CUTTING INTO BONE
Hospitals are shutting down critical units. Nurses are fighting back

TAKING CARE OF BUSINESS
Nurses rally for a tax on Wall Street

RNs hit the streets for a Main Street Contract

Taking Action

RNs Say

HEAL AMERICA
Tax Wall Street
Letter from the Council of Presidents

IT’S BEEN A WILD month! By now, we hope most of you are familiar with our Main Street Contract for the American people campaign. It’s really a no-brainer to understand: Our economy has gotten so out of whack, tilted in favor of the wealthy and big corporations, that our country needs to reprioritize the needs of regular, working Americans: living wage jobs, good educational opportunities, guaranteed healthcare, a clean environment, a decent retirement, housing, enough food to eat. The necessities. One start would be to make Wall Street pay for all the damage it’s done to the economy by levying a small tax on every stock market and similar financial transaction in this country. We could raise up to $350 billion to reinvest in our social infrastructure.

We kicked off our campaign at our 2011 Staff Nurse Assembly held in early June in Washington, D.C. It’s always great when nurses get together, but this year’s gathering was the biggest and best ever! More than 800 nurses attended, and nearly 1,000 of us rallied in front of the U.S. Chamber of Commerce to promote our Main Street Contract. Everybody shared stories from their own lives, their neighborhoods, and about their patients to illustrate why we need a Main Street Contract. So many people are suffering needlessly; we could hardly keep from crying at times. All of us left reenergized, educated, and ready to go back to our workplaces and communities to talk about the contract and how nurses can organize people to win these basic provisions. Check out coverage of the Staff Nurse Assembly in this month’s news section.

We immediately followed up the assembly with a massive march on New York City’s Wall Street on June 22 to promote the transaction tax and the Main Street Contract. What a scene! We put those wheeler dealers on notice with thousands of nurses in red scrubs waving signs reading “Heal America, tax Wall Street.” Our June 22 protest was part of an International Day of Action called by the European Trade Union Confederation for a similar tax in Europe. Many tourists, including some nurses from France and Australia, stopped to tell us they were so glad to hear our message. It’s high time all corporations and the wealthy pay their fair share.

But a nurse’s work is never done, right? Meanwhile, all of us are still fighting corporate healthcare back at home and this issue’s feature story about how hospitals are running around cutting units it no longer wants to operate exemplifies that struggle. So many units are on the chopping block that many hospitals no longer seem like hospitals to us. Some of the most popular units to cut include inpatient psych, rehab, skilled nursing, labor and delivery, hospice, home health, and even pediatrics! Read the story for more details.

We urge all of you to take a moment to learn about the Main Street Contract campaign. You can read stories and find out more information through our website page devoted to the campaign at www.nationalnursesunited.org/affiliates/entry/msc1. This is not something for just those nurses who are already very active or “have the time.” If you have children or grandchildren, if you care about their future and your own future once you are no longer able to work, you need to be out there on the streets with us. See you there.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents
4 News Briefs
Nurses brought the Main Street Contract campaign to Washington, D.C. during their 2011 Staff Nurse Assembly 6 | University of Chicago RNs win new contract 7 | Nurses protest Wall Street 8 | USC RNs settle new contract; Wilkes-Barre General Hospital RNs win great contract after long struggle; Texas nurses come to support of fired ICU RNs; VA nurses start bargaining master contract.

9 Making Wall Street Pay
Nurses are on a campaign to make Wall Street pay for the damage it’s done to Main Street. 
By RoseAnn DeMoro

10 Cutting to the Bone
Unprofitable units are on the chopping block as hospitals across the country use the poor economy as a reason to downsize. How nurses can fight back.

12 A Life of Service
Bunny Engelendorf, RN has worked tirelessly to expand the power of registered nurses to take charge of patient care. 
By Lucia Hwang

14 CE HOME STUDY
Rapid Response Teams: Another “Safety” Scheme?
Hospitals everywhere are rapidly adopting Rapid Response Teams to bring critical care expertise to patients’ bedsides, but do they really work? Take this home study CE to learn what the research says about Rapid Response Teams and their relationship to safe staffing levels. 
Submitted by the Joint Nursing Practice Commission, DeAnn McEwen, RN, and Hedy Dumpel, RN, JD
This economy is killing us, and America’s registered nurses are determined to stop the bleeding and start the healing.

That was the main theme of National Nurses United’s 2011 Staff Nurse Assembly, a three-day conference held in Washington, D.C. which drew more than 800 RNs from across the country.

At the top of the nurses’ agenda was discussion and education about the Main Street Contract for the American People, a campaign that NNU is launching to reverse national priorities and policies that have concentrated wealth in the hands of corporations and the super rich, while many working people suffer without adequate healthcare, enough food, or even a roof over their heads.

“In order to protect your patients, you are going to have to come out and talk about what’s really going on in this country,” said Jean Ross, a Minnesota RN and a member of the NNU Council of Presidents, to the assembled delegates.

Much of the conference was devoted to sharing stories about why the country needs a Main Street Contract, what that contract entails, and how nurses can lead the way to winning these basic securities. Nurses spoke eloquently about the economic hardships they are enduring in their own households, in their neighborhoods, and that they are seeing among their patients.

Nurses assessed how prolonged economic hardship is linked to broad declines in health and living standards for substantial segments of our population. Low wages and unemployment, hunger, substandard housing and education (including fewer opportunities for children to exercise), less access to healthcare, and other factors of serious economic distress, were cited by RNs as the reasons communities across the nation are quickly dying, literally.

Among the health conditions nurses identified as connected to the depressed economy are stress-induced heart ailments in younger patients, especially in men in their 40s; hypertension for all ages, including children; pancreatitis among non-drinkers, children included; a range of “gut” disorders, such as colitis; increased obesity linked to poverty; and manifold mental illnesses, including anxiety disorders, in young people. Also, asthma conditions for children are worse as a result of postponing treatments, with reports surfacing of deaths as a result of the delays tied to poverty or insurance obstacles.

Deborah Burger, a California RN and also an NNU Council of Presidents member,
said that patients are routinely delaying procedures, such as colonoscopies, because they cannot afford the copays. Some people are working multiple jobs, while others who used to have decent jobs but got laid off, have given up seeking work because they are older professionals who have no career prospects in this economy. “There are men in their 50s, engineers, in my community, who were laid off,” said Burger. “They’ve stopped looking because there’s nothing out there for them.”

The Main Street Contract is simple. It calls for jobs at living wages for everyone; a quality, public education for our kids; guaranteed healthcare with a single, high standard of care; a secure, dignified retirement for those too old to work; good housing and protection from hunger; a safe and healthy environment; and a just taxation system where corporations and the wealthy pay their fair share.

To raise funds for these goals and to reinvest in America, NNU nurses are proposing the Main Street Reinvestment Act, legislation that would levy a small tax on the financial transactions—the buying and selling of stocks, credit default swaps, derivatives—of Wall Street’s banking giants.

