1. Section 1: The final Plan

2. Section 2: The union’s proposal and rationale

3. Section 3: Management’s proposal and rationale

4. Section 4: CEO’s written submission
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### Notes

- **PCA**
- **PCT**
- **PSHT**
- **Nurses Aide**

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**RA101605 Jacobi Medical Center**
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- PCT
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- Nurses Aide
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Hi Mr. Mastramano,

We are submitting proposals from the labor side of the table related to RN staffing at Jacobi. As we were informed at the final Friday meeting of the committee, proposals for all areas where we don't have consensus are to be submitted directly to you by 12p tomorrow.

DC 37 Local 420 and Local 1549, along with our NYSNA sisters and brothers, support the staffing figures outlined below. The safe staffing legislation is about providing safe patient care by providing sufficient staff. The safe staffing legislation is about ensuring that the staff have a safe workplace. The safe staffing legislation is about ensuring that the experience that the patients have is the best possible one, where they get excellent care and attention which will be reflected in better health outcomes and better overall HCAPS scores.

In addition, having a truly safe staffing ratio will help to reduce significant workplace injuries that are common when there is unsafe staffing. Dozens of staff are injured at Jacobi every year. Many PCA’s report that historically the lack of staff has led to a staffing ratio far exceeding 1:12 and more commonly a 1:20 ratio if not more. BHA’s left alone have had to deal with significant workplace injuries on units where at any moment an emotionally disturbed person can go from calm to brutal acts of physical violence leading to members being out and units being left further understaffed.

HH staff have endured short staffing for many years and pushed back against it with only moderate success. The safe staffing legislation was not passed for several years after introduction. NYSNA was able to achieve staffing ratios in their most recent collective bargaining agreement while simultaneously pursuing the legislation. The pandemic exposed to the world the critical need for safe staffing at all levels, not just nurses.

Together with our management partners we are able to turn a crisis into an opportunity. We can establish true safe staffing ratios in out in patient units that will lead to better health outcomes and a safer workplace.

These proposals cover areas where we were not able to reach consensus or there are absent Management proposals or insufficient accounting for staffing needs beyond ratios from Management. According to the law, the CEO has the authority to agree with Labor proposals, Management proposals, or a compromise between the two.
The following proposals are focused on areas where staffing is necessary in locations above and beyond the contractually obligated ratios that we have already reached consensus on. Just for clarity, "inclusive of break coverage" means that those assignments and areas need break coverage while still staffing those areas at the amount stated rather than having them not being staffed or staffed with a lower amount during break times.

**2022 Jacobi Labor Proposals:**

**Non-RN staffing proposals:**

- Nursing Support staffing ratio in inpatient areas: 1:8 per unit per tour for PCA/PCT/Nurse Aides

- Behavioral Health - 4 BHA's per unit per tour

- AED - 4 BHA, 10 PCA/PCT/NA, 2 Clerical staff per tour

- PED - 3 PCA/PCT, NA, 2 Clerical staff per tour

**Rationales:**

In order to provide safe care for patients with bedsores, fall risks, elopements, diabetes, multiple medications, just to state a partial list of responsibilities, we need to ensure that each patient is getting the appropriate care and attention.

- A 7 hour day for a PCA equals 420 minutes. With 12 patients, that equals **35 minutes** per patient per 8 hour shift, which is not enough to safely take care of all the patients’ needs and do the necessary documentation.

- A 1:8 ratio equals **52 minutes** per 8 hour shift. Since patients need to be seen several times a day, and some patients take much more time than others, this is a much safer ratio. Patients are often waiting for an additional staff person to be available, a nurse or a PCA to move someone from bed to bed who has come from ICU to med surg or vice versa, and this cannot be done by one person.

