NYC HEALTH+ HOSPITALS | Jacobi | North Central Bronx

PFI-001165 NYC Health + Hospitals | Jacobi

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

PFI -001165 Jacobi Medical Center

JA					RN		Nursing Support			BHA			HN			Clerical		
Dept Name	Service	Functional Service	Physical Bed Count	ADC	Shift 1 Ratio	Shift 2 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio
JA IP 3A SURGERY	Med/Surg	Med/Surg	24	20.9	1:6	1:6	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 3B MED	Stepdown	Stepdown	12	11	1:4	1:4	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 4A MED/SURG	Med/Surg	Med/Surg	33	31.3	1:6	1:6	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IPR 4D REHAB	Med/Surg	Rehab	24	22.2	1:7	1:7	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 5A MED/TELE	Med/Surg	Med/Surg	35	14	1:6	1:6	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1 : Unit	1 : Unit
		Stepdown		20	1:4	1:4												
JA IP 5D MED/TELE	Med/Surg	Med/Surg	31	31.9	1:6	1:6	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 6A MED/TELE	Med/Surg	Med/Surg	35	32.8	1:6	1:6	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 3A STEPDOWN	Stepdown	Stepdown	11	10.2	1:4	1:4	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 2A BURN ICU	ICU	Burn Center	8	6.1	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 2B SURGICAL ICU	ICU	ICU	12	10.6	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 4B MICU	ICU	ICU	12	10.2	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 5B ICU/SDU	ICU	ICU	12	8.9	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit`		N/A	1: Unit	1: Unit
		Monitor Tech			N/A	N/A	2 : Unit	2 : Unit	2 : Unit	N/A	N/A	N/A				N/A	N/A	N/A
JA IP 6B PICU	Mat/Child	PICU	8	4	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 6D PEDIATRICS	Mat/Child	PEDs	18	12	1:6	1:6	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 7NJ NICU	Mat/Child	NICU	25	17.7	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JA IP 7W MOTHER BABY	Mat/Child	Mat/Child	22	12.6	1:3 couplets	1:3 couplets	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit		N/A	1: Unit	1: Unit
JAC01 10E ADULT DETOX	BH	Adult Psych	0	0	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed	Closed
JA IPP 7A PSYCHIATRY	BH	Adult Psych	22	22	1:7	1:7	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit		1: Unit		N/A	1: Unit	1: Unit
JA IPP 7D PSYCHIATRY	BH	Adult Psych	22	22	1:7	1:7	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit		1: Unit		N/A	1: Unit	1: Unit
JA IPP 8A PSYCHIATRY	BH	Adult Psych	23	23	1:7	1:7	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit		1: Unit		N/A	1: Unit	1: Unit
JA IPP 8D PSYCHIATRY	BH	Adult Psych	22	22	1:7	1:7	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit	2: Unit		1: Unit		N/A	1: Unit	1: Unit
JA IP 7EJ L&D	L&D	Labor and Delivery		6	1:2	1:2	1:12	1:12	1:12	N/A	N/A	N/A		1: Unit	1: Unit			
CPEP	BH	Emergency Dept		16.5	5: Unit	5: Unit	2: Unit	2: Unit	2: Unit	5: Unit	5: Unit	5: Unit		1: Unit				

Department - DOH Required	Facility Department Name:	Service Line	Planned Volume / Day shift	Planned Volume / Evening shift	Planned Volume / Night shift	# of RN during Day Shift	# of RN during evening shift	# of RN during night shift	# of LPN during Day Shift	# of LPN during evening shift	# of LPN during night shift	# of Ancillary Members during Day Shift	# of Ancillary Members during evening shift	# of Ancillary Members during night shift	# of unlicensed personnel during Day Shift	# of unlicensed personnel during evening shift	# of unlicensed personnel during night shift
Ambulatory Surgery	Ambulatory Surgery	Surgery	5.1	5.1	0	5	2	NA	NA	NA	NA	NA	NA	NA	1	NA	NA
Cardiac Catheterization	Cardiac Cath Lab	Medicine	2.8	1.6	0	5	5	NA	NA	NA	NA	NA	NA	NA	6	6	NA
Endoscopy	Endoscopy	Medicine	10.5	0	0	7	4	NA	NA	NA	NA	NA	NA		4	NA	NA
Medical/Surgical Ambulatory	Surgical Clinic	Ambulatory	99.99	89.5	0	12	12	NA	1	NA	NA	NA	NA	NA	12	NA	
Medical/Surgical Ambulatory	Medical Clinic	Ambulatory	99.99	99.99	0	21	6	NA	NA	NA	NA	NA	NA	NA	26	5	NA
Obstetrics/Gynecology	Women's Health initiatives	Ambulatory	99.99	36.5	0	9	7	NA	2	NA	NA				12	2	NA
Dental O/P	Dentistry	Dental	5	0	0	2	NA	NA	NA	NA	NA	NA	NA	NA	12	NA	NA
Dialysis - Acute	Renal Dialysis	Medicine	5.33	4.2	0	5	5	NA	1	0.3	NA				1.5	0.5	NA
Infusion Center	6 South	Medicine	20.6	0	0	4	NA	NA	NA	NA	NA	NA	NA	NA	4	NA	NA
Operating Room	2E	surgery	15.5	7.7	0	19	10	6	1	NA	NA				10	1.5	2
	2D PACU	surgery	10	10	0	6	5	2	NA	NA	NA	NA	NA	NA	1	0	0
MRI	Radiology Diagnostic	Radiology	8.3	8.3	8.3	1	1	1	NA	NA	NA	NA	NA		NA		
Mental Health Services O/P	9West/chemical dependency	Psychiatry	2	0	0	1	NA	NA	NA	NA	NA				1	NA	NA
Pediatric Primary Care	Pediatric Primary Care	Ambulatory	99.99	40.2	0	7	7	NA	4	NA	NA				12	1	NA
Nuclear Medicine/Radiology	Radiology Diagnostic	Radiology	47	23.5	0	4	2	1	NA	NA	NA	15	4	2	6	1	NA