Economists estimate that a transaction tax could raise up to $350 billion in new revenue that could be invested in job (Continued on page 6)
creation, healthcare, education, and other social infrastructure programs.

Many labor organizations and progressive groups are supporting NNU RNs in fighting for a Main Street Contract. "It takes nurses who truly care about quality care to raise a stink about staffing decisions, so patients don’t have to suffer. And it takes nurses who truly care about a fair shake for Main Street to raise a stink about the Wall Street agenda, so working Americans don’t have to suffer!" said Richard Trumka, president of the AFL-CIO, in encouragement to the nurses during his speech at the conference.

The Staff Nurse Assembly culminated for the nurses in a spirited protest they staged in front of the offices of the U.S. Chamber of Commerce, the lobbying arm of America’s corporations and big business, and then another rally at Upper Senate Park. They chanted, “Hey Chamber, you can’t hide. We can see your greedy side.” They carried “invoices” to bill the Chamber and Wall Street for the damage done to their lives and communities. Sen. Bernie Sanders of Vermont, a champion of single-payer healthcare, and Sen. Barbara Boxer, who has introduced national RN-to-patient ratio legislation on behalf of NNU, addressed the crowd of almost 1,000 nurses.

Many of the RNs then broke off into groups organized by their home state to pay legislative visits to their federal elected officials. They asked for their representatives’ support of the Main Street Contract and lobbied their positions on other pending bills affecting nurses and patients.

RNs reported feeling recharged by networking with other RNs, celebrating NNU’s successes this past year, learning about national issues nurses are facing, and participating in the street actions.

“I’m really enjoying meeting nurses from a variety of different parts of the country,” said Naomi English, an RN from Minnesota. “I’m really enjoying learning about the Main Street Contract because I think it’s the absolute right intervention at the absolute right time and I’m really proud to be a registered nurse because I think we’re the perfect people to advance it.” —Staff report

University of Chicago RNs Defeat Concessions, Win Improvements in New Contract

Registered nurses at the University of Chicago Medical Center (UCMC) in early June approved a new contract achieving the nurses’ main negotiating goals of winning major improvements in patient care protections and economic and workplace standards for RNs, while at the same time rejecting all of the hospital’s concessionary demands.

The contract covers 1,300 UCMC RNs, who last year voted to join National Nurses United. Being a part of NNU, the nation’s largest union and professional association of registered nurses, was critical to achieving the settlement, RNs say.

A key to the settlement was significant improvements in hospital staffing and other patient care issues, including a commitment to employ 16 new patient care support nurses positions to provide coverage so RNs can take meal and rest breaks, and to assist with admissions, discharges, and other needs.

Further, the agreement establishes a new professional practice committee (PPC) of RNs, elected by their peers, to strengthen the voice of UCMC RNs in meeting with management on patient care issues and with specific timetables for management action on patient care concerns raised by the RNs.

RNs also secured a major goal in substantially limiting a much disliked mandatory scheduling policy that forces nurses to continually shift between working days and nights which studies have shown leads to performance deficits from fatigue, sleeplessness, and reduced alertness—heightening the danger of medical errors that put patients at risk.

On economic issues, the RNs will earn additional pay increases of at least 15 percent over the next three years, and secured limits on out-of-pocket costs for their healthcare benefits. Additionally, the hospital will give preference to regular UCMC RNs over agency nurses in scheduling when the hospital census is low.

UCMC had sought reductions for the RNs in wage scales, tuition reimbursement, sick leave provisions, and other areas, all of which were dropped in the final settlement.

—Staff report
As part of their Main Street Contract campaign, thousands of NNU nurses on June 22 staged a massive protest along Wall Street in New York City, the nation’s money capital, to demand that the country’s financial giants and other corporations pay their fair share of taxes. RNs took over the steps of Federal Hall, across from the New York Stock Exchange, and promoted the Main Street Reinvestment Act, a small tax on Wall Street’s financial transactions that could raise up to $350 billion to spend on creating jobs, providing healthcare, and shoring up the country’s social infrastructure.

Just like many of us pay a sales tax when we buy toilet paper, eat at a restaurant, or pay our utility bill, Wall Street would pay a small fee when it trades stocks. The fee would be negligible for ordinary, individual investors, instead targeted at the brokerage houses, hedge funds, and other corporations who routinely speculate on a large scale in the stock market.

This kind of transaction tax is not new in the country’s history. In fact, the United States used to tax all stock sales and transfers at 0.2 to 0.4 percent from 1914 to 1966. In 1966, the tax was reduced to the current 0.004 percent, and those proceeds currently fund the Securities and Exchange Commission.

The protest was part of an International Day of Action called by the European Trade Union Confederation for a similar tax in Europe. “There’s a financial transaction tax that we’re going to make Wall Street pay,” said RoseAnn DeMoro, executive director of NNU, at the rally. “It’s very American, and it basically says that just like working people pay taxes on all of their purchases, that these yo-yos that buy and sell and buy and sell our country should pay a minimum tax on that.”

—Staff report
California

Registered nurses at University of Southern California University Hospital and USC Cancer Norris Center in Los Angeles ratified in early June a new three-year contract.

The pact, covering some 700 RNs, wraps up a long contract dispute between the nurses, who are represented by the California Nurses Association/National Nurses United, and the hospital administration.

RN bargaining team members say that the agreement addresses major concerns the RNs have long had regarding key patient care issues, as well as providing economic improvements for the nurses.

“This agreement will greatly improve our ability to assure safe staffing at all times, which is so critical for quality patient care,” said Frances McKeever, an intensive care RN at USC.

One key aspect of the new contract provides for guaranteed resource RNs to provide patient care so that regularly scheduled RNs are able to take needed meal and rest breaks, and to provide coverage when nurses take patients to special procedures.

Nurses won improved healthcare coverage with no increase in out-of-pocket costs; pay increases of at least 4 percent each year for all RNs, plus additional compensation for long-term RNs and those who train new hires; improved employer retirement plan contributions; and free tuition for RNs and dependents who enroll in degree programs at USC.

Pennsylvania

On May 3, Wyoming Valley Nurses Association/PASNAP members voted overwhelmingly to ratify their new contract with Community Health Systems at Wilkes-Barre General Hospital in northeastern Pennsylvania.

The settlement came after a nearly two-year campaign which included an intense community outreach campaign, numerous legislative visits, a one-day strike last December, and the threat of a second strike on May 1. Nurses continued to work under the preferred terms of the expired contract during the contract fight.

“Community Health Systems bought our hospital in 2009 with the intention of breaking our union and putting their profits before our patients. What they got instead was a bolder, stronger union membership that will continue to advocate for our patients and our community,” said Fran Prusinski, RN, a critical care nurse and president of the local. “We are very proud of the strength of our union and proud of our new contract. We will continue to fight for the RN staffing needed for quality care. We will always advocate for our patients, our rights, and our profession.”