- The hospital already commits to a 1:1 staffing ratio for the sitters, however a minimal budget and a reliance on temporary agency staff is not sufficient to meet the required amount of sitters even with revising criteria for who needs a 1:1. This leaves critical areas in the ER and Med Surg uncovered with the PCAs having to replace the “sitters”. In addition this leaves the nurses with additional responsibilities not incorporated into their current ratios.
RN staffing proposals:

**Adult Emergency Room:**
Greeter/EFAST nurse: 1 RN, 24 hours, inclusive of break coverage
Front Triage: 2 RNs, 24 hours, inclusive of break coverage
EMS Triage: 2 RNs, 24 hours, inclusive of break coverage
Charge Nurse: No patient assignment
Trauma/Resuscitation Nurse: 1 RN 3a-11a, 2 RNs 11a-3a

**Pediatric Emergency Room:**
Greeter/EFAST nurse: 1 RN - 11a-11pm, inclusive of break coverage
Front Triage: 1 RN 24 hours, inclusive of break coverage
Charge Nurse: Only assigned 1:4 “low-resource” resource patients.

Rationale: Triage and greeting in the emergency department are the most high stakes areas RN assessment ensures patient safety, Greeters screen potentially critically ill patients upon their very first arrival in the ED while triage nurses may be busy triaging patients, often with conditions that are not obvious, and facilitate rapid additional assessment and treatment. Additionally, adequate triage is necessary for deeper assessment for life threatening conditions and those likely to worsen in a short period of time. This staffing proposal ensures optimal minimum time to triage during peak hours. Charge nurse in the AED is an all-encompassing assignment that needs to be strictly focused on patient flow and assignment and ensuring safe staffing and care of critical patients. The need for specially assigned Trauma nurses has already been acknowledged and implemented. The amount of patients in need of trauma and/or resuscitation assessment and care on arrival to the ED is high enough to necessitate 2 nurses from 11a-3a. This also mitigates against nurses assigned patients in the rest of the ED having to leave their patients to respond to traumas/resuscitations. The PED is a smaller unit so charge nurses can be assigned patients but only those that require minimal time away from organizing patient flow, monitoring overall patient acuity, and other charge duties.

**CPEP**
6 RNs on unit, 24 hours

Rationale: This number of minimum nurses in the unit allows for 1 RN to staff the following 6 assignments: triage, pediatrics, non-HN charge duties/break coverage/respond to needs of higher acuity patients, medication, EOB, and Hold.

**Critical Care**
Float team of 2 RNs per 24 hours to cover Rapid Responses and immediate care of patients
that require 1:1 for certain procedures or acuity changes in 2A/2B/4B/5B/3ASD.
Non-HN charge nurse: Only assigned 1 lower acuity ICU patient.

Rationale: When CC nurses have to leave patients for rapid responses it leaves their critical
patients unmonitored. Also patients often deteriorate or need other 1:1 nursing care for
certain procedures or modalities of care. Regular staffing for this eventuality above and
beyond the 1:2 ratio that the current staffing model is based on is necessary. As per a
previously agreed upon framework, charge nurses should have a reduced assignment.

**Labor and Delivery**

7E
Triage - 2 RN, 24 hours.
Non-HN charge nurse: Only assigned 1 lower acuity L&D patient.

Rationale: Triage in L&D is a necessary way for the unit to assess acuity and get women and
future children to the most appropriate care and efficiently use unit resources in a highly
fluctuant and unpredictable patient census and acuity area. L&D triage is a more care
intensive process. There are 5 triage rooms in L&D and when full this violates the ratio for one
RN in that area. Break and volume coverage is a persistent issue as currently a nurse is floated
from PACU or 7W to cover so that adequate staffing exists. As per a previously agreed upon
framework, charge nurses should have a reduced assignment.

7W
Newborn nursery - 1 RN, 24 hours, inclusive of break coverage, regardless of lower census,
with additional nurses needed as 1:6 ratio is exceeded.
Non-HN charge nurse: 1:3 ratio

Rationale: Needing to care for newborn babies in the nursery could happen at any time of the
day and the volume and care needs of these patients are highly unpredictable and fluctuant.
The area needs at least 1 RN staffed around the clock with additional nurses shifted when
census spikes. As per a previously agreed upon framework, charge nurses should have a
reduced assignment.

**Inpatient Medical/Surgical**

Non-HN charge nurse: 1:3 ratio of lower acuity patients

Rationale: As per a previously agreed upon framework, charge nurses should have a reduced
assignment.

**Inpatient Behavioral Health**

Non-HN charge nurse: 1:4 ratio of lower acuity patients
Rationale: As per a previously agreed upon framework, charge nurses should have a reduced assignment.

