NYC HEALTH+ HOSPITALS

Carter

July 1, 2022

NYS Staffing Committee Submission
Facility: Carter Specialty Hospital
Facility PFI#: 1486

1) The final plan

Attached (Attachment 1) is the staffing grid for the various direct care titles: Head Nurse (HN), Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nurse Aid / Patient Care Technician (CNA/PCT), Clerical. All play a role in the care and services of patients in the Carter Hospital, a 201-Bed Long Term Acute Care Hospital (LTACH). The Final Plan was developed in coordination with Carter Hospital Management and representation from our various labor union partners. The following labor unions were represented during a series of Labor Management Committee Meetings to discuss elements that impact staffing ratios: New York State Nurses Association (NYSNA), AFSCME District Council-37, Locals 1549 and 420 (DC-37) and 1199 SEIU – United Healthcare Workers East.
2) The union’s proposal and rationale for areas where there was no consensus

There was a consensus on most of the staffing ratios, however, there was not a consensus on several titles by tour. The title and tour of the most significant divergence of an agreement was found in the Tour 1, the 8-hour midnight tour. The labor partners felt that the proposed ratio for Tour I (Evening) should be increased to match the Tour II (Daytime) and Tour III (Evening) ratios. An additional area of significant divergence with management was seen with the clerical title. The union partners felt that there should be a significant increase in clerical support for both Tours II and III. Their emails communicating the rationale from NYSNA and DC-37 are in the excerpts below.

From: Roxanne Romney <roxanne.romney@nysna.org>
Subject: Re: [EXTERNAL] Re: Staffing Grids - Carter

First, the good news. The NYS Henry J. Carter Staffing Committee was able to reach consensus for frontline nurse to patient ratios on most unit. That was an achievement. However, there are areas where we do not agree. Particularly, the change in nurse-to-patient ratios on tour 1. During tour 1, the patient load almost doubles. How does this provide for safe patient care? Patients on ventilators require constant monitoring and nursing care. We have updated the staffing committee grid to reflect our staffing proposals.

We agree with our Labor partners on their proposed staffing ratios.

Based upon the bedside nurses' experience, patient needs, NYC H+H agreed upon staffing and similar staffing at Long Term Care facilities such as Kingsbrook Jewish, here are our proposed staffing:

3 East Tour 1 H+H proposed 1:7, NYSNA proposed 1:5
3 West Tour 1 H+H proposed 1:11, NYSNA proposed 1:6
4 East Tour 1 H+H proposed 1:10, NYSNA proposed 1:6
4 West Tour 1 H+H proposed 1:10, NYSNA proposed 1:6
5 East Tour 1, 2, 3 H+H proposed 1:7, NYSNA proposed 1:6
5 West Tour 1 H+H proposed 1:11, NYSNA proposed 1:6
6 West Tour 1 H+H proposed 1:10, NYSNA proposed 1:6
7 West Tour 1 H+H proposed 1:10, NYSNA proposed 1:6

From: Dolan, Moira <MDolan@dc37.net>
Sent: Tuesday, June 28, 2022 12:41 PM
Subject: [EXTERNAL] Re: Staffing Grids - Carter

- Ms. Miller Aponte - Thank you for the opportunity to attend the HH staffing meetings with our members from Local 420 and Local 1549. After careful review of the plans we have the following responses. Our recommendations are below, not in the chart, I hope that will be ok.
DC 37 Local 420 and Local 1549, along with our NYSNA sisters and brothers, support the staffing figures we propose 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 the excellent care and attention, which will be reflected in better health outcomes and better overall HCAPs scores.

* In order to provide safe care for patients with bedsores, fall risks, diabetes, multiple medications, just to name a few, we need to insure that each patient is getting the appropriate attention. At Henry J. Carter, LTACH these are patients with the most severe conditions, in addition to regular medical care, they are seriously disabled and/or on ventilators and have difficulty with the functions of daily living.

* Unlike in Acute Care facilities, where we are supporting a 1:8 ratio, we strongly feel that the LTACH needs a 1:6 ratio of Nursing Support staff (PCA/MST/CNA). Even the 1:7 ratio proposed by HH is not sufficient to provide the safe care and monitoring necessary.

* At 1:6 ratio, which is what the unions supports, it equals 70 minutes per day. Patients need to be seen several times a day for feeding, cleaning, medications, monitoring and cannot often help themselves. This would allow staff to have adequate time to properly provide patient care. We see that the combination of RN, LPN and Nursing support may provide what appears to be a good overall ratio but we disagree, especially on 6W, with a bed count of 38.

HH staff have endured short staffing for many years and pushed back against it with no 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.

HENRY J. CARTER

* LTACH is a particular area that we are concerned needs additional staffing support.