The primary issue in the fight was an insistence by CHS that they have the right to change benefits in the middle of the contract without bargaining with the union. In addition, CHS had proposed a far inferior healthcare deal than what had been in prior contracts. On the eve of the second strike called for May 1, CHS finally withdrew their “benefit modification” proposal and proposed a new healthcare plan that the nurses could accept.

In addition to the planned strike, CHS was on the defensive regarding allegations of defrauding Medicare and Medicaid by fully admitting patients that should have been admitted merely for observation.

The entire community was engaged in this struggle, and after the contract was ratified, Wilkes University contacted Prusinski to say they’ve been following the fight very closely. In fact, they have now added “Unionization of Nurses and the Collective Bargaining Process” to their curriculum, and their students will be working closely with our unionized RNs.

Reflecting on the nurses’ two-year struggle against CHS, Prusinski stressed the importance of being patient, strategic, and smart. “This fight was the best chess game I’ve ever played. Every time they made a move against us, we reacted in a ‘union positive’ way, showing them our solidarity and determination,” she said.

And the lesson learned? “No matter how rich and powerful a corporation is, if you stand as one, you are BIGGER!”

Texas

Support grows for seven fired nurses of Valley Regional Medical Center in Brownsville who are members of National Nurses Organizing Committee-Texas, the state’s largest RN union and an affiliate of National Nurses United, the country’s largest RN union.

Hospital management fired the seven ICU nurses in May for their refusal to take on additional “charge nurse” duties that the nurses say would unsafely take them away from their ICU patients. Charge nurses make clinical assignments for patients and staff on the floor and for code teams, which respond to cardiac emergencies. The fired nurses and the union argue that charge nurse duties—including responding to emergencies on other floors—could jeopardize ICU patients.

In ICU, each nurse is assigned two patients, and their students will be working closely. In fact, they have now added “Unionization of Nurses and the Collective Bargaining Process” to their curriculum, and their students will be working closely with our unionized RNs.

“If we had been aware of the serious damage they caused to the RNs affected,” wrote fellow Houston nurses in a letter of support to the RNs. “What a blatant disregard for the well-being and security of the nurses and their families...Keep up the good fight and justice will prevail.”

Veterans Affairs

The NNU-VA negotiating team headed to Pittsburgh, Penn. in June to start NNU master contract negotiations with VA. The team’s mantra is “no take-backs,” better working conditions for the 8,000 RNs represented by NNU-VA, and safe patient care for the veterans of the United States. The VA is quickly learning that NNU nurses are tough negotiators who do not back down easily.

One early example is, when attempts to agree on bargaining locations failed to resolve diplomatically, nurses opted to take to the streets. While RNs were planning the picket at the Washington, D.C. VA headquarters, VA was notified and quickly chose to come back to the table for a resolution. “NNU will not take informational picketing off the table or any other action we feel will get the results we need for our nurses,” said Irma Westmoreland, chief RN negotiator. —Staff report
Making Wall Street Pay

Nurses know it’s high time to force the corporations that broke our economy to pony up the money to fix it.

From Maine to California, nurses have launched a campaign for a new direction for America to reverse the disastrous course of policies that demand ever more hardship for Main Street while giving more tax breaks and special favors to Wall Street.

National Nurses United proposes a Main Street Contract for the American People to reclaim an economy premised on good jobs at living wages, healthcare for all, quality education, good housing, protection from hunger, a safe environment, and a secure retirement for everyone.

It’s a program that says we’ve all had enough of the calls for “shared sacrifice,” where all the concessions come from working people while resources continue to be transferred to those who need it the least.

A big rally in Washington, D.C. in early June astride the White House and the Chamber of Commerce, the lobbying arm for big business, kicked off this effort. Nurses stepped it up on June 22 with a protest on Wall Street in New York to demand that the high rollers who created the economic crisis pay to rebuild America.

The message is directed to policy makers in Washington and state capitals who push for deeper cuts in jobs, education, healthcare, retirement plans, secure housing, protection from hunger, and other bedrock programs that are not just a “safety net,” they are the foundation of our society.

We have become a nation of communities and people who are enduring unconscionable pain through staggering unemployment. Millions of people have given up looking for work and are facing unpayable medical bills that are the main cause of bankruptcy. Our children are in overcrowded classrooms and our sick in overflowing emergency rooms. Soup kitchens, food pantries, and food stamps have become the new norm for 49 million households.

At the same time, economic wealth is concentrated among a shrinking percentage of the super rich, and corporations make record profits while nearly 60 percent of U.S. firms paid no taxes for a year or more the past decade.

America has the wealth to end the despair and deprivation; it’s just being hoarded by those on Wall Street and corporate board rooms, and the politicians they elect and control to protect their privilege.

To reclaim this nation, that’s where we have to start. To make Wall Street pay. A first step, the one nurses and many others in labor and community groups have embraced, is a tax on Wall Street greed and speculation.

It would be a small fee on the buying and selling of stocks, bonds, credit default swaps, derivatives – all that speculative activity that brought foreclosures and ruin to so many and brought so little in return. Europeans are on the verge of enacting a similar tax, and our June 22 action was held in concert with events across Europe for a financial transaction tax.

The lobbyists and their shills in the media would have us believe that the big corporations will leave this country if asked to pay their fair share. We’ve heard that story before. Corporate America has received an endless stream of tax cuts, bailouts, loopholes, shelters, rollbacks in regulations, and other handouts that have fueled their economic bonanza and lavish lifestyles. But what have they given back in return other than spiraling unemployment, and demands for more and more corporate charity?

It’s a sad fact that we have to shake up Wall Street and Washington to persuade the policy makers that the most pressing problem in America is not the debt ceiling, or how much they can slash Medicare or Social Security.

There’s a reason that so many politicians are unwilling to look beyond their corridors to the wreckage and hurt in our communities. As one Congressional aide recently told NNU, “Wall Street runs this place.”

But there is an antidote in the collective voices that can ring out from coast to coast, like the ones that have been shaking Madison, Lansing, Columbus, and other cities this year.

As part of our Main Street campaign, NNU is asking people to tell us their stories. How is your family facing the economic struggles endured by so many? Read the stories nurses across the country are sharing at www.nationalnursesunited.org/blog/entry/stories-from-main-street/. And, please tell us where it hurts, at www.nationalnursesunited.org/story.

We’ll use these accounts to make the case for change in policies and priorities and for a rebirth for our nation. It’s long overdue.

RoseAnn DeMoro is executive director of National Nurses United.

Corporate America has received an endless stream of tax cuts, bailouts, loopholes, shelters, rollbacks in regulations, and other handouts that have fueled their economic bonanza and lavish lifestyles. But what have they given back in return other than spiraling unemployment, and demands for more and more corporate charity?
About two years ago, the registered nurses who worked at Kaiser Permanente’s urgent care clinic in Fremont, Calif. received news that their employer intended to basically gut after-hours services by closing the clinic at 5 p.m. on weekdays, cut hours in half on Sundays, and funnel more patients into telephone consultations with physicians. The plan, they thought, was a total disaster. Many of their patients were modest-income, working families who could not afford to take time off from their jobs to attend appointments during the day. For them, the evening urgent care clinic was their go-to place for that bad cough that’s stuck around for two months, or the fever of a child that’s high enough to have the parents worried, but not high enough to justify the emergency room. If Kaiser killed after-hours appointments and the ability to just walk in, the nurses feared that serious health problems would not be treated early enough to prevent full-blown medical emergencies.

