFING

According to the Oregon Nurse Practice Act, nurses have a responsibility to promote and advocate for an environment conducive to safety by identifying safety concerns and taking action to address those concerns. Unity nurses reported unsafe conditions in 52 SRDFs filed from 39 separate incidents between Nov. 2020 and Jan. 2021. This equates to an unsafe staffing incident occurring every 2-3 days. Numerous unsafe situations were reported including:

1) Compromised patient and nurse safety
2) Risk of nurse fatigue due to missed breaks and overtime,
3) Failure to deliver basic human care, including hygiene and psychosocial support,
4) Late medications and medical orders/treatments, and
5) Delays in critical safety observation, assessment, and monitoring.

Staffing reorganization and high staff turn-over force nurses at Unity to work “short” as a routine matter. For the purpose of this report, “working short” is defined as not having enough nurses in each unit to safely care for patients. This is based on the hospital’s own staffing guidelines and the clinical judgment of professional nurses who encounter these unsafe circumstances.

Over the years Unity management has made changes to the roles and schedules of other health care workers on staff (e.g. social workers, counselors, therapists) so that many of their duties now fall to nurses who are already managing their regular patient loads. Additionally, nurses note that changes in Unity policy put further restrictions on nurses’ time to treat and provide meaningful interventions that guide patients through a plan of care.

As a behavioral health hospital, Unity routinely admits patients who require a high level of care from nurses to maintain patient and nurse safety. This, in turn, requires a higher staff-to-patient ratio to ensure the safety of all patients and nurses. Over half of the SRDFs filed by nurses at Unity reported that the patient acuity level (or care required to ensure safety) was too high for the number of nurses on shift. Moreover, nurses report that the hospital’s staffing guidelines are not based on the clinical judgement of frontline staff. These guidelines don’t account for acuity and nursing intensity. Yet according to the Oregon Hospital Nurse Staffing Law, frontline staff should have an equal say in their staffing plans, and those staffing plans must take into account the unit activity, patient diagnoses, and nursing care intensity required to manage that set of diagnoses and patient acuity. Not staffing to the patient acuity or nursing care intensity required to care for the patients at Unity not only violates the Oregon Hospital Nurse Staffing Law but is a chronic problem which led to the various conditions outlined in this report.
“We are not staffed at a level to safely carry out interventions needed to properly care for our patients.”

The dangers associated with inappropriate staffing are real to both the nurses at Unity and to their patients and have been well documented in federal and state investigatory reports in addition to nurse reports. Below are issues related to patient care and nurse safety, as documented by nurses at the facility.

1) Compromised patient and nurse safety

In 73% of the SRDFs, nurses indicated that the inadequate staffing led to compromised patient safety or patient injury. Three instances of staff injury were also documented in the Emergency Psych department over the three-month period. As one nurse plainly put it: “we are not staffed at a level to safely carry out interventions needed to properly care for our patients.”

In January 2021, a nurse was physically assaulted and injured by a patient because of inadequate staffing. As documented in the SRDF, the “triage nurse could not leave triage area to assist nurse being assaulted because patients were present and could not be left unattended.” A nurse must stay with an incoming patient for liability purposes. Additionally, leaving patients unattended in a triage area poses its own safety risks because incoming patients are often dysregulated and need immediate care to prevent harm.

Nurses reported having to leave the open nurse station unattended to attend to emergent patient needs, a serious safety risk given the potentially hazardous items (e.g. computers, phones, hard moveable objects) patients had access to at those times.

2) Risk of nurse fatigue due to missed breaks and overtime

Because nurses are committed to providing the best possible patient care even with these staffing shortages, they frequently work without any lunch or rest breaks during shifts that often last 12 hours, or longer due to overtime.

Sixty-two percent of nurses reported missing rest breaks and 33% reported missing meal breaks on their shift. On 52% of the SRDFs filed, nurses indicated working overtime to meet patient care needs which, when combined with 12-hour shifts and missed breaks, creates a significant risk for nurse fatigue which can further compromise patient safety.

52% of nurses reported working overtime to meet patient care needs
When staffing is not adequate to ensure nurses take the breaks that are mandated by the Bureau of Labor and Industry, it not only breaches state law but also compromises the culture of safety and healthy work environment required to reduce the potential for negative outcomes associated with nurse fatigue.

