The Frontline Newsletter

A newsletter for the members of HPAE Local 5106 JUNE 2016

President's Message

"By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care." The president "believes that innovations in electronic health records will help transform healthcare in America." Envisioned is "a drastically changed system"

President George W. Bush, State of the Union Address, January 20, 2004

I attended several presentations on this subject of electronic medical records at the AFT Professional Issues Conferences in the early years after this announcement was made. Outlined were many of the steps we as Union Leaders needed to take to ensure that our members were protected during this process. It was explained that the goal date for implementation was 2017. Hospitals that went live with EMR before 2017 would receive hefty incentive funding to accomplish this, and penalties would be imposed on hospitals that did not comply with the mandate. It is now 2016, time is running out, and I have been waiting since 2004 for the opportunity to have our Union Voice heard. Need I say that our Union was never approached for any input or negotiation on how the EMR was to be selected or implemented at our facility. The selection of Epic was never discussed with the nurses, techs, or professionals that would actually be using the Epic charting system. It is my understanding that Epic charting can be built and tailored to the needs of a particular department or unit to facilitate accurate and ease of charting. Up until February 26, 2016 I know of no one who was approached to represent us and to be our voice. It was at a meeting I learned that there were nurses that were somehow involved in this process, but their role was never explained or defined to the Union. We learned that the Epic rollout was to be in August of 2016 and that there would be training for Super Users and for all other staff to be completed by July 31, 2016.

I am thoroughly disillusioned by the way in which this entire process has been implemented. Several of my coworkers responded to an email inviting them to be Super Users. I have watched them struggle and become increasingly frustrated just signing up for Super User classes. Instructions were minimal and vague at best. They went to classes and were denied entry and told to go home because their names were not on the list. I observed them attempting to practice what they had learned in class, but unable to do so because no one could figure out how to get on the "Playground" site. If Super Users were having such difficulties I could not imagine how difficult it was going to be for the rest of the staff. I attended my Epic 100 and 200 classes with much anxiety and trepidation. I was not disappointed....my fears and anxiety were most definitely warranted. Our instructor was very knowledgeable about all aspects of Epic charting. However she was not a nurse and did not seem to grasp how the nurses think, learn and how we document. I expected to start at point A and finish at point Z. Meaning I would first learn how to enter a patient, then triage the patient, place said patient in a bed and assign myself or another nurse care of this patient, enter an assessment, take off orders, sign out meds and either admit or discharge the patient.

After completing the class I am unable to complete any of this documentation with any hope of accuracy or facility because I was not instructed on how to chart most of this medical information. Our class started with acknowledging orders, and viewing the reports sections of the chart. I found this extremely confusing because I could not comprehend what she was teaching as I had not yet been taught the basics. We were given information to chart-- but our work was not checked for accuracy, so I have no clue whether I documented this information correctly or not. We were shown how to document during a code, IV charting,--- bouncing from one charting area to the next. I was completely lost, but was repeatedly reassured that we could practice in the "Playground" and have our questions answered there. Will our work in the "Playground" be checked for accuracy? How will I know if I charted everything required and where do I find these sections of the chart?

At the end of the day the instructor remarked that "most of you look confused" and unable to process much more information. We took the test and we all "passed". I went home with much more trepidation and anxiety than I had prior to starting the class. I believe that one, three hour, and one, five hour class is an insufficient amount of time to grasp all of the information necessary to accurately document on patients in our care. I fear that we will be so focused on our documentation that actual patient care may fall to the wayside and our patients may be neglected. No one seems to be listening! Our frustration and fears are real. I dread the arrival of August but am thankful that I will be on vacation when Epic goes "live". Hopefully the onsite trainers and Super Users that were promised to be present during the rollout phase will provide the necessary assistance to our members so that the care we provide our patients can be accurately documented. GOOD LUCK EVERYONE !!!

Elizabeth Nulty
Local 5106 President

Grievance Update

On May 31 the Union went to arbitration and succeeded in negotiating a very good settlement for a nurse who was terminated without just cause. After twenty-six years of faithful service this nurse certainly deserved better than being disciplined so harshly for a questionable offence. The nurse had serious concerns about even returning to work in an environment where her value and commitment were not recognized. During the pre-arbitration period the Hospital reached out to the Union for a possible settlement. Our grievant was in no hurry to settle and the decision to wait resulted in a financial settlement that was significantly higher than what the hospital had originally proposed. Terms of the agreement included a neutral reference and resignation in lieu or termination. The arbitrator congratulated all parties on doing the difficult work of negotiating a settlement which was acceptable to both sides. He noted that when the decision was left in the hands of the arbitrator rarely were people happy with the outcome.