But the urgent care nurses didn’t just get mad. They got organized. Under the leadership of Michelle Gutierrez-Vo, an urgent care charge RN who’s also head of the professional practice committee and a California Nurses Association board member, the RNs waged a campaign to save after-hours urgent care. They started collecting all kinds of data to show how the proposed cutbacks would hurt patients—everything from the types of appointments people were booking, to the volume of appointments, to how much more people were paying when they had to use the emergency room versus urgent care. They monitored all the workflows so they knew exactly what was going on in their department. Nurses filled out assignment despite objection forms at every opportunity, and also kept notes in their own journals. They presented that data to Kaiser at meeting after meeting, they used it to garner the support of their local elected officials against the closure, and they showed it to the media to support their position.

The campaign culminated in a major picket of nearly 300 RNs, complete with speeches by concerned politicians and TV cameras capturing all the action. That same day, management announced that there would be no reductions to urgent care clinic hours and that, no, they never planned to close at 5 p.m.!

“It pays for nurses to really take ownership of their work and collect the data,” said Gutierrez-Vo. “You need to paint a picture of what happens to the patients when these cuts are made. Focus on the patient. Where does the patient go and what kind of hardship does it pose for them?”

Gutierrez-Vo’s advice is needed now more than ever, as hospitals across the country are shutting down units that they simply don’t feel are worth the money to run anymore. The desire by hospitals to slash costs during this poor economy has simply accelerated the closures. Often, healthcare management consultants are telling hospitals that they can save money and increase efficiency by “streamlining” their operations. Sometimes the units are money losers, and sometimes the units still operate in the black, but at not a high-enough profit margin to please their corporate owners. Often such closures are part of a healthcare trend of hospitals consolidating or regionalizing services at one of their campuses. In California, many hospitals are building new facilities to comply with seismic safety requirements and using the construction as an opportunity to drop units and services that they no longer want to operate.

Nurses across the country are fighting closures of critical units by hospitals. Learn what works and what’s needed to keep these services open. A STAFF REPORT
According to reports from NNU nurses, the most popular units for the chopping block include psychiatric, skilled nursing, acute rehabilitation, hospice, and home care. As a result of lower birth rates due to the lousy economy, labor and delivery units have also been targeted in this trend of closures. In the outpatient area, clinics are often shut down or have had their hours of operation radically reduced.

And, of course, when units are shut down, registered nurses and other staff are often at risk of losing their jobs.

When NNU nurses across the country fight aggressively against closures, however, they have been successful at stopping them—particularly those at public or district hospitals where RNs can put pressure on elected officials. In this way, years-long campaigns led by nurses have kept two much-needed hospitals in the San Francisco Bay Area, San Leandro Hospital and St. Luke’s Hospital, open when Sutter Health wanted to shutter them.

“We really scared them,” said Gutierrez-Vo about their fight against Kaiser. “They backed off, but that was because we really fought them. We were all really opposed to it and took it very seriously.”

For some hospitals, the unit closures and cutbacks are part of a concerted strategy, often touted by management consultants, to reorganize the way healthcare is delivered in order to maximize the return out of every dollar spent. One of the most popular schemes goes by the name “Lean Six Sigma” and is modeled after a variety of programs implemented in manufacturing industries in the 1980s and 1990s to eliminate variability in the work process, eliminate defective products, and, of course, save money by cutting waste. Business consultants soon began applying Lean Six Sigma to other industries, and registered nurses are now dealing with its use in hospitals.

NNU RNs and other critics argue that these types of management consulting strategies are inappropriate for use in healthcare settings. Nursing very sick patients back to health is not the same as producing a car bumper or microchip, and never will be. People are extremely complex and variable. A person’s physical health can even be heavily influenced by their psychological or emotional state.

Nevertheless, hospitals eager to maximize profit have rushed to adopt these management consulting practices, which are often characterized by making deep cuts in all areas—staffing, inventory, units, even whole hospital campuses—and shifting the problems those cuts create onto employees and patients. After such programs are enacted, employees often find themselves working faster, harder, and longer to create onto employees and patients. After such programs are enacted, employees often find themselves working faster, harder, and longer to make surgical patients recover in the operating room? “This is a disaster waiting to happen. It’s not fair to the patients or the staff.”

Now Wolfe said the hospital is calling Code Helps nearly every day. “To protest the closure, Wolfe and her colleagues have staged pickets and spoken out to the public through the news media about how overcrowded and dangerous conditions are at the hospital. Though the RNs are determined to ultimately bring back all the beds that were eliminated, the hospital in the short term has agreed to restore about 10 of the beds that were lost. The unit closure is still a contentious issue that RNs plan to make a focal point of bargaining talks.

Shutting down or having their hours of operation radically reduced.

And, of course, when units are shut down, registered nurses and other staff are often at risk of losing their jobs.

When NNU nurses across the country fight aggressively against closures, however, they have been successful at stopping them—particularly those at public or district hospitals where RNs can put pressure on elected officials. In this way, years-long campaigns led by nurses have kept two much-needed hospitals in the San Francisco Bay Area, San Leandro Hospital and St. Luke’s Hospital, open when Sutter Health wanted to shutter them.

“We really scared them,” said Gutierrez-Vo about their fight against Kaiser. “They backed off, but that was because we really fought them. We were all really opposed to it and took it very seriously.”

F or some hospitals, the unit closures and cutbacks are part of a concerted strategy, often touted by management consultants, to reorganize the way healthcare is delivered in order to maximize the return out of every dollar spent. One of the most popular schemes goes by the name “Lean Six Sigma” and is modeled after a variety of programs implemented in manufacturing industries in the 1980s and 1990s to eliminate variability in the work process, eliminate defective products, and, of course, save money by cutting waste. Business consultants soon began applying Lean Six Sigma to other industries, and registered nurses are now dealing with its use in hospitals.

NNU RNs and other critics argue that these types of management consulting strategies are inappropriate for use in healthcare settings. Nursing very sick patients back to health is not the same as producing a car bumper or microchip, and never will be. People are extremely complex and variable. A person’s physical health can even be heavily influenced by their psychological or emotional state.

Nevertheless, hospitals eager to maximize profit have rushed to adopt these management consulting practices, which are often characterized by making deep cuts in all areas—staffing, inventory, units, even whole hospital campuses—and shifting the problems those cuts create onto employees and patients. After such programs are enacted, employees often find themselves working faster, harder, and longer to pick up the slack; that’s where the employer often realizes the promised “efficiencies.” Patients suffer without needed services.

Such is the case at UMass Memorial Medical Center in Worcester, Mass., where interventional radiology RN Colleen Wolfe works. Last September, management announced that census was down from the year before and it would be closing an entire floor of 28 medical-surgical beds. “I couldn’t believe it,” said Wolfe. “It was the exact opposite of what I expected to hear.”

Wolfe had assumed that her facility would be overcrowded and dangerous conditions are at the hospital. Though the RNs are determined to ultimately bring back all the beds that were eliminated, the hospital in the short term has agreed to restore about 10 of the beds that were lost. The unit closure is still a contentious issue that RNs plan to make a focal point of bargaining talks.

Fighting unit closures is hard work, but nurses report that what seems to work best is an organized campaign, led by dedicated and motivated RNs, that puts nonstop pressure on hospital executives through a combination of media coverage, well-attended actions like pickets or candlelight vigils, support of elected officials, alliances with the public and concerned community groups, and data to back up the nurses’ warnings.

The proposed closure of Kaiser Permanente’s pediatrics department in Hayward, Calif., is a perfect example of how nurses must get creative and organized in pushing back against such cuts. Last June, nurses learned that after Kaiser moves its services in 2014 to a new facility in nearby San Leandro, that it would no longer house a pediatrics department. Members would have to drive their sick children 20 to 30 miles farther to access the nearest Kaiser pediatric unit, a huge burden for parents—especially those that depend on public transit. Pediatric nurses immediately geared up against the planned closure by educating families of patients and collecting signed cards, securing letters of support from local politicians, waging a sticker campaign when they knew a Kaiser executive was visiting their hospital, crashing an upper-level management meeting to protest the closure, and even picketing the groundbreaking ceremony for the new hospital. The nurses also plan to write letters to the editor and notify the Kaiser membership of the planned closure. Once school starts in the fall, Richter said nurses will leaflet the pediatric clinics and start visiting local PTAs.

“Our goal is to educate as many people as we can,” said Kristine Richter, a pediatric RN for nearly 35 years. “I’m really proud of our peds nurses for sticking together. Not one nurse has gone looking for another job. Hopefully we’ll get enough public outcry to make them rethink their decision.”
Bunny Engeldorf, RN believes the nation’s nurses must take charge of patient care on all levels, and has worked tirelessly to help build their power to do just that

By Lucia Hwang

A Life of Service

Bernadine “Bunny” Engeldorf is what we call a nurse’s nurse. She’s always been one of those registered nurses who, in addition to her regular job, helps educate coworkers about the latest issue her union is battling, keeps tabs on any changes that might encroach upon the RN scope of practice, and gives input on workplace safety issues.

So it’s only natural that Engeldorf would rise to become a leader of the national nurses movement as a member of the executive council of National Nurses United, and one of the top nurses in her home state of Minnesota.

“I’m not one of those people who has some great story about how I became a nurse,” said Engeldorf, who currently works as a psychiatric nurse at United Hospital in St. Paul, Minn., where she’s been employed for more than 20 years. “For me, it was always about doing service. If I was going to do anything, it would be something to give back to the community.”

This ethos of service runs in her family, said Engeldorf. A native Minnesotan, Engeldorf was the eldest of five children, and her father worked as a union carpenter as well as serving as a volunteer firefighter. Her mother was a nursing assistant. Before her job at United Hospital, where she would work for most of her career, she worked in long-term care in a rural community. “It was a great experience,” remembered Engeldorf.

But life took her back to the city, where she took a position in orthopedics and neurology, a specialty she was drawn to because she had the chance to get to know her patients better. “It was very interesting to me,” said Engeldorf. “People were in the hospital longer, usually because of some orthopedic intervention, so I had the opportunity to develop relationships with people.”

As an ortho and neuro RN, Engeldorf was often willing to take assignments that other nurses found “difficult,” perhaps because the patient was moody or not cooperative. Often, the reason for the patients’ challenging dispositions was a mental health issue. Engeldorf eventually realized that she enjoyed working in mental health, so when the opportunity arose to work for a crisis intervention program at a different facility, she jumped at it.

In her new job, Engeldorf provided emergency, face-to-face mental health consultations, evaluated patients, and would refer patients to needed services. She loved it but, unfortunately, she was laid off after just a few years when the company reorganized—even though she had seniority over other coworkers. “I thought, ‘Never again will I take a nonunion job!’” said Engeldorf.

She returned to United Health and worked again in orthopedics and neurology for eight years before she pursued an open position in the psychiatric unit. She’s worked as a psych nurse for 12 years now for a busy four-unit ward, and also acts as assistant head nurse, doing education, orientation, and mentoring.

As an RN working in mental health, Engeldorf is acutely aware of the effects that the depressed economy, budget cuts in public and mental health, cuts in community services, and the lack of a universal, single-payer healthcare system have on patients suffering from mental illness. Patients sometimes have to be sent out of state...
because her community does not have enough inpatient psych beds, and as more and more people have lost their insurance through unemployment, patients are coming to her hospital as a last resort. “Community services have been cut, so it’s taken away the ability of patients to seek care prior to a crisis,” said Engeldorf. “If you don’t have insurance or money’s tight, you cut back on your medication. If you’ve been taking it, you’re feeling good, you think, ‘Why do I need to spend my money on this?’ And of course we know what happens then.” Lately, Engeldorf said she’s seen an increased in psychiatric patients who also have other medical comorbidities.

Early in her career, Engeldorf recognized the importance of bedside nurses banding together. In the 1980s, as her hospital tried to cut costs by experimenting with and changing delivery-of-care models, Engeldorf began to get active in her union, the Minnesota Nurses Association. “They were doing all kinds of things that were really infringing on the RN scope of practice,” said Engeldorf. “They called it ‘patient-focused care,’ but it was really deskilling. They were saying that pretty much everyone can do nursing.”

To fight back, Engeldorf became a nurse representative at her facility and her involvement with MNA grew steadily. Soon she became a delegate to MNA’s annual convention and then began running for officer positions. In 2003, she was elected to the Economic and General Welfare Commission, which develops and implements economic and employment standards and policies for the organization. She held that position for six years, and acted as commission chair the last two years.

Starting in 2007, Engeldorf became active in organizing delegates to vote for MNA to disaffiliate from the American Nurses Association, as the state nursing associations in California, Massachusetts, and Michigan had already done. The ANA was, and still is, a nurse management-driven group unwilling to champion the agenda of bedside nurses who desperately need an organization to help them challenge hospital corporations. The ANA found collective bargaining distasteful. The state associations discovered themselves in a situation where they were often paying millions of dollars in annual dues to the ANA, but the ANA did not represent their interests or at times even worked against staff nurse interests. “We said, ‘Minnesota needs to leave,’” remembered Engeldorf. “We can’t stay as a labor organization in this parental organization run by supervisors.” The Minnesota Nurses Association successfully left the ANA in October 2008 and refocused its efforts on building itself as a union for “regular nurses.”

The next year, Engeldorf won a seat on the MNA board of directors and today serves on its executive board as a second vice president, as well as the executive council of NNU. In addition, she continues to be active on a local level as a bargaining unit member at United Hospital.

In her role as a nurse leader, she’s been most proud to help MNA achieve independence and in forging collaborative relationships with other unions, most notably in the 2009 merger of MNA with the California Nurses Association, Massachusetts Nurses Association, and other United American Nurses groups to form National Nurses United. “It truly makes sense to bring together nurses,” said Engeldorf. “If you get bedside nurses together in the same room, the issues are the same for nurses. It’s about, ‘How do I take care of patients to the best of my ability in a way that’s safe for me?’”

Minnesota nurses have already felt the benefits of joining a national nurses movement, said Engeldorf. When nearly 12,000 RNs went on strike last spring, “it did feel different. Minnesota nurses felt power being part of the coordinated larger group,” she said. They have also noticed that, through their collective resources, nurses seem to be able to respond and adapt much more quickly to a pressing issue or concern – such as instantly organizing RNs to lead a march during the massive protests against anti-union, anti-worker legislation in Madison, Wis.

The ongoing struggle for RNs and for NNU, sees Engeldorf, is one and the same: to challenge corporate healthcare. To maintain the integrity of the registered nurse scope of practice, to win good working conditions and high standards for RNs, to win single-payer and make sure that patients can access the healthcare they need regardless of their ability to pay – all of that means RNs need to fight and defeat the profit motive in healthcare.

“We need to keep RNs in charge of care,” said Engeldorf. “Hospitals only see opportunities to replace or reduce nurses at the bedside. But [nothing] replaces human touch and human assessment.”

Lucia Hwang is editor of National Nurse.

Profile

Name: Bernadine “Bunny” Engeldorf, RN
Facility: United Hospital
Unit: Psychiatric
Nursing for: 39 years
Sign: Aquarius
Pet nursing peeve: Can’t stand it that nurses are caretakers, but often don’t take care of themselves.
Favorite work snack: Coffee
Latest work accomplishment: Last year, she won a labor award from MNA and she was recently nominated by a group of peers for a nursing excellence award.
Color of favorite scrubs: She wears street clothes, not scrubs
Hobbies: Reading, listening to music, travel, and seeing her grandchildren
Favorite book: Gone With the Wind, by Margaret Mitchell
Favorite movie: Gone With the Wind (See a pattern here?)
Secret talent unrelated to nursing: She used to be good at water sports, like water skiing; also has a green thumb.
CE Home Study Course

Rapid Response Teams 
Another “Safety” Scheme?

Description. This home study examines the proliferating usage of Rapid Response Teams (RRT), a team of critical care experts established to bring critical care expertise to the patient’s bedside, and their relationship to the unit placement of the patient and reductions in the rate of mortality.

Introduction

In 2004 the Institute for Healthcare Improvements (IHI) encouraged hospitals in the United States to implement Rapid Response Teams (RRTs), which was one of six life-saving strategies recommended by the IHI to improve patient outcomes. It was part of its 100,000 Lives Campaign. www.ihi.org. Today, more than 2,700 hospitals have joined nationwide and implemented RRT strategies which now have become the standard of care for prevention of avoidable deaths. Proponents of rapid response teams have been given names such as STAR or STAT teams. These teams are composed of clinicians with ICU-level clinical expertise.

The Latest Safety Scheme

Management consultants, pushing their “safety” schemes, state that there are various systemic factors that contribute to the variability of the safety of patients in healthcare today: (1) failure in planning patient care (including patient assessments, treatments, identifying and implementing goals); (2) failure to communicate (patient to direct-care RN, shift/transfer report from RN to RN; and RN to MD reports); and (3) failure to recognize deteriorating patient condition.

According to these consultants, the RRT stands to impact this “failure to rescue” state of affairs by identifying unstable patients and those patients likely to suffer cardiac, respiratory arrest, or some other deadly outcome. The goal is to respond to a “spark” (subjective patient complaints, signs, and symptoms) before it becomes a “forest fire” (cardiac or respiratory arrests).

Critics of the RRT strategy have argued that this is just another corporate “penny wise pound foolish” scheme to countermand the “failure to rescue” criticism directed towards the hospital industry. Instead of placing the patients in a higher level of care based on their severity of illness and acuity, these patients are admitted on medical-surgical units with less rich RN staffing ratios, being cared for by nurses who do not have demonstrated and validated competencies in providing critical care. According to critics, the deployment of RRTs has created a false sense of security among RNs and patients alike, including the patients’ families who are given the RRT’s stat Code H number so they can call the team directly.

They further question the logic. Who has the responsibility and accountability to identify and recognize the patient’s deteriorating condition? Answer: the direct-care RN assigned to the patient, not the RRT team. Who has the responsibility to initiate competent interventions? The answer again is the direct-care RN assigned to the patient, not the RRT team.

Early Detection and Early Intervention

In order to be able to assess and intervene in a timely manner, there must first be sufficient numbers of direct-care RNs with current demonstrated competency present and available. What is confusing is that the RRT team is touted as the stabilizer of a pre-“forest fire” condition and not the identifier of deteriorating conditions.

The requirement is that when a patient’s vital signs reaches a close to what is sometimes called a “flat line” or “near miss,” then stat page the STAR or similar type of team.

Question: Why wait? There seems to be three stages of deterioration: (1) subtle decline in the patient’s vital signs and status; (2) STAR or RRT-team level of deterioration creating a “near miss” situation; and, (3) patient crashed, requiring full resuscitation/Code Blue or ending up in a “failure to rescue” situation.

This conjures up another question. Why is there a need for an intermediary team? In many instances hospitals “break” the “ratios” when the team is deployed. Members of the RRT team may be assigned to provide meals/break relief and are instantaneously pulled off, or a 1:1 ICU patient may be instantly reclassified as a 1:2 to accommodate the RRT team.

Current, Demonstrated and Validated Competency

Prior to market-driven corporate healthcare, direct-care RNs, in general, had the required unit-specific demonstrated and validated competency to take care of patients who were admitted to the unit. Units would have a designated Charge Nurse and/or Clinical Nurse Specialist (CNS), an expert, who would be available to assist with assessments, provide consultation, and perform sophisticated and
Safe Staffing Standards

Compare this with California’s Safe Staffing Standards. These standards are clear as to its priority: (1) Staffing standards based on individual patient acuity of which the ratio is the minimum; (2) Additional licensed and unlicensed staff based on direct-care RN assessment and documented patient classification system; (3) The ratios apply at all times including meals and breaks, and authorized absences from the unit.

This means that all California acute-care hospitals must first budget for the mandated ratio threshold and the additional RN and non-RN staff needed to meet the patient’s requirements and needs. Next, the budget must provide for a Float/Meals and Break Relief Team, now including relief when the RRT responds to a stat call and is absent from the unit. The mandate requires no doubling-up of the assignment.

Research findings have documented significant relationships between failure to rescue and nursing organizational characteristics. Failure to recognize deterioration in the patient condition until major complications, including death, have occurred is referred to as “failure to rescue,” which is a measure of the overall performance of a hospital with respect to the healthcare professional’s ability to recognize subtle changes in the patient’s condition and react independently to post-operative complications such as bleeding or sepsis. Failure to rescue is increasingly studied as a quality-of-care measure.

The original research conducted on failure to rescue identified a strong and significant association with nurse-to-patient ratios in a sample of surgical patients (Silber Rosenbaum, & Ross, 1995). They concluded that failure to rescue is an appropriate measure to study quality of care because hospital staffing characteristics are more likely to influence the measure. The complications studied are detectable by nurses and can be managed successfully with timely intervention. Recognition of complications at an early stage and initiation of therapeutic interventions reduces morbidity and mortality.

For decades, nurses have reported that there are not enough nurses in hospitals to provide high-quality care. In response to
these concerns, Congress in 1993 requested an Institute of Medicine (IOM) study of the adequacy of nurse staffing in hospitals and nursing homes. The IOM noted there was insufficient empirical evidence to determine adequacy. Since then, the evidence supporting an association between nurse staffing and better patient outcomes has grown.

In October 1999, the California State Legislature passed AB394 (Knehrl), adding section 1276.4 to the Health and Safety Code (HSC). This landmark safe-staffing legislation required the California Department of Health Services (CDHS) to develop a staffing ratio threshold based on scope of practice which includes minimum, specific, numerical licensed nurse-to-patient ratios for specified units of all general acute-care hospitals in California.

The Legislature examined the evidence and decided that the quality of patient care was related to the number of RNs at the bedside, and pushed to ensure a minimum, adequate number. In addition the regulations require that hospitals have a valid patient classification system (PCS) in place, requiring hospitals to flex-up their staffing, above the minimum required, to assure that the number of nursing staff was aligned to the healthcare needs of individual patients.

The California Department of Health Services undertook a multiyear process to determine the minimum ratios to be mandated based upon research and other factors. Aiken et al. (2002) reported that each patient added to nurses’ workloads was associated with a 7 percent increase in mortality following common surgeries. Replications in Canada, England, and Belgium produced similar findings as did other studies in the United States.

The Department of Health Services further defined hospital units and appropriate patient population for the purposes of licensing and certification of healthcare facilities and for monitoring compliance with existing public health and safety regulations. Because the literature describes the most common factor underlying failure to rescue as “triage error” or admission to a unit other than that which provides the optimal level of care required by the patient, it’s instructive to include a review of unit/patient population definitions upon which the California nurse-to-patient ratio law and staffing standards are predicated.

The California nurse-to-patient ratio in a step-down unit shall be 1:3 or fewer at all times. A “step-down unit” is defined as a unit which is organized, operated, and maintained to provide for the monitoring and care of patients with moderate or potentially severe physiologic instability requiring technical support but not necessarily artificial life support. Step-down patients are those patients who require less care than intensive care, but more than that which is available from medical/surgical care. “Artificial life support” is defined as a system that uses medical technology to aid, support, or replace a vital function of the body that has been seriously damaged. “Technical support” is defined as specialized equipment and/or personnel providing for invasive monitoring, telemetry, or mechanical ventilation, for the immediate amelioration or remediation of severe pathology.

The California nurse-to-patient ratio in a telemetry unit shall be 1:4 or fewer at all times. “Telemetry unit” is defined as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals.

The California nurse-to-patient ratio in medical/surgical care units shall be 1:5 or fewer at all times. A medical/surgical unit is a unit with beds classified as medical/surgical in which patients, who require less care than that which is available in intensive care units, step-down units, or specialty care units, receive 24-hour inpatient general medical services, post-surgical services, or both general medical and post-surgical services. These units may include mixed patient populations of diverse diagnoses and diverse age groups who require care appropriate to a medical/surgical unit.

The California nurse-to-patient ratio in a specialty care unit shall be 1:4 or fewer at all times. A specialty care unit is defined as a unit which is organized, operated, and maintained to provide care for a specific medical condition or a specific patient population. Services provided in these units are more specialized to meet the needs of patients with the specific condition or disease process than that which is required on medical/surgical units, and is not otherwise covered by the described units.

Identifying a unit by a name or term other than those described does not affect the requirement to staff at the ratios identified for the level or type of care described in the California regulations.

The California mandates can be viewed as a benchmark against which to compare hospitals within California and between California and other states, according to Aiken et al. In 2010 Aiken published the results of their study which examined how nurse and patient outcomes, including patient mortality and failure-to-rescue, are affected by the differences in nurse workloads. (The study is suggested reading and included in the references. It can be found online by typing “Aiken HSR” into the search field at www.nationalnursesunited.org.)


New Jersey hospitals would have 14 percent fewer patient deaths and Pennsylvania 11 percent fewer deaths if they matched California’s 1:5 ratios in surgical units.

Fewer California RNs miss changes in patient conditions because of their workload than New Jersey or Pennsylvania RNs.

In California hospitals with better compliance with the ratios, RNs cite fewer complaints from patients and families and the nurses have more confidence that patients can manage their own care after discharge.

California RNs are far more likely to stay at the bedside, and less likely to report burnout than nurses in New Jersey or Pennsylvania.

**Duty and Standard of Care**

Let’s review relevant laws regulating RN practice. The primary duty performed by registered nurses in acute-care hospitals is ongoing patient assessment, sometimes referred to as ongoing patient surveillance or monitoring. In general, such assessment requires direct observation of signs and symptoms of illness, reaction to treatment, general behavior, or general physical condition, and a determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics (Nursing Practice Act). Furthermore, RNs must formulate/design and implement a care plan based on observed abnormalities and then evaluate the patient’s response.
According to the Institute of Medicine (IOM), assessment is “an important mechanism for the detection of errors and the prevention of adverse events.” Studies have shown that errors typically result from problems within the system (e.g., acute-care hospitals or nursing homes) where people work.

In its publication *To Err is Human*, the IOM endorses the systems approach to understanding and reducing errors and notes that failure in large systems, such as hospitals and their various patient care units, are mostly due to unanticipated events or factors occurring within multiple parts of the system.

Direct-care registered nurses, typically, do not control the system. The corporation controls the system. It determines budgetary priorities, expenditures, and cost containment schemes based on its philosophy, mission, and vision.

An overt violation of safety standards set by a state, e.g., safe staffing ratios or interfering with the RN ability to perform ongoing patient assessment for early detection of a change in the patient status, can cause devastating errors resulting in sentinel events.

**Duty and Right to Advocate in the Exclusive Interest of the Patient**

RNs have a duty to recognize circumstances that cause harm to their patients and activities and decisions that in their professional judgment are against the interest of their patients. RNs have the right to advocate in the exclusive interest of their patients and must be able to do so without fear of retaliation or reprisal.

Direct-care RNs are inseparably linked to patient safety. Safe staffing standards, based on the patient’s acuity, allow the direct-care RN to observe the subtle changes in the patient condition and recognize the early signs and symptoms of the beginning of a patient’s decline. These can only be detectable through the direct-care RN physical presence and her/his ability to directly observe changes in the patient’s physical and cognitive status.

This Rapid Response Team approach has not been scientifically validated; it is based on assumptions and so called “best practices” also known as “just-in-time” nursing and medicine. It blatantly disregards scientific studies finding that the association of RN staffing levels with the rescue of patients with life-threatening conditions suggests that RNs contribute importantly to surveillance, early detection, and timely intervention that save lives.

RNs should always advocate for the appropriate placement of the patient, where the patient is cared for on a unit that can provide safe, therapeutic, and effective patient care delivered in a competent manner.

**Rapid Response Teams Do not Cut Hospital Heart Attacks and Death Rates**

In the December 2008 edition of the *Journal of the American Medical Association* (JAMA) titled: “Hospital-wide Code Rates and Mortality Before and After Implementation of Rapid Response Teams,” Chan PS, et al reported that Rapid Response Teams set up to spot patients at risk of having cardiac or respiratory arrests in the United States hospitals do not save lives and may not be a good use of resources. The researchers stated that hospitals have widely adopted this practice with little evidence to suggest they help save lives. The researchers further noted that another phenomenon has surfaced, namely, the secondary effect of the team may have resulted in an increase in patients and families issuing “Do Not Resuscitate” or DNR orders that prohibits hospital staff from taking life-saving measures.

In the September 2010 edition of the *Journal of the American Medical Association* (JAMA) titled: “Rethinking Rapid Response Teams,” Litvak and Pronovost concluded that “For the majority of patients whose condition deteriorates while receiving inadequate care in an improper unit, efforts should be made to ensure they receive adequate care in the proper unit, to move away from taking credit for rescuing patients who experience triage errors, to focus on patient flow, and to provide the patient with the right care at the right time, not more and not less.”

According to Litvak and Pronovost, underlying inadequate care is that patients have been admitted or transferred to a unit unable to provide an appropriate level of care, where sufficient nurse, physician, and monitoring resources are available. A triage error (patient misplacement), or an inability (or unwillingness because of cost containment/profit motive) to place the patient in the preferred unit, subjects patients to an unreasonable risk of suffering complications, preventable harm, and even death. Researchers should seek to identify and mitigate risks borne by patients admitted to the incorrect hospital unit.

In the September 2010 issue of the *Journal of the American Medical Association*, researchers concluded that underlying inadequate care is that patients have been admitted to a unit that provides inadequate care.

The philosophy of RRTs is premised on the idea that current care is inadequate; therefore, introducing ICU-level care will benefit the patient.

In response to the study, Dr. Gregg C. Fonarow, director of the Ahmanson-UCLA Cardiomyopathy Center at the University of California, Los Angeles said, “This latest study failed to show reductions in hospital-wide code rates or mortality with a rapid response team.”

The September 2010 issue of *Johns Hopkins Medicine News* wrote, “The success of a rapid response team is determined through what Pronovost calls ‘perverse accounting.’” They are judged, he says, by counting the number of people saved or identified to be sent back to the ICU.

“Imagine if we sent everyone from the ICU to the parking lot instead of to the floor,” Pronovost says. “The rapid response teams would look like they’re doing wonders because they would have to come in and save all of those patients. It’s not a rapid response team issue. It’s sending them to the proper level of care. It’s a silly science where you take credit for your own bad decisions.”

**Conclusion:** It seems perverse to measure the success of RRTs by counting the number of saved lives that were put at risk by triage errors, driven by ineffective management of patient flow, hospital restructuring, and market-driven budget constraints.

Furthermore, the Rapid Response Team, as intended, is an attempt to circumvent the ratios mandates and other specialty-specific safe staffing standards. It is redundant, causing further fragmentation and confusion surrounding needed levels of patient care and should be abolished for misleading the public. Unlike the ratio solution, there is no empirical evidence validating the beneficial effects of the Rapid Response Team scheme on the mortality rate in U.S. hospitals. On the contrary, studies show that Rapid Response Teams set up to spot patients at risk for cardiac or respiratory arrest in U.S. hospitals do not save lives.
Rapid Response Teams
For continuing education credit of 2.0 hours, please complete the following test, including the registration form at the bottom, and return to: NNU Nursing Practice, 2000 Franklin St., Oakland, CA 94612. We must receive the complete home study no later than October 15, 2011 in order for you to receive your continuing education credit.

1. Ensuring that all direct-care RNs have the skill and knowledge of how to recognize early alteration in the patient’s physical and cognitive condition requires a vibrant education/in-service department, and a commitment to striving for true excellence.
   - True
   - False

2. Collaboration with a charge nurse, clinical nurse specialist (CNS), or resource nurse validates deterioration of the patient’s condition.
   - True
   - False

3. Highly paid management consultants’ “best practices” show that patients can be cared for on the med/surg unit rather than ICU or step-down with the RRT ready for “just-in-time” nursing and medicine.
   - True
   - False

4. In addition to being an effective evidence-based patient safety strategy, rapid response teams are a good way to measure patient satisfaction.
   - True
   - False

5. Consultants created the RRT to compensate for systemic factors that include failure to assess and plan patient care, failure to communicate, and failure to recognize deteriorating patient condition.
   - True
   - False

6. Minimum staffing ratios and staffing up based on acuity is a safety standard that allows the direct-care RN’s physical presence and her/his ability to directly observe the early signs and symptoms of the beginning of a patient’s decline.
   - True
   - False

7. The safe staffing standards in California allow the hospital to “break” the ratios when the rapid response team is responding to the stat page.
   - True
   - False

8. The direct-care registered nurse assigned to the patient has the responsibility and accountability for identifying and recognizing the patient’s deteriorating condition.
   - True
   - False

9. Research has shown that Rapid Response Teams do cut death rates. It has been scientifically validated.
   - True
   - False

10. The Rapid Response Team may have resulted in an increase in patients and families issuing “Do Not Resuscitate” or DNR orders that prohibit hospital staff from taking life-saving measures.
    - True
    - False

Name: ____________________________________________________________

Address: ______________________________________________________________________________________

City: _____________________________________ State: __________________ Zip: __________________________

Day phone with message machine: _____________________________ Email: _______________________________

RN license #: _____________________________ Job Classification: ______________________________________
Tell us where it hurts!

As patient and social advocates, registered nurses across the nation are calling for a Main Street Contract for the American people. Our communities are sick. They need living-wage jobs, healthcare, good schools, food, shelter, and other basic necessities.

To show the extent of the problem and win this contract, we need everyone to speak up about how the depressed economy is hurting your household, your friends, your patients, and your community. We’ve all kept silent for too long. It’s not your fault.

Please visit www.nationalnursesunited.org/story to share your story.