Both the American Nurses Association (ANA) and the Joint Commission have released statements recognizing that nurse fatigue increases the risk of errors and adverse events, compromises patient safety, and can have serious implications on the health and safety of nurses, further exacerbating the concerns at Unity.

3) Failure to deliver basic human care, including hygiene and psychosocial support

Short staffing compromises nurses’ ability to provide basic care for their patients. In more than half of shifts where an SRDF was completed, nurses report a failure to be able to provide basic hygiene in a timely manner or at all.

In 81% of reports, nurses said that their ability to provide psychosocial support was either delayed or completely absent. Delayed or absent psychosocial support means that psychiatric patients are missing critical one-on-one time with a nurse that is an essential part of patients’ recovery.

Nurses are committed to providing the best care possible to their patients but are often left without adequate staff to do more than the bare minimum, which itself is often delayed.

• Normally a task designated to support staff, watching bathroom doors for safety reasons, often falls to nurses so they are “not able to tend to patient care needs” during those times.
• One nurse stated, “Being short staffed creates an environment of chaos on the unit that can lead to unsafe events. We are not able to spend the time we would like to spend with our patients.”
• Nurses report being frustrated that there is not enough staff to deliver the care they believe patients deserve, potentially compromising patient outcomes.
• Another nurse said, “Nursing staff must focus on the most acute patients leaving the other patients of their load to receive the most basic interventions to meet the mandated requirements.”

“Being short staffed creates an environment of chaos on the unit that can lead to unsafe events.”
4) Late medications and medical orders / treatments

Because of short staffing, nurses at Unity were unable to follow medical orders, provide treatment, or deliver medications by physicians in a timely manner in 58% of the instances documented. Care that is most often delayed or omitted include critical mental health therapies, support in eating, socialization, and outside time.

As one nurse reports, when staffing levels don’t match the acuity levels of patients, there is “disruption to care and other services provided to clients as well compromises to patient and staff safety. Unity is not staffed appropriately to handle this level of agitation and violence.”

In another instance of inadequate staffing, a behavioral incident took multiple nurses off their assignments, leaving just three nurses to intervene with the remaining 34 patients present in the Psychiatric Emergency unit. “We are not staffed at a level to safely carry out interventions to properly care for our patients.”

In 58% of instances documented, nurses were unable to follow medical orders, provide treatment, or deliver medications in a timely manner.

5) Delays in critical safety observation, assessment, and monitoring

Observation, assessment, and monitoring of behavioral health patients is especially important because these patients can have added risk factors of harm to self or others. In 56% of reports nurses said that observation, assessment, and monitoring was delayed or omitted.

Nurses reported being unable to consistently perform safety checks on patient rooms and having to leave the main milieu unsafely monitored.

The Centers for Medicare & Medicaid Services (CMS) also reports Unity has been cited for several incidences that led to compromised patient safety and/or patient harm due to inadequate or delayed observation/assessment/monitoring. Though Unity management has committed to fix the problem with policies and trainings, they are still not providing the number of staff required to effectively implement these plans.
CONCLUSION

It is clear from the firsthand accounts of frontline caregivers documented in the SRDFs submitted over the last three months that Unity has significant and ongoing understaffing issues which affect patient and nurse safety.

The ANA calls all nurses, including those in non-clinical roles (such as managers and administrators) to collaborate to provide high-quality care, sharing in the responsibilities for outcomes in nursing care, and in maintaining nursing’s primary commitment to the patient. It is a moral and ethical imperative that nurses on Unity’s management team work with frontline nurses to provide a higher level of care than is currently being delivered. All must work together to reach and maintain the best policies, practices, and staffing plans to eliminate the harmful practices documented in the SRDFs.

Unity has failed to address these persistent problems internally. Nurses have been in union contract negotiations for more than a year and yet Unity management has failed to make significant movement on the matters that would create a safer environment for nurses and patients. We urge Unity management to engage in good faith negotiations with the nurses to secure safe and enforceable staffing levels in their labor agreement.

The ANA also calls nurses to collaborate with other health professionals and the public to protect human rights and reduce health disparities. This is why the direct care nurses at Unity, in collaboration with ONA, are committed to improving working conditions and raising the standard of nursing care for patients. ONA nurses strongly advocate for safe and appropriate staffing so that those in acute mental health crisis can get the care they deserve.
REFERENCES