Staffing Emergency

There is, and has been for some time, a staffing emergency in the ED. Five unfilled positions on the night shift means nurses work short every night of the week. Despite the lack of staff, patients continue to pour in. The closure of St. Joseph Hospital has had a direct impact on the number of patients seen in our ED. Not every patient is acutely ill, but they must all be triaged, assessed, treated and medicated. There must be appropriate disposition, which might mean transfer to Temple or another facility, admission to C6 or discharge. The necessary documentation must be done. Time and resource mean enough nurses to do the job and do it right.

The Hospital has put our nurses in a difficult and dangerous situation, physically and legally.

Some of our clientele have no qualm about causing a ruckus or even assaulting a staff member if they are not treated promptly. As the nurses are rushing to get the physical work done will they forget to document something that will land them in the disciplinary process or a lawsuit?

So Temple is seeking Magnet Status. *A Magnet hospital is stated to be one where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution.*

Our ED staff is struggling to survive let alone reach those lofty Magnet goals. It is inconceivable that this situation even exists. Our pool rates have not increased in ten years so we are losing those nurses to higher paying, less stressful institutions. The Hospital must fill open positions now and get agency staff on board to fill the gaps until new staff is up and running.

In the meantime, ED nurses must continue to fill out short staffing forms. They are our way of telling the Hospital and *documenting* such that you have left us in an unsafe situation for patients and staff, that we will do our best to care for the patients, but ultimately, the Hospital is responsible for negative outcomes that result from short staffing.

Inpatient Staffing issues

As nurses on the inpatient units read about the problems in the ED, they can also attest to the times they have worked short staffed. A single nurse on an acute behavioral unit with 20 plus patients is ludicrous. How can that one nurse give meds, assess patients, respond to emergencies, document, admit and discharge patients and do it right? She can't; and the Hospital knows that this is an impossible situation. Even on the extended acute units, when the acuity levels are high and the med pass is never-ending, staffing becomes an issue. On the medical unit, one nurse was the only qualified RN for five hours on the night shift with 12 patients and the possibility of admissions. Sending a behavioral health nurse to the unit to be the second licensed person was the fulfillment of a regulatory requirement or in nursing terms—"putting a body in a place."

When nurses worked short staffed they do not *have a high level of job satisfaction* nor can they *deliver excellent patient outcomes*. They feel undervalued, overworked and exhausted.

If we are going on this "Magnet Journey" the Hospital better get on board to provide safe staffing or we will all be left waiting at the station.

HPAE. Putting care first.

When Hospitals Are Also Corporations

U.S. Hospitals started as charitable institutions in the late 1800s, funded by wealthy donors and religious organizations. The mission was focused on health care and care for the poor. It was clear where the money came from, clear where it went.

Much has changed. More and more, our community hospitals are disappearing, and in their place large corporate systems are emerging Hospital revenues now also come not just from patient care, but from for-profit subsidiaries, investments, ambulatory surgical-centers, and income from hospital-controlled physician practices.

One Bergen County hospital that started in 1880 with 12 beds is now part of a system with 28 hospitals. A recently merged hospital system will employ nearly 50,000 people, with revenues of $8 billion dollars.

As hospital systems grow, they often begin to act more like for-profit institutions, even while maintaining not-for-profit status. The source and use of their funds becomes both more complicated and less transparent. So does their mission, their relationship to local communities, and their relationship to their employees and physicians.

It's now common for not-for-profit hospitals to own and provide financing to for-profit subsidiaries, to have for-profit entities operating from their tax-exempt property, to engage in profit-sharing with their physicians; and for hospital CEO compensation to reach into the millions.

In Trenton, elected officials are scrutinizing whether not-for-profit hospitals that own for-profit entities and permit for-profit physicians to use their hospitals with minimal control (especially over billing practices) are solely focused on a "charitable" mission of health care service to the community, or are part of a profit-making corporate structure that is not paying their fair share of property taxes.

This debate is happening not only because of the growth of hospital systems, but because many of our towns and cities are facing fiscal problems, and having difficulty absorbing the costs of critical public services. Hospitals, like other corporations, are large employers and large users of local services such as police, fire, infrastructure, and public safety.

Both not-for-profit and for-profit hospitals have an obligation to be good corporate neighbors, reinvesting in healthcare, listening to the needs of the community, and sharing in the costs of local services, whether through community contribution fees or property taxes.

In New Jersey, the average nonprofit hospital receives a $1.6-million benefit annually as a result of exemption from property taxes. While much of this tax benefit supports charitable activities, profit-making entities and activities at not-for-profit hospitals are benefitting from loopholes in existing law.

In return for exemption, the government requires nonprofit hospitals to provide community benefits, which includes research, health professions training, and community health education programs. It also includes charity care provided to patients who cannot pay, which all hospitals must provide, regardless of their tax status.

Hospitals are anchors in our community, providing essential services and employing large numbers of our citizens. Both for-profit and not-for-profit hospitals have moral, as well as legal, responsibilities to the hospital's patients and our communities, to focus on promoting health as well as treating illness. Hospitals should continue to be driven primarily by these obligations, rather than profit or competition.