Nursing Support Titles
PCA
PCT
PSHT
Nurses Aide

PFI 001165- Jacobi Medical Center

Adult Emergency Department

		RN		Nursing Support			BHA			Sitter		
		Shift 1 Ratio	Shift 2 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio
Applies to All Adult Emergency Departments	ESI 1	1 : 1	1 : 1	1 : 12	1 : 12	1 : 12	2 : Unit	2 : Unit	2 : Unit	2 : Unit	2 : Unit	2 : Unit
	ESI 2	1 : 2	1 : 2									
	ESI 3	1 : 5	1 : 5									
	ESI 4 + 5	1 : 8	1 : 8									

Ratio does not change based on ESI

PEDs Emergency Department

		RN		Nursing Support			BHA			Sitter		
		Shift 1 Ratio	Shift 2 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio
Applies to All PEDs Emergency Departments	ESI 1	1 : 1	1 : 1	1 : 12	1 : 12	1 : 12	N/A	N/A	N/A	N/A	N/A	N/A
	ESI 2	1 : 2	1 : 2									
	ESI 3	1 : 5	1 : 5									
	ESI 4 + 5	1 : 8	1 : 8									

Ratio does not change based on ESI

Operating Room

	RN		Surgical Tech			Nursing Support			Clerical
	Shift 1 Ratio	Shift 2 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio	Shift 2 Ratio	Shift 3 Ratio	Shift 1 Ratio
Operating Room	1 : 1	1 : 1	1 : 1	1 : 1	1 : 1	2: unit	N/A	N/A	1:unit

Nursing Support Titles
PCA
PCT
PSHT
Nurses Aide

From: Petty, Sean RN <Sean.Petty@nychhc.org>
Sent: Thursday, November 9, 2023 12:02 PM
To: Nolan, Thomas <nolant2@nychhc.org>; Barlis, Ellen <Ellen.Barlis@nychhc.org>; Pennacchio, Suzanne <Suzanne.Pennacchio@nychhc.org>; Haynes, Gail <haynesg3@nychhc.org>; Paige, Salwa <paiges1@nychhc.org>; zakiyyah.zaimah@nysna.org; Fredericks, Ani <frederia7@nychhc.org>; Heron, Mark <MHeron@dc37.net>; Diamond, Geretha <Geretha.Diamond@nychhc.org>; stacyG@1199.org; Rock, Albert <Albert.Rock@nychhc.org>; Simon, Mary <Mary.Simon@nychhc.org>; Sample, Janiqua PCA <Janiqua.Sample@nychhc.org>; Soliman, Carmen RN <Carmen.Soliman@nychhc.org>; Dolan, Moira <MDolan@dc37.net>; Jenkins, Beverly <Beverly.Jenkins@nychhc.org>; O'Neill, Andrea <Andrea.ONeill@nychhc.org>; Patel, Kanish <patelk56@nychhc.org>; Collins, Christopher <collinsc5@nychhc.org>; selina.grey@nysna.org; judgefelecia@yahoo.com; Judge, Felecia <Felecia.Judge@nychhc.org>; Mastromano, Christopher <Christopher.Mastromano@nychhc.org>; Coleman, Lazon <colemanl4@nychhc.org>
Subject: NYS Staffing Committee Labor Table Proposals - 2023 November Update

Hi Mr. Mastramano,

We are submitting proposals from the labor side of the table related to staffing at Jacobi for compliance with the NYS Safe Staffing law.

First a note about process. Our submission was unfortunately hurried as we were only informed of this mid-year submission necessity on the day of the last in-person Staffing Committee, Thursday, November 2, 2023. This rushed nature of process compromises the Labor Table's ability to provide as comprehensive of an analysis and evidence based practice documentation as we would like.

DC 37 Local 420 and Local 1549, along with our NYSNA sisters and brothers, support the staffing proposals 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 truly safe staffing ratios and unit-based requirements will help to reduce significant workplace injuries that are common when there is unsafe staffing. Dozens of staff are injured at Jacobi every year. BHAs 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 of work with physical disabilities and units being left further understaffed.

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 for RNs and other areas that we have already have reached consensus on. Just for clarity, "inclusive of break coverage" means that those assignments and areas need break coverage while continuing to maintain the safe patient ratios and stands in opposition to the current practice of breaking the ratios during staff break times.

2022 Jacobi Labor Proposals:

Non-RN staffing proposals:

- Nursing Support (PCA/PCT) staffing ratio in the 2B Burn
- ICU 1:4
- Nursing Support (PCA/PCT) staffing ratio in all other Critical
- Care ares (3ASD, 2B, 4B, 5B) 1:6
- Nursing Support (PCA/PCT)
- staffing ratio in all other inpatient areas: 1:8 per unit per tour for PCA/PCT/Nurse Aides
- Inpatient Behavioral Health
- - 3 BHAs per unit per tour
- AED - 4 BHA, 10 PCA/PCT, 7 Clerical staff per tour (1 EFAST/greeting
- station, 2 for Registration, 1 EMS Registration, 3 for property/transportation/inside registration/financial, 1 additional unit needs)
- 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. This is especially necessary in the Burn ICU where intensive, careful patient care is at its highest level. Similarly in the other ICUs, more frequent vital signs, glucose monitoring, and more attentive patient care is necessary so it is very problematic to have the same ratio for support staff in the ICUs vs the other inpatient units. For the other inpatient units, here's a clear breakdown of patient need

- 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 threathing 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 above and beyond what is necessary to meet 1:2 patient ratio in the units 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.

3A Surgical Step Down: 1:3

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. For Surgical Step Down, we are a Level 1 Trauma Center. Our regular SICU is persistently full, backing up patients in the AED and the PACU, as well as transferring patients to the Surgical Step Down with significantly high acuity. The amount of patients on ventilators or the amount of drip medications are not an accurate indication of the needs of these patients, rather it is the necessity for close post-surgical monitoring of signs and symptoms of patients with very precarious conditions and risk for sudden, rapid deterioration.

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. Since lower acuity monitoring now takes place outside of the hospital setting, when patients are in the hospital, they need higher monitoring. Many of our children are in precarious social circumstances because we care for patients in a county with one the highest levels socio-economic disadvantage. Disproportionate lack of home-based social support increased the need for nursing to play a greater role in patient care. This is especially true for disease processes that our patient population suffers from disproportionately - weapons-based trauma, asthma, and SSD to name the most significant. 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

Karen B. Lasater, Linda H. Aiken, Douglas M. Sloane, Rachel French, Colleen V. Anusiewicz, Brendan Martin, Kyrani Reneau, Maryann Alexander, and Matthew D. McHugh. (2021) Medical Care. Vol 00, Number 00.

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

Karina Dietermann, Vera Winter, Udo Schneider, Jonas Schreyogg. The European Journal of Health Economics Vol 22 Page 833-846 (2021).

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.

Diane E. Twigg, Lucy Gelder, and Helen Myers. (January 2015). Journal of Advanced Nursing.

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

Kathleen Van Allen. 2012 Elsevier Inc. doi:10.1016/j.pedn.2012.07.005

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

NYC HEALTH+ HOSPITALS | Jacobi | North Central Bronx

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November 13,2023

Mr. Christopher Mastromano, CEO:

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 for inpatient units with the exception of behavioral health. 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 and surgical stepdown units.
    - 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.
- 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 addresses any unforeseen surges and ensures that one to one coverage does not impact nursing support assigned to units

Our review of the average daily census and bed count of our units in our hospital indicates that nursing support staff will often have fewer than12 patients.

BEHAVIORAL HEALTH ASSOCIATES

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:
    - 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 2023 NYSNA contract is 1 RN to 6 patients.
- The CMI for pediatrics for calendar year 2023 is 0.90. This CMI reflects that the acuity of the patients is not high.
- The ADC of the pediatric unit for calendar year 2023 is 11.5 with a LOS of less than 2.55 days.
- Our readmission rate is less than 2%.

SURGICAL STEP DOWN UNIT:

NYC Health + Hospitals/Jacobi was not able to come to consensus with frontline staff on the Surgical Stepdown Nurse-Patient ratio. Our ratio has been 1:4 for the last 7 years with no negative outcomes related to staffing. 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 2023 NYSNA contract is 1RN to 4 patients in the stepdown units.
- The average daily census for this unit for calendar year 2023 is 9.9 patients.
- There was consensus for the medical stepdown ratio being 1 RN to 4 patients

Additionally, the committee is working on ambulatory staffing ratios.

Sincerely,

Suzanne Pennacchio

Suzanne Pennacchio, CNO
H+H | Jacobi

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November 14, 2023

To Whom it May Concern:

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

- PCA Staffing (Nursing Support)
- BHA Staffing (Nursing Support)
- Surgical Step-Down Nurse Staff Ratios
- 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.

Additionally, consensus was not reached in the surgical step-down unit. The request is to move to a 1:3 instead of the current 1:4. There is agreement with the 1:4 for the medical stepdown and that is the ratio in their current contract. This has been the ratio for the last several years with no adverse outcomes related to staffing.

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 and the surgical step down. 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.

Sincerely,

Christopher Mastromano, CEO