

Falling From Grace:

St. Joseph Health RNs Raise Ethical
and Patient Care Concerns

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Report by California Nurses Association/
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St. Joseph Health – From Moral Compass to Moral Questions

Healthiest communities, perfect care, and sacred encounters. These are values under which the St. Joseph Health system (SJH) was founded and claims to operate today. However, as chronicled in this report, based on the experiences of SJH registered nurses,¹ values that meant something to the SJH founding Sisters have given way to the priorities of present-day corporate management—who increasingly value maximized profits at the expense of patients, RNs, taxpayers, and SJH’s own stated principles.

Founded in 1920 by the Sisters of St. Joseph of Orange with a hospital in Eureka, California, to help a rural community suffering from the great influenza pandemic of 1918, the St. Joseph Health system has burgeoned to become one of the largest hospital and healthcare systems in California, New Mexico, and Texas. That expansion has been accompanied by growing concerns that SJH has strayed far from the moral compass that inspired and guided its founders.

In the early days, Sister Bernard and 18 other Sisters worked at their Eureka Hospital in “12-hour shifts, seven days a week. Their responsibilities included nursing, administration, purchasing, record keeping, billing, laundry work, and cooking. They did it all.”² As they opened other hospitals, they spoke out for social justice—including for farmworker rights in the 1970s, leading to the arrest of several Sisters in solidarity with César Chávez.³

Over time, however, the relationship of the Sisters to the hospital system changed. Fewer and fewer Sisters took part in day-to-day activities of their hospitals and in 2004, the Sisters applied to the Vatican to change their relationship with the SJH system—ultimately transitioning to a “Sponsorship Board” where a few Sisters could share governance responsibilities with lay, business people.

Today, the SJH system has shifted dramatically from its early days, raising broad questions about a moral compass that seems more driven by business and financial goals than by patient care and community service—particularly for a system that enjoys substantial benefits from the preferential tax treatment it receives in exchange for the promise of care and community benefits.

No one has seen and experienced the new face of the St. Joseph Health system more than its registered nurses. The direct-care RNs who work at SJH hospitals in California, whose collective voices are reflected in this report, describe a very different health system with very different values today than those upon which it was founded.

1. Nurses (RNs) who work for the SJH system are duty bound by law to advocate in the exclusive interests of their patients to help them achieve their optimal level of health and well-being, and to provide the direct and indirect nursing care services required for their patients’ safety, comfort, hygiene, protection, and disease prevention and restorative measures.

<http://www.rm.ca.gov/regulations/title16.shtml#1443.5>

2. “A History of the Sisters of St. Joseph of Orange,” <http://www.stjosepheureka.org/About-Us/Our-History.aspx>.

3. Freedman, Samuel. “Theology Finds its Way Into Debate Over Unions.” *New York Times*, 9 August 2009.

http://www.nytimes.com/2008/08/09/us/ogreligion.html?_r=0.

Skimping on Charity Care, Investing Offshore: The New Corporate Face of St. Joseph Health

In recent years, according to the latest data publicly available, St. Joseph Health has:

- Spent less on charity care than any other major Catholic hospital system in California, and less on charity care than the average hospital in California as a percentage of operating expenses.⁴
- Poured millions of dollars, diverted from patient care, into hedge funds and offshore accounts in the Cayman Islands.⁵
- Spun off and invested in for-profit entities to further swell revenue and profits for a system that, as a result of its “not-for-profit” status, does not pay taxes.⁶
- Paid a growing number of executives within the SJH system more than \$1 million every year.⁷

Cutting Patient Services, Reducing the Number of Caregivers, and Violating Nurses’ and Patients’ Rights

While recording more than \$500 million in profits the last two years alone, SJH has:

- Closed cardiology and outpatient clinics and reduced hours for services.
- Reduced patient access to registered nurses, other caregivers, and support staff, leading to unsafe staffing and delays in care, which put patients at risk.
- Failed to properly maintain equipment needed for patient care, and under-stocked basic supplies, which has led to delays in bedside care and the provision of medication to patients.
- Made sweeping cuts to employee disability benefits, needed medical leave, and retirement security for many employees, disproportionately impacting those with years or decades of service.
- Threatened, harassed, spied on, and committed numerous violations of federal labor laws guaranteeing the rights of RNs to form a union to advocate for safer patient care.
- Required new nurse graduates to work for free, while not offering any discount for patients who benefit from this unpaid labor.

These trends illustrate how the SJH system is influenced less and less by the Sisters’ historical commitment to service—despite the ongoing insistence of system executives that their hospitals are dedicated to providing “Perfect Care,” creating “Sacred Encounters,” and building “Healthiest Communities”—the three central themes splashed across the SJH website.

For SJH registered nurses, the goal is to hold SJH management accountable to its stated mission and to ensure that the lofty promises to patients and communities are upheld.

It is the experience of SJH nurses, including current members and those who are seeking to join the California Nurses Association/National Nurses United (CNA/NNU), which forms the basis of this report.