**Perioperative Services**

**PACU:**
Ratio of 1:3 RNs for PACU patients, ratio of 1:2 RNs for SICU overflow patients in PACU
Daily staffing minimums:
7a-7p, Monday thru Friday: 7 RNs
7p-7a and weekends: 3 RNs

OR: Non-HN charge nurse not assigned a patient and covers PACU

Rationale: As per a previously agreed upon framework, charge nurses should have a reduced assignment and HNs should not be counted in numbers and have patient assignments.

**Ambulatory care**

All departments: 1 nurse per 4 provider panels
Non-HN charge nurses not assigned patients

**Children's Health Services**

**PICU/NICU:**
Non-HN charge nurse: Only assigned 1 lower acuity ICU patient.

Inpatient Pediatrics/6D:
1:5 nurse to patient ratio
Non-HN charge nurse: Maximum 1:3 ratio of lower acuity patients

Rationale: The national best practice standard is 1:4 for pediatrics for the lowest acuity inpatient units (see staffing plan from hospital in WA and CA state ratio law). We are only proposing 1:5 for now. As has been relayed to us by Management data, even though acuity has slightly decreased over time in pediatrics, the length of stay has drastically shortened and this increases the proportion of time nurses spend on admissions and discharges. The current 1:6 ratio is inadequate to provide quality care according to the following evidence and the RN staff currently working on the unit. As per a previously agreed upon framework, charge nurses should have a reduced assignment.

The studies/data listed below with hyperlinks bolster these claims.
An observational study of nurse staffing ratios and hospital readmission among children admitted for common conditions

BMJ Quality and Safety in Healthcare online May 2013

Adding just one child to a hospital's average staffing ratio increased the likelihood of a medical pediatric patient's readmission within 30 days by 11%, while the odds of readmission for surgical pediatric patients rose by nearly 50%.

Nurse Staffing and Children's Safety

RN4CAST@IT-Ped: Nurse staffing and children's safety (wiley.com) (editorial)

Staffing Plan Mary Bridge Childrens Hospital

Mary Bridge Childrens Hospital January 1, 2022 Staffing Plans for Childrens Hospital
Mary Bridge Children's Hospital Nurse Staffing Plan (wa.gov)

Sample brief: 1 to 3-4 patients based on intensity of care, geography and skill mix for Medical Surgical Pediatric patients. Ambulatory Pre-surgery 1 to 5. Ambulatory Post-Surgery/phase two 1 to 3. Emergency Room, GI Lab, PACU unit, PICU, Sedation Services ratios included (see article).

Is Hospital Nurse Staffing Legislation in the Public’s Interest? An Observational Study in New York State


Hospital staffing ranged from 4.3 to 10.5 patients per nurse (P/N), and averaged 6.3 P/N. After adjusting for potential confounders each additional patient per nurse, for surgical and medical patients, respectively, was associated with higher odds of in-hospital mortality [odds ratio (OR)=1.13, P=0.0262; OR=1.13, P=0.0019], longer lengths of stay (incidence rate ratio=1.09, P=0.0008; incidence
rate ratio=1.05, P=0.0023), and higher odds of 30-day readmission (OR=1.08, P=0.0002; OR=1.06, P=0.0003). **Were hospitals staffed at the 4:1 P/N ratio proposed in the legislation, we conservatively estimated 4370 lives saved and $720 million saved over the 2-year study period in shorter lengths of stay and avoided readmissions.**

**The Impact of Nurse Staffing Levels on Nursing-Sensitive Patient Outcomes: A Multilevel Regression Approach**


The results have several implications for management and policy. The article provides further evidence that there is a link between nurse staffing levels and NSPOs. In particular, it is shown for Germany that this association varies by unit type. Variation among unit types may be different in other health care systems. This understanding can help to better allocate nursing resources and might support policy makers in developing measures to ensure adequate staffing levels. **In particular, the differences observed among unit types and clinical complexity categories are relevant for designing minimum staffing regulations, which are currently one of the most common approaches to improving nurse staffing in hospitals.**

**The impact of understaffed shifts on nurse-sensitive outcome.**


To explore the relationship between exposure to understaffed shifts and nurse-sensitive outcomes at the patient level, this study was conducted in 2014 and was a secondary analysis of administrative data from a large acute care hospital in Western Australia. The sample included 36,529 patient admissions over a two-year period from October 2004–November 2006. Results of the study showed strong associations between nurse staffing and surgical wound infection, urinary tract infection, pressure injury, pneumonia, deep vein thrombosis, upper gastrointestinal bleed, sepsis and physiological metabolic derangement.

**The Society of Pediatric Nurses Safe Staffing for Pediatric Patients Literature Review**
SPN believes that all children and their families should receive safe, high quality, culturally sensitive, family-centered care in an environment that supports the development of the child and promotes excellence in nursing care. As an advocate for patients, families, and the pediatric nursing profession, SPN endorses the following recommendations: (see Article)

We look forward to hearing your decision and your rationales for those decisions in terms of the final Jacobi Staffing Plan in the coming week.

Sincerely,

Labor table of the Jacobi New York State Staffing Committee
DC 37 Local 420 and Local 1549 & NYSNA
CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe. Forward suspect email to spamadmin@nychhc.org as an attachment (Click the More button, then forward as attachment).

Thank you Sean. Outstanding work.

Mr. Mastromano,

Please consider our proposals carefully as safe patient care depends on your decision. Also, as the Union has provided proposals based not only on experience, but also on scholarly data, we hope that you require as much from the Nursing Leadership at Jacobi. We would greatly appreciate the ability to review that data.

Roxanne Romney

Hi Mr. Mastramano,

We are submitting proposals from the labor side of the table related to RN staffing at Jacobi. As we were informed at the final Friday meeting of the committee, proposals for all areas where we don't have consensus are to be submitted directly to you by 12p tomorrow.

DC 37 Local 420 and Local 1549, along with our NYSNA sisters and brothers, support the staffing figures outlined below. The safe staffing legislation is about providing safe patient care by providing sufficient staff. The safe staffing legislation is about ensuring that the staff have a safe workplace. The safe staffing legislation is about ensuring that the experience that
June 29, 2022

To Whom it May Concern:

RE: PFI 001165 – JACOBI MEDICAL CENTER

PCAs

NYC Health+Hospitals | Jacobi was not able to come to consensus with frontline staff on Nursing Support ratios. Nursing Support includes Patient Care Associates (PCAs), Patient Care Technicians (PCTs), Psychiatric Social Health Technician (PSHTs), and Nurses Aides. At our facility, the majority are PCAs who check vital signs, weigh and measure patients, obtain specimens, perform specimen screening tests, and records findings on patients’ charts, among many other important tasks.

Our proposal for Nursing Support ratios is one nursing support person to every twelve patients. The rationale behind the 1:12 nursing support ratio is:

- The staffing studies and literature support a 1:12 ratio.
  - The most robust study of RNS and supporting frontline staff supported a model of two non-RN nursing personnel for every 25 patients, equaling to a 1:12.5 ratio.
  - The Healthcare Center at the University of California San Francisco published a Health Workforce Baseline and Surge Ratio chart based on the “best available literature” and crowd sourced information on March 21, 2020. They also endorsed a 1:12 nursing support ratio where the RN ratio is 1:6, as it is in all of our med/surge units. Our Stepdown RN ratio is 1:4 and the critical care units are 1:2.

- Our RN ratios are robust.
  - As noted in the plan, RN ratios were agreed upon by both frontline staff and management alike with the exception of the inpatient pediatric unit.
  - AT NYC Health+Hospitals | Jacobi RNs and nursing support work as a team with one another. By ensuring that RN ratios are robust, our model enables RNs to step in and help nursing support staff during times when they are at a 1:12 ratio.
  - In the same study as cited above, “The effect of substituting one nurse assistant for one professional nurse to care for every 25 patients—thus reducing the skill mix from 66.7% to 50%, or by 16.7%--would be to increase the odds on morality by 21%.”

- NYC Health+Hospitals | Jacobi is committed to ensuring that nursing support staff do not exceed twelve patients at a time by building a robust nursing support pool.
  - The pool will be prepared to address any unforeseen surges and ensure that one to one coverage does not impact nursing support assigned to units.
Our review of the average daily census and bed count at the units in our hospital indicates that nursing support staff will often have fewer than twelve patients.

**BHAs**

Behavioral Health Associates (BHAs) at NYC Health+Hospitals | Jacobi work primarily in behavioral health units. They perform crisis and de-escalation interventions, therapeutic observations, and patient supervision. As a public health care hospital that sees some of New York City’s most acute psychiatric patients, our BHAs are essential to the functioning of our behavioral health units.

- Our proposal for BHAs is 2 BHAs per shift per inpatient unit for the following reasons:
  - One to two PCAs are assigned to each inpatient unit per shift. They support the team by taking vital signs, EKGs, glucose checks and assist patients with ADLs.
  - During Blue light episodes, called when patients become aggressive, there is a response team from all other units consisting of physicians, nurses, and additional BHAs, to assist with de-escalating the situation.
  - BHAs are not assigned to specific patients, but rather perform de-escalation functions and routine observations. Our facility has staffed 2 BHAs for each shift and have found the number to be sufficient to ensure patient and staff safety.

**PEDIATRIC NURSE PATIENT RATIO**

- NYC Health+Hospitals | Jacobi was not able to come to consensus with frontline staff on the Pediatric Nurse Patient ratio. Our ratio on the pediatric unit has been 1:6 for the last 6 years with no negative outcomes. This ratio meets the needs of the patients and the unit. The rationale for our recommendations is based on the following statistical data points:
  - The current contractual ratio as outlined in the NYSNA contract is 1 RN to 6 patients.
  - The CMI for pediatrics for calendar year 2022 is 0.90. This CMI reflects that the acuity of the patients is not high.
  - The ADC of the pediatric unit for calendar year 2022 is 11.2 with a LOS of less than 2.5 days.
  - Our readmission rate is less than 2%.

**ADULT and PEDIATRIC ED ASSIGNMENTS**

- The number of FTEs allocated for both the Adult and Pediatric ED permits coverage of the assignments proposed by labor.

**CPEP**

- As discussed with the committee, the CPEP staffing model is pending.

**CRITICAL CARE**

- Currently the ICU staffing allows for the nurses to respond as part of a rapid response and
cardiac arrest needs.

**CHARGE NURSE**

- Routinely, the only indirect caregivers are the Head Nurses. Charge nurses are expected to take an assignment.

Sincerely,

Suzanne Pennacchio, CNO
H+H | Jacobi
June 29, 2022

To Whom it May Concern:

The documents enclosed reflect the staffing plan for Jacobi Medical Center, PFI- 001165. There were three work areas where consensus was not achieved:

- PCA Staffing (Nursing Support)
- BHA Staffing (Nursing Support)
- Pediatric Floor Nurse Staff Ratios.

For the PCA Staffing, the literature supports 1:12 ratio which we have been operating with. To ensure that the 1:12 ratio is sustained, a nursing support staffing pool is being created to handle the supplemental areas which could detract from a 1:12 ratio, including care for patients who require 1:1 support.

At Jacobi, the BHA staff are supplemented by PCAs to perform the nursing support duties (performance of vital signs and ADLs), including any 1:1 coverage. This allows the BHAs to perform their primary functions of de-escalation, therapeutic and crisis interventions. Additionally, Jacobi has a Blue Light Response system when there is an active crisis on any behavioral health unit. During a Blue Light, a response team comprised of team members from other units (physicians, nurses, and BHAs) respond.

The last area where consensus was not achieved is on the pediatric in-patient unit. The current RN model of 1:6 is already a contractual standard. The unit has sustained a lower acuity with a CMI of only 0.9, an average length of stay of 2.5 days, and a readmission rate of less than 2%. All three of these indicators support the current 1:6 ratio.

Finally, it is my understanding that RN ratios were agreed upon by consensus of the committee across the units, except for the pediatric inpatient unit. In their response staff have included a number of additional recommendations. Jacobi will continue to adhere to the Collective Bargaining Agreement with NYSNA, as reflected in the final staffing plan. The CPEP unit is under review and will be brought to the committee as soon as possible.

Please let me know if you have any additional questions.

Sincerely,

Christopher Mastromano,
CEO, H+ H | Jacobi/ North Central Bronx