* Nursing Support staffing in Med/Surg/ the union supports a staffing ratio of 1:6 per unit per tour for PCA/MST/CNA, not the formula of 1:17 proposed by HH for all the reasons above.

* Clerical - The Union does NOT support the .5 Clerical per Tour 2 on Tour 2 only. There should be 1 clerical per unit, on both Tour 2 and 3. Currently the nurses and the nursing support staff have to pick up the phones when able, which is not often. Patients families and patients DOCTORS are not able to get through to the units using the call center and critical information is getting delayed, especially when transfers in and out of acute care happen. Recently a patient I am personally familiar with has been hospitalized twice for infections that should have been caught at the facility level, including in the ports which were "filthy". The transfers were further complicated by communication difficulties.
Regards,
Moira Dolan
Sr. Assistant Director
Research & Negotiations

3) Management’s proposal and rationale for areas with no consensus

- Henry J. Carter Nursing Department and NYSNA reached a consensus on the staffing ratio of 1:6 on days and evening shifts however, there was no consensus for the night shift.
- Both Nursing administration and Labor partners agreed to have the same number of staffing on both day and evening shifts for nurses and ancillary staff for the following reasons:
  - Majority of patients are on ventilator with multiple comorbidities and multiple pressure injuries
  - Nursing activities during both shifts are similar such as medication administration, pressure injury care, suctioning every 2 hours and PRN, Finger stick monitoring, tube feeding, patient family teaching (RNs), documentation, admission assessment and care
  - 98% of admissions come during evening shift
- Nursing administration’s rationale for the different number of nurses for night shift are as follows:
  - There are less medications to administer during night shift
  - Most treatments are done daily at 9 AM and PRN so they will only have to do treatments PRN
  - Admissions and discharges seldom happen during nights
  - Tube feeding set up are divided
  - Direct patient care is done by ancillary staff who also perform vital signs taking, weighing, intake and output, turning and positioning, transfers among many other things
  - There are no visitors during night shift
  - All three shifts have respiratory therapist on each floor who also evaluates patient’s respiratory status, do ventilator care, suctioning and administer respiratory treatments
  - There was a proposal for 1 Clerical Associate for each unit during the day. Nursing administration’s proposal is to maintain 1 Clerical Associate per floor as their tasks has reduced due to electronic documentation. However, we proposed to add 1 Clerical Associate to cover the facility on evenings and 1 Clerical Associate to cover half day on weekends.
  - There are also Institutional Aides who provide support to nursing for non-patient care activities such as environmental and equipment maintenance.
  - Our facility is committed to address any unforeseen surges and ensure that one to one coverage does not impact nursing support to units.

4) CEO’s written submission explaining the elements that did not gain consensus and brief explanation of determination:

Carter Specialty Hospital is a 201-bed long term acute care hospital (LTACH). With an average length of stay of 48 days, Carter is the only LTACH in the New York City and manages high acuity post acute care patients. Carter’s admissions originate from short term acute care hospitals (STACH) in the NYS Metropolitan area.
Admissions are considered stable and meeting the InterQual LTACH Criteria. All admissions require continued skilled care and monitoring.

Carter's staffing pattern to date has been supported by key performance indicator (KPI) data points. During our analysis of appropriate staffing ratios, we identified that national quality and patient satisfaction data places Carter as one of the top LTACHs in the Country. Our KPI quality indicators are at or better than the national average in the areas of "Falls with major injury", "C-Diff Infections", "Blood stream infections". Respiratory Management and ventilator weaning is considered a "Center of Excellence" and is nationally recognized. Our ventilator weaning rate of 73% is well above the national average with our best practices have been published. Although we have validated that Carter exceeds quality thresholds with our current staffing ratios, Senior Administration recognizes the value in improving ratios focused areas and tours.

As the CEO, I have reviewed the Carter Staff Committee’s activity through several meetings and email communication. I have also reviewed the rationales from both Labor and Management, of which I am most appreciative of all participant’s perspectives and collaborative input into the process. At this time, I am fully supportive of the Management Proposal and prepared to proceed with increasing the LTACH staffing ratios. The new staffing ratios constitute a significant investment into Carter LTACHs RN and frontline support staffing and further advance Carter’s commitment and mission to deliver the highest quality of care.

Respectfully Submitted,

Floyd R. Long, CEO

Stanlee Richards, Chief Nurse Officer
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<th>Dept Name</th>
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<th>Physical Bed Count</th>
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<th>Shift 1 Ratio</th>
<th>Shift 2 Ratio</th>
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- * UNITS TEMPORARY NOT ACTIVE
- ** 7 WEST PRESENT BED CAPACITY = 20