4. Office of Statewide Health Planning and Development (OSHPD), 2013 Hospital Annual Financial Data.

5. St. Joseph Health 2012-2013 IRS Form 990, <http://www.guidestar.org/FinDocuments/2013/953/589/2013-953589356-0a71101d-9.pdf>

6. <http://www.informationweek.com/it-leadership/why-we-started-a-health-it-innovation-institute/d/d-id/1111468?>

7. St. Joseph Health 2012-2013 IRS Form 990

Does SJH Provide Perfect Care?

“Delivering Perfect Care” for all patients is the pledge SJH advertises on its website. But in monitoring conditions in the SJH system, its registered nurses—who have ethical and legal obligations to advocate on behalf of their patients even when it conflicts with the economic interests of their employer⁸ – report that SJH is not living up to its goal of “Perfect Care.”

The following findings are from a nurse survey of SJH RNs in the first quarter of 2015 and Assignment Despite Objection⁹ (ADO) documents submitted by SJH RNs to hospital managers. All reporting is consistent with HIPAA guidelines.

Insufficient Supplies & Resources

Hospitals are legally required to maintain equipment and supplies adequate for the needs of the patients they admit and the services they provide.¹⁰ It’s for good reason: Under-stocking of basic supplies can result in delays in bedside care or medication administration. The time an RN spends problem solving or searching for supplies for one patient can interrupt or delay care for his or her other patients who also require timely and regular nursing assessments.

“Central supply is still not stocked properly so many wasteful minutes spent looking for supplies.” —ADO: Petaluma Valley Hospital, Medical-Surgical Unit, December 2014

How does the SJH system fare when it comes to stocking its hospitals? **An overwhelming 78 percent of the SJH RNs surveyed say that they cannot always rely on equipment they need for charting, medications, and patient care to be readily available and in good working condition.**

“The ice machine on the unit was gone. The day shift had reported seeing mold in the machine and so it was removed. We were unable to make patient ice packs, the lab was without ice to make lactic acids and ammonias.” —ADO: St. Joseph Hospital, Eureka, Medical-Surgical Unit, July 2013

In emergency or critical-care settings, such interruptions and delays in care can even be fatal. Studies have shown links between RN availability and patient outcomes, because “the effectiveness of nurse surveillance [of patients] is influenced by the number of registered nurses available to assess patients on an ongoing basis.”¹¹ If RNs are away searching for supplies, that time cannot be spent providing assessment and intervention if they detect subtle symptoms signaling deterioration in their patients’ condition.

8. <http://www.rn.ca.gov/regulations/title16.shtml#1443.5>

9. Assignment despite Objection forms are tracking tools that RNs use to record and protest patient care assignments they believe are unsafe or required to be completed under unsatisfactory conditions. These forms enable nurses to document cases when they are not given adequate resources, time, authority, and support to provide safe, effective, and therapeutic care to their patients.

10. Title 22 §70207, Medical Service Equipment & Supplies.

11. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2906760/>

"We need more Alaris pumps. We never have enough pumps or channels in the ER. We literally have to stop antibiotic infusions on one patient to sedate another patient after intubation. This is a daily issue that has never been addressed adequately. We spend hours looking for pumps weekly, and we delay antibiotics and IV drips because we have no pumps for rate control/safety." —ADO: Emergency Department RN, St. Joseph Hospital, Eureka, April 2015

Why would SJH operate with a dearth of supplies and resources, putting patients at risk? The problem is not that SJH has difficulty affording or obtaining the supplies, say SJH RNs. Rather, SJH simply chooses to run under "just in time" management principles, adapted from the manufacturing sector to the healthcare setting. These principles are intended to keep parts or other supplies in low stock to reduce inventory costs. In manufacturing, this practice can lead to production delays, but in healthcare, the delays have a human cost. When necessary items are not available, patients can experience dangerous delays in care.

Unsafe Staffing Levels

Hospitals are required to comply with licensing and certification regulations at all times as a condition of doing business. In California, one of these regulations is mandated nurse-to-patient ratios, as required by AB 394, enacted in California in 1999. **Almost half of all SJH nurses surveyed reported that they have been assigned more patients than California's ratio law allows.** Nurses also report that standard meal break procedure in SJH facilities violates the staffing law, which, despite legal challenges,¹² applies "at all times." Of the SJH nurses surveyed, 92 percent report that staffing is not sufficient to enable them to consistently exercise their legal rights to take breaks without interruption, in compliance with ratios mandates and the safety of their patients.

"We had no Certified Nurse Assistants, no resource nurse, back-to-back admissions, high-acuity patients with no meal or break relief RN." —ADO: St. Mary Apple Valley, RNs in Telemetry Unit, October 2014

Safe RN staffing has long been directly associated with improved patient outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Mark, Harless, McCue, & Xu, 2004; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). For example, one study¹³ found an increased risk of 30-day mortality, as well as an increased risk of failure-to-rescue, for surgical patients in hospitals with high patient-to-nurse ratios.