That means doing more than charity care. It means ensuring that 'community benefits' are based on true community need, and will improve health outcomes for our residents. It means using surpluses to re-invest in the hospital, in public health measures, and other activities that are the hallmark of charitable institutions.

I know that many hospitals take that mission seriously. Paying property taxes commensurate with the value of the property used by for-profit subsidiaries or by physicians engaged in for-profit activity independent from the hospital's jurisdiction should be part of that mission.

As the NJ legislature debates new legislation and the establishment of a study commission, we urge the inclusion of community residents, municipal officials, healthcare workers and advocates in the process. Solutions must account for and protect the services of community, urban and safety net hospitals, and include financial transparency, since the size and speed of hospital mergers and subsequent mingling of funds makes it increasingly difficult to 'follow the money.'

We should expect all of our hospitals to be good corporate citizens and neighbors, and responsible stewards of our healthcare.

Ann Twomey
HPAE President

RN TECH PROFESSIONAL PRACTICE COMMITTEE

June 16, 2016

Attendance: Barbara Gennello, Betsy Nulty and Sue Clements

ED Registration:

Union: There continues to be problems on the 11p to 7am shift with a delay in the registration process. If the first part of the process is not completed the nurse cannot pull meds for the patients. If the second part is not completed doctors cannot enter orders. In both circumstances there is a delay in treatment. Betsy suggested that increased census from 11pm to 3am and the delay in registration might warrant a second admission clerk.

Epic training

Union: The training has been less than adequate to prepare staff to go live on 8/5/16.

Even super users are not adequately prepared. Training is fragmented and does not follow any logical progression that would enable the staff to go step by step in learning how to document in the system. We will need a significant number of Epic support people to do on the job training.

Management: Barbara—We will be hiring some agency nurses to help provide care while staff is learning the new system. There will also be Epic trainers on campus to assist with the transition. In terms of behavioral health, Episcopal administrators had to build the Behavioral Health documentation. The first 2 to 3 weeks will be a challenge.

ED staffing

Union: Short staffing in the ER in critical and dangerous. Where are the agency nurses that we heard were coming?

Management: We are aware of the staffing situation and have been working with an agency, ATC, to get the necessary number of nurses. We expect eight nurses to come for orientation on Monday. The agency contract will be for 13 weeks to see us through the Epic transition. We are also looking to get qualified pool nurses hired and oriented as soon as possible.

Preceptor differential

Union: Contractually, preceptors must receive "instruction" in order to be a preceptor. Some managers have not paid the preceptor differential to nurses unless they have attended the preceptor class. The Union position is that the contract does not make the preceptor class prerequisite for receiving the differential, only that the preceptor receive instruction.

Management: Barbara agreed that the preceptor class was not mandatory, but an option for a preceptor. Any nurse who has precepted and not received the differential should provide that information to Barbara for retroactive compensation.

ER Pool Requirement

Union: The previous nursing manager stated that they were no requirements for pool staff. What is happening to the previous minimal shifts and holiday requirements?

Management: Barbara's understanding was the requirements have not been changed or eliminated. Pool is required to offer two shifts a pay period and work one minor and one major holiday.

WELCOME

The Local welcomes the following new members to the Hospital and our bargaining unit:

Kellieanne Lauer, RN (ER), **Kathleen Brophy**, RN (PM5), **Lizy Varghese**, RN (C5) and **Samantha Opalka**, RN (C6). Welcome back to Kathleen Yoast (Lab) who recently returned to the bargaining unit. We invite all of you to become actively involved in the life of the local. We hope to see you at the next General Membership Meeting in August when we kick off our contract campaign.

GOODBYE

The Local wishes a fond farewell to three recent retirees. **Kathy Sutton** (lab), **Donna Holzer** (C5) and **Edel Callery** (C6). Each of these women were excellent, well respected workers and they will be missed by co-workers and patients alike. We wish them every happiness and hope they can sit back, relax and enjoy retirement

A special thank you to Edel for her past service to the Union as a unit representative and a member of the negotiating team. Edel was there from the beginning, attending meetings at Shannon's bar while we secretly plotted to become union. She was there when we organized as Episcopal employees and then when we were forced to re-organize as Temple employees.

She got to see first-hand how being union gives us a voice. She was a valuable member of the team, with good insight, lots of nursing experience and a great sense of humor. We are grateful for your contributions, your time and your efforts. Our best to you for your faithful service.

FYI

Seniority lists are presently posted on the Union Bulletin boards outside the nursing office on the first floor and by the radiology time clock on the third floor. Please check the list for accuracy. Should your date be incorrect, please contact **Sue Clements** at suehpae@aol.coom subject seniority date.

SAVE THE DATE

HPAE CONVENTION 2016
October 6 & 7
Bally's—Atlantic City, NJ