12. "There is ample evidence in the rulemaking file which supports the adoption of the regulation, the ratios, and the regulation's requirement that the ratios be maintained at all times." – Gail D. Ohanesian, Judge of the Superior Court

13. Aiken, Clarke, Sloane, Sochalski, et al (2002) <http://www.ncbi.nlm.nih.gov/pubmed/12387650>

The importance of complying with California ratios is highlighted in a 2010 University of Pennsylvania study¹⁴ comparing California hospitals to facilities in Pennsylvania and New Jersey. It was found that New Jersey would have 14 percent fewer patient deaths and Pennsylvania 11 percent fewer deaths if they matched the California ratios in surgical units. The study also illustrated that the higher the proportion of nurses in hospitals whose patient assignment is in compliance with the benchmark set by California's ratios, the lower the nurse burnout and job dissatisfaction, the less likely nurses are to report that their workload causes them to miss changes in patients' conditions, and the less likely nurses are to leave their jobs.

Another recent study¹⁵ revealed that reducing the patient load for nurses dramatically reduces the risk for a number of complications. This study showed that excessive patient assignments for nurses result in a significant increase in the risk of children being readmitted to the hospital due to inadequate care and patient education. For children admitted with common medical and surgical conditions, every patient assigned to a nurse above four resulted in an 11 percent increased risk for readmission, and for children recovering from basic surgeries, each additional patient assigned to a nurse increased the risk of readmission by a shocking 48 percent.

The aforementioned study builds on earlier research published in the Journal of the American Medical Association (JAMA), which found that every adult patient assigned to a nurse above the recommended four patients resulted in a 7 percent increase in the risk of death for those patients.¹⁶ When nurses are assigned too many patients, their inability to take breaks is not only in violation of their rights, it can also endanger patients. Studies have shown that short breaks not only improve performance and reduce subjective fatigue, but are also effective in controlling the accumulation of risk associated with prolonged task performance (e.g., two hours sustained work) and sleepiness¹⁷ which can lead to medical errors or injuries for nurses and patients.

"Other babies on the unit were ignored and not cared for while an emergency delivery was performed. We had nine babies and only three RNs and emergent deliveries. We notified our manager and the Chief Nursing Officer and their response was 'absolutely nothing.'"
—ADO: Queen of the Valley, NICU Day Shift, May 2014

Not only are SJH hospitals repeatedly characterized by systematic, unlawful, and unsafe short staffing, but, SJH RNs say, hospital managers are also unresponsive when patient needs or emergency situations require additional staff. According to those surveyed, more than 95 percent of RNs cannot count on getting increased staffing when a direct-care RN reports that staffing is insufficient. Limited resources and understaffing undermine nurses' ability to provide quality care and consequently put patients at risk.

14. Aiken, Sloane, Cimiotti, Clarke, et al (2010)

<http://www.nursing.upenn.edu/chopr/Documents/Aiken.2010.CaliforniaStaffingRatios.pdf>

15. http://www.massnurses.org/files/file/Legislation-and-Politics/An_Observational_Study_May_2013.pdf

16. <http://jama.jamanetwork.com/article.aspx?articleid=195438>

17. <http://www.ncbi.nlm.nih.gov/books/NBK2645/>

"No aide on the floor, lift team only available until midnight, no patient transport available, sharps and medical waste bins overflowing, isolation carts not restocked. Result was delays in answering calls, delays in toileting, delays in answering bed alarms, missed ambulations and turns, delays in incontinence clean up and delays in transferring patients from ED [Emergency Department]."—ADO: St. Joseph Hospital, Eureka, Medical-Surgical Unit Night Shift, June 2013

Elevated Infection Rates

In 2014, St. Joseph of Orange and Mission hospitals were penalized by Centers for Medicare and Medicaid Services (CMS) for high infection rates.¹⁸ The federal government cut payments to more than 700 hospitals, including St. Joseph of Orange, as a part of the health law mandating reductions for hospitals cited by Medicare as having the highest rates of "hospital-acquired conditions," or HACs. Such conditions include infections from catheters, blood clots, bedsores, and other complications that are considered avoidable.¹⁹

Addressing the staffing issues raised by nurses in this report would help decrease risk of further infections and adverse effects, counsel SJH RNs. A study²⁰ conducted by researchers at Brigham & Women's Hospital and Massachusetts General Hospital found that overcrowded and understaffed hospitals that are pushing too hard to streamline and cut costs are putting their patients at risk for medication errors, nerve injuries, infections, and other preventable mistakes. A 10 percent increase in the number of patients assigned to a nurse was found to result in a 28 percent increase in these adverse events.

SJH Patients Deemed to Be in Immediate Jeopardy (2007 to Present)

Since 2007, the California Department of Public Health (CDPH) Licensing and Certification Program has levied 20 administrative penalties upon SJH hospitals. An administrative penalty is a penalty in an amount up to \$100,000 per violation or deficiency that CDPH determines could cause "immediate jeopardy" to the health and safety of a patient. These penalties are assessed against hospitals after an investigation of a facility's noncompliance with conditions of licensure.²¹

Immediate jeopardy is "a situation in which the hospital's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient."²² Following, is a summary of immediate jeopardy situations from within SJH from 2007 to 2014:²³

18. <http://www.ocregister.com/articles/hospital-638523-mission-infections.html>

19. <http://www.ocregister.com/articles/hospitals-645751-hospital-medical.html>

20. http://www.massnurses.org/files/file/Legislation-and-Politics/4_24_07_Adverse_Events_Article.pdf

21. <http://www.cdph.ca.gov/certlic/facilities/Documents/HospitalApFAQ.pdf>

22. <http://www.cdph.ca.gov/certlic/facilities/Documents/HospitalApFAQ.pdf>

23. <http://www.cdph.ca.gov/certlic/facilities/Pages/Counties.aspx>

Hospital Name	Summary of Immediate Jeopardy Findings	Death
Mission Hospital Regional Medical Center	<i>RN without appropriate competency.²⁴ Patient catheter removed while patient in the wrong position.</i>	No
	<i>Two separate incidences of sponge retained during surgery. Removed in second surgery.</i>	No
	<i>Improper marking of surgical site resulting in wrong site spinal fusion.</i>	No
Mission Hospital, Laguna Beach	<i>Infant given morphine IV meant for mother. Infant dusky, intubated and placed on ventilator.</i>	No
	<i>Five lap sponges left in patient after surgery. Second surgery required to remove sponges.</i>	No
St. Joseph Hospital of Orange	<i>Patient with low blood count that was not reported to MD prior to Caesarian section. Blood pressure and heart rate changes not reported to MD in recovery room or Post-Partum. Seizures to ICU.</i>	Yes
	<i>Patient sent to ultrasound on 15 liters/minute of oxygen without licensed staff. 45 min of oxygen at the flow rate. Patient in procedure for more than an hour. Patient dead upon returning to room.</i>	Yes
Redwood Memorial Hospital	<i>Wrong knee surgery despite two nurses noting error prior to surgery. Procedure performed on wrong knee. Second surgery to correct knee.</i>	No
	<i>Guide wire not removed for femoral line for central venous catheter.</i>	No
St. Joseph Hospital, Eureka	<i>Retained foreign object during surgery.</i>	No
St. Mary Medical Center, Apple Valley	<i>Patient received second-degree burns on face during flash fire in OR.</i>	No
	<i>30-hour delay in communication of x-ray results showing possible perforated viscus in ED patient with advanced metastatic cancer. After third visit to ED, patient was admitted with acute respiratory failure, septic shock, and peritonitis.</i>	No

24. According to Title 22, §70016.1, Competency validation for registered nurses is a determination based on the satisfactory performance of the statutorily recognized duties and responsibilities of the RN, as set forth in Business and Professional Code Section 2725 (The Nursing Practice Act), and regulations, and the competency standards required specific to each patient care unit.

St. Jude Medical Center	<i>Removal of normal kidney in wrong-site surgery instead of one with cancerous mass due to failure to review relevant images during pre-procedure verification process.</i>	No
	<i>Surgical sponge retained for over two months after two-stage bilateral mastectomy/reconstructive surgery, due to failure to conduct sponge count after first stage, and failure to thoroughly investigate report of a missing sponge after second stage.</i>	No
	<i>Death of ED patient admitted with increasing chest pressure due to failure to assess patient upon observing zero heart rhythm on cardiac monitor screen and monitor alarm set to inaudible level.</i>	Yes
	<i>Retention of foreign body (non-radio opaque plastic drape used to hold back bowel during abdominal hysterectomy), which was not accounted for during post-surgical OR count. Patient had to be reintubated and incision reopened to remove drape.</i>	No
Petaluma Valley Hospital	<i>Lap sponge retained after colon resection surgery, with post-surgical count documented as correct, was removed during second surgery one year and 9 months later, after patient developed bowel obstruction and adhesions.</i>	No

The above instances fail to meet the test of “perfect” care, and highlight the importance of safe staffing and proper compliance with state laws and conditions of licensure, which were enacted to protect patients from risk of harm.

Included in those legal requirements is Title 22, Section 70217(a), California Code of Regulations, which provides that “No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital’s clinical area sufficient to provide competent care to patients in that area.” Among St. Joseph Health nurses surveyed, however, only 12 percent report a consistent practice of being oriented prior to floating to a new unit, and only 15 percent reported that RNs who float to their unit are given a competency check prior to accepting a patient assignment.

“Four out of six of the nurses on our unit today were floated from other units. One had not worked our unit in over two years and another had just returned from a one-year leave. We had a very high patient load with high acuity. Having this many nurses unfamiliar with the unit is unsafe for patient care and left many nurses feeling overwhelmed.”—ADO: St. Joseph Hospital, Eureka, Medical-Surgical Unit, July 2013

Does SJH Actually Provide Sacred Encounters?

“Every interaction will be experienced as a sacred encounter,” proclaims SJH on its website, adding, “Our value of Dignity calls for us to respect each person as an inherently valuable member of the human community and as a unique expression of life.”²⁵ Too often that lofty rhetoric turns into a less-than-sacred experience for SJH’s patients and frontline caregivers.

Imperfect Care, Stressed Encounters

The chronic understaffing and unavailability of resources outlined above have implications beyond immediate patient outcomes. They also lend to an environment where patients and families may feel that a lack of time and resources equates to a lack of respect. To provide truly dignified services, SJH needs to increase its staffing so that RNs can provide therapeutic care in an environment that promotes healing, and that includes proper time for care, as well as emotional support and education for patients and their families.

“RNs are expected to staff all functions (answer call lights, pass meds, bedside care, answering unit doorbell/phones, chart prep, tray passing, teaching, discharge prep, admissions, etc. We are often made to [do nursing administrative tasks such as] fix staffing needs ourselves, taking away more time from patient care.” —Patient Care Survey: Pediatrics RN, Santa Rosa Memorial Hospital, March 2015

When RNs are overwhelmed by too many patients or time is spent on supply retrieval, administrative tasks, or duties that could be performed by ancillary staff, patients are deprived of valuable nursing care time—resulting in an experience which does not best affirm the inherent “dignity” SJH proclaims to uphold.

Frequent readmissions are just one example of the less-than-sacred outcomes that patients experience as a result of understaffing. Study results²⁶ suggest that reducing nurses’ workloads could result in fewer readmissions for Medicare beneficiaries with common medical problems. Analysis of linked data from California, New Jersey, and Pennsylvania shows that each additional patient per nurse in the average nurse’s workload was associated with a 7 percent higher odds of readmission for heart failure, 6 percent increased risk of pneumonia, and 9 percent higher odds for myocardial infarction (heart attack). Lack of time for proper patient education exacerbates the problem. According to the aforementioned 2010 University of Pennsylvania study,²⁷ the higher the percentage compliance with benchmarks based on California ratios, the more likely nurses are to have confidence that their patients can manage their own care after discharge.

How does SJH fare with ensuring patients are not faced with unnecessary readmissions? Currently, SJH nurses estimate they are able to spend less than 42 percent of their time on direct patient care.

25. <http://www.stjhs.org/About-Us/Mission-Vision-and-Values/Sacred-Encounter.aspx>

26. http://www.massnurses.org/files/file/Legislation-and-Politics/Hospital_Nursing_and_30-Day_Readmissions_Jan_2013.pdf

27. <http://www.nursing.upenn.edu/chopr/Documents/Aiken.2010.CaliforniaStaffingRatios.pdf>

"[Our electronic health records system]... takes a lot of time and does not capture the core of nursing care. We are currently being penalized for giving meds without scanning them, but L&D is like the ER in that it is not in the patient's best interest to wait for the patient to be admitted into the computer, then enter orders, then wait for them to be verified by the remote pharmacy, then available in [the medication distribution machine], then scanned. This would take at least 40 minutes on a good day." —Patient Care Survey: L&D RN, Redwood Memorial Hospital, March 2015

A workforce study²⁸ published in 2007 highlights another factor eroding RNs' ability to provide the safe and effective care that is, or should be, the essence of a "sacred encounter": the electronic health record (EHR). Of RNs surveyed in the workforce study who were using EHRs, 66 percent indicated that electronic documentation increased time spent on computer data entry, time diverted from direct interaction with the patient.

The implementation of the EHR in SJH hospitals, SJH nurses say, has increased RN workloads and poses a threat to patient safety by reducing the amount of time available for the initial and ongoing assessments of the assigned nurse. In particular, SJH nurses have reported that the EHR interferes with their ability to collect relevant data; synthesize and analyze the patient's data; develop and implement the care plan; and individualize, prioritize, evaluate, and document the nursing care and medical treatment as required by law.²⁹

Another condition at SJH that robs both patients and nurses of inherent dignity involves a lack of support from management in matters of safe patient handling. Insufficient lift and transport resources frequently require nurses to risk injury by lifting or turning patients on their own.

"No transportation available to move a patient, transfer by RN was unsafe with minimal help. No lift team, equipment, or transporter available." —ADO: All RNs, St. Mary Apple Valley, Post-Anesthesia Care Unit, January 2014

Although a "Safe Patient Handling" bill³⁰ was signed into law in California in 2011, with subsequent regulations adopted by the California Occupational and Health Administration (Cal/OSHA) requiring acute-care facilities to provide 24/7 lift teams and equipment to assist in the handling of patients based on severity of illness and worker safety, the SJH system facility has consistently failed to implement these provisions.

The combination of undernourishment and fatigue from lack of breaks, pressure to treat more patients than what is legally sanctioned, lack of time for proper patient education, and lack of support around safe patient handling all undermine the efforts of RNs to safely provide patients with the highest possible standards of care. Consequently, 69 percent of RNs within the SJH system reported below average morale at work. Such low morale, resulting from such poor working conditions, is neither sacred nor dignified—despite the advertised values under which SJH claims to operate.

28. http://www.mbon.org/commission2/documenation_challenges.pdf

29. <http://www.rn.ca.gov/pdfs/regulations/npr-b-53.pdf>

30 http://nurses.3cdn.net/413c8aadf32569fe84_5ym6i6tg9.pdf

"I notified the lead that the unit was best positioned to admit an incoming Intensive Care Unit (patient) between 1 and 5 am, which would have been best for the patient as well as current patients. Instead, the patient was transferred at 6:30am, just before change of shift. This left the patient feeling rushed, without required telemetry monitoring, and in a manner that was less safe. In short, this was poor planning that resulted in inadequate care for this patient and my other patients. We can do better."—ADO: Petaluma Valley Hospital, Medical-Surgical Unit Night Shift, March 2015

Violating Patients' Rights

Hospital administration has a legal obligation to plan for the provision of care for each patient, and to "establish mechanisms for rapid deployment of personnel when any labor-intensive event occurs which prevents nursing staff from providing full attention to all assigned patients."³¹ Unfortunately, in the aforementioned understaffed conditions at SJH, patients who required ongoing assessments, analysis and interpretation of data, and the provision of nursing care were at risk of preventable harm due to the administration's deficient staffing policies and procedures. And what nurses were reporting was backed up by State of California facility licensing and certification inspectors.

St. Joseph Hospital in Orange, California (St. Joseph of Orange), was recently cited with a statement of deficiency and fined by the State of California, and threatened with a loss of Medicare reimbursement for failing to comply with the CMS Conditions of Participation. These conditions require all SJH facilities to, among other things, maintain evidence of education, training, and competency validation for the staff regarding restraint policies and procedures.³² The use of restraints in lieu of employing alternative methods such as assigning additional staff to watch a patient, is an unlawful, budget-driven shortcut that undermines the dignity and the safety of the patient. In particular, CMS cited St. Joseph of Orange for the following patient rights violations (summary):

- *The hospital failed to ensure patients received care in a safe setting.*
- *The hospital failed to identify the use of a mechanical device, material, or equipment that immobilized or reduced the ability of a patient to move freely.*
- *The hospital failed to ensure care plans were developed to address the use of restraints, bedrails.*
- *The hospital failed to ensure restraint orders were only initiated when documented behaviors warranted and physician's orders were obtained daily for their use.*
- *The hospital failed to ensure assessment, monitoring, and interventions were provided every two hours regarding the use of restraints and bedrails.*

CMS can disqualify the hospital from eligibility for Medicare reimbursement unless an approved plan of correction to remedy the deficiencies is followed.³³ In a public statement, the Hospital noted that it "will no longer use mittens as restraints unless ordered specifically by a physician."^{34 35}

31. Title 22, §70213 nursing service policies and procedures

32. <http://voiceofoc.org/2015/05/feds-threaten-to-cut-off-medicare-payments-to-st-joseph-hospital/>

33. Ibid.

34. Ibid.

35. Note: "Mitts" or "mittens" are medical devices that require a physician's order before they can be applied to patients under certain conditions. They are a form of restraint that is applied to prevent patients from inadvertently removing therapeutic devices such as feeding tubes, drains, and intravenous catheters. They are also applied as a form of treatment restraint to patients who are cognitively impaired while emerging from anesthesia and sedation to help prevent injury. The mitts keep patients from closing their hands. If cinched too tight around the wrists, they can harm the patient by restricting circulation to the hand. Patients who

Violating Nurses' Rights

As SJH RNs have jointly sought redress over workplace concerns, to the benefit of patient safety, SJH management has launched a coordinated campaign to prevent RNs from unionizing. In direct contradiction to SJH's stated principle that "We endorse the right of employees to choose whether or not they want to have union representation...", the system has actively interfered with nurses' rights to organize. This campaign has included spending precious patient care funds on hiring outside anti-union consultants (commonly referred to as "union-busters") to plan and implement an anti-union strategy in every non-union SJH hospital. SJH nurses have been pressured to take so-called "ACT" classes on the National Labor Relations Act (NLRA) which would, according to a leaked email, provide them with "legally accurate facts regarding the issue of unionization" and the "potential impact to you." According to SJH nurses, however, these classes—taught by an anti-union firm—featured an openly anti-union curriculum.

RNs have also been inappropriately forced at mandatory "skills day" trainings in several SJH hospitals to listen to incorrect information about unionization. According to RNs, management threatened during these trainings that unionization would result in the loss of current help with patient lifting and with current scheduling benefits—and that a "vote no [on unions] is a vote for the hospital."

Management's drive to prevent SJH nurses from joining together to improve working conditions, wages, and other workplace standards extended beyond the spreading of *misinformation*—and into barring nurses from sharing correct information amongst themselves. This did not go unnoticed in the eyes of the law. Federal labor law protects nurses' rights to engage in concerted activity regarding their terms and conditions of employment. Under the NLRA, the National Labor Relations Board (NLRB) investigates conduct by employers that violates nurses' rights.

In October 2014, the NLRB found meritorious a complaint against St. Joseph of Orange for prohibiting employees from talking about the union in nurses' stations or patient care areas where employees were free to talk about other wide-ranging topics. The NLRB also agreed that the hospital had unlawfully threatened nurses with discipline for choosing to engage in union activities. The NLRB found that SJH policies on solicitation and distribution unlawfully restricted nurses from soliciting or distributing information about unionizing due to an overbroad definition of where such conduct could be prohibited. St. Joseph of Orange avoided further sanctions by entering into a settlement which required it to revise its policies and announce to nurses its resolve not to prohibit talking about the union and not to threaten nurses.

While that settlement was still in effect, from November 2014 through the spring of 2015, St. Joseph of Orange further interfered with nurses' rights by again directing employees not to talk about the union at the nurses' station where all other subjects of conversation are fair game. Nurse leaders who advocated on behalf of their coworkers at St. Joseph of Orange have also been barred unlawfully, on multiple occasions, from speaking to coworkers while off duty, interfering with the RNs' ability to inform each other about patient care and nurse safety issues at SJH facilities. The hospital's policy on off-duty access was also found unlawful and the term solicitation was so broadly defined that it encompassed one nurse's urging another to support the union—yet another aspect of the wide-ranging attempt to stifle nurses' communications with one another. The NLRB also is prepared to issue complaint against St. Joseph of Orange for prohibiting nurses from using email to communicate with each other about working conditions, safe staffing, and their efforts to secure union representation. The hospital was required to agree to change its policies and announce this to nurses by the end of July 2015, or the NLRB would take further action.

are restrained and agitated or disoriented can dislocate limbs, dislodge intravenous or intra-arterial shunts and catheters that can lead to severe blood loss.

The same policies that unlawfully restricted employees' ability to communicate with one another at St. Joseph of Orange have been found unlawful at another SJH facility, Mission Hospital, which has campuses in Mission Viejo and Laguna Beach, California. That hospital also unlawfully denied off-duty employees access to break rooms so that they could talk with coworkers about the union. CNA also charged Mission Hospital with unlawfully denying nurses the right to use email to communicate with one another. Mission Hospital will have to enter into a settlement and agree to change its policies or face sanction by the NLRB this summer.

SJH's Petaluma Valley Hospital in Petaluma, California, has also been charged with unduly restricting nurses' rights to talk with their coworkers and distribute union literature, as well as maintaining an illegal Solicitation and Distribution Policy. The hospital has agreed to settle these charges by changing its policies and notifying nurses.

Charges are currently pending against five SJH hospitals: St. Jude Medical Center (Fullerton, California), St. Mary Medical Center (Apple Valley, California), St. Joseph Hospital (Eureka, California), Petaluma Valley Hospital (Petaluma, California) and Queen of the Valley Medical Center (Napa, California), based on similar illegal policies. SJH's prohibition on employees using email and restrictions on off-duty employee access, are also under investigation at these hospitals.

At facilities where SJH RNs are represented, SJH management has also bargained in bad faith by failing to respond to nurses' requests for information that is necessary for the collective bargaining process, or by unilaterally changing hospital policies related to nursing duties, staffing, and other working conditions. At Queen of the Valley Medical Center in Napa, California, the NLRB issued two successive legal complaints against the facility for unilaterally changing the nurse staffing model without bargaining with the RNs' representative.

In addition, exploiting a job market that has made it increasingly difficult for new graduates to find RN employment, SJH has "hired" new graduates at hospitals, such as Queen of the Valley Medical Center, under the condition that they work for free—while not reducing the cost to patients (or their insurers) who receive the benefits of care from RNs who are effectively working as indentured servants.

"I was disappointed to learn that the hospital has ignored our rights again, and in doing so has degraded the profession of nursing by suggesting that it should be done for free. Nurses have filed charges with the federal labor board and we will fight back when the hospital violates our rights and disrespects our profession." —ADO: Queen of the Valley Medical Center, Intensive Care Unit, April 2015

How Well Does SJH Promote Healthy Communities?

“Building Healthiest Communities” is the third prong of the pledge made by SJH on its website, promising, “We commit resources to improving the quality of life in the communities we serve.” SJH says it has developed programs to support its goal of serving communities that will be among the healthiest in our nation. These programs include SJH’s work towards advocacy and community benefit.³⁶ As a tax-exempt, not-for-profit institution, SJH has a legal obligation to provide charity care and community benefit programs, but RNs are concerned with the lack of transparency and accountability in how it meets that responsibility.

Community Benefits and Advocacy

In 2010, California counties and cities lost more than \$1 billion as a result of the tax exemption for non-profit hospitals, as well as direct payments counties make to hospitals in their geographic area to provide uncompensated hospital care for the poor. At that time, 75 percent of California not-for profit hospitals—including SJH—garnered tax benefit in excess of what they returned to charity care.³⁷

Like other not-for-profit hospitals, SJH enjoys many tax exemptions including: federal and state income taxes on profits, property taxes, and almost all state and local taxes. Additionally, as a not-for-profit, SJH can and has received financing through tax-exempt bonds and receives tax-deductible charitable contributions. In 2013,³⁸ however, the SJH system provided less charity care as a percentage of its operating expenses than the average California hospital, and less than the average Catholic System.

Hospital	2013- Charity Care as a Percentage of Operating Expenses ³⁹
St. Joseph of Eureka	1.22%
Redwood Memorial	2.22%
Santa Rosa Memorial	2.00%
Petaluma Valley	2.07%
Queen of the Valley	1.11%
St. Joseph of Orange	1.44%
St. Jude Medical Center	1.78%
St. Mary’s Medical Center	3.10%
Mission Hospital	1.76%
All SJH	1.80%
All CA Hospitals	1.95%
All CA Major Catholic Systems	2.57%

36. <http://www.stjhs.org/About-Us/Mission-Vision-and-Values/Healthiest-Communities.aspx>
 37. IHSP Charity Care Report- 2012. http://nurses.3cdn.net/2c18b9633089481d2c_qrm6yn2ci.pdf. pg. 54-55.
 38. 2013 is the most recent available data from OSHPD.
 39. OSHPD. “Annual Hospital Financial Data 2013”. 23 October 2014.
<http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfiles/default.asp>.

In 2013-2014, SJH actively lobbied local and state lawmakers to oppose California legislation, AB 975,⁴⁰ a 2013 bill that would have defined community benefits in California and created transparency and accountability for not-for-profit hospitals like those within the SJH system that take advantage of tax exemptions. Currently, according to the California Legislative Analyst's Office, there is no uniform definition of charity care in state or federal statute.⁴¹ Nor are there any requirements for nonprofit hospitals to provide a certain amount of charity care or community benefit in order to maintain their tax-exempt status.^{42 43}

AB 975 failed to pass the Legislature due to extensive lobbying by hospital chains such as SJH, and the California Hospital Association, the trade association that represents nonprofit hospital giants like SJH in Sacramento. Successor bills were also introduced in 2014 (AB 503), and in 2015 (SB 346)—both of which were again stalled by vehement opposition of the hospital industry, and the latter of which may be heard again in 2016.

State law mandates private nonprofit hospitals in California conduct a community needs assessment every three years and develop a community benefit plan to be updated annually.⁴⁴ Currently, state law prohibits the use of a hospital's community benefit plan to justify its tax-exempt status.⁴⁵ Moreover, the keeper of the plans, the Office of Statewide Health Planning and Development (OSHPD), does not review them for consistency in reporting, nor does OSHPD have any authority to apply sanctions if hospitals do not submit their plans.⁴⁶

All three versions of the proposed legislation would clearly define what constitutes charity care as a direct provision of care, not promotional activities or cost containment, as currently provided within the guidelines of "community benefit." Additionally, the legislation would require improved reporting requirements for greater public transparency in how hospitals meet their charity care obligation.

"Community benefit" spending, under the legislation, would be required to meet real community needs by addressing the root causes of poor health, such as poor nutrition and unsafe housing, as well as investing in community-building activities in medically underserved or low income communities.

Yet few of the SJH hospitals provide any detail on what "community benefit" programs they provide. Hoag Hospital of Newport Beach, California (Hoag), an affiliate of the SJH system, one of the few that lists any "benefits for the broader community," includes funding for a "Health Ministries Program," which it defines as a "spiritually-based wellness program" targeting faith communities. Hoag also lists funding for a beach safety program, and unspecified "community education." All these programs may well provide a useful service, but do they justify a tax-exempt status that earned the SJH system \$152 million in tax-exemptions in 2010 alone, according to a research report by the California Nurses Association?⁴⁷ Do they address the root causes of poor health, such as poor nutrition and unsafe housing, and do they target medically underserved or low-income communities? Hoag also lists a contribution to the California Associations of Hospitals and Health Systems, an affiliate of the California hospital industry's major lobbying group, as a part of its health professions education. Was that part of what the hospital counts as a "community benefit?" That is a part of what the legislation opposed by SJH is intended to address.

40. SJH Advocacy webpage, accessed June 17, 2015.

41. "2011 Initiative Analysis: Charity Care Act of 2012," Legislative Analyst's Office, January 3, 2012, p. 2.

42. Martha H. Somerville, "Community Benefit in Context: Origins and Evolution – ACA 9007," The Hilltop Institute, June 2012.

43. State law requires hospitals to offer reduced rates to certain financially qualified individuals as required by the Hospital Fair Pricing Act of 2006.

44. Chapter 812, Statutes of 1994 (SB 697, Torres).

45. *Ibid.*, p. 6.

46. *Ibid.*, p. 4.

47. IHSP Charity Care Report- 2012. http://nurses.3cdn.net/2c18b9633089481d2c_qrm6yn2ci.pdf. pg. 54-55

If SJH were really interested in building healthy communities, it would encourage efforts to enhance transparency rather than draw on loopholes and short-comings in the current law to actively conceal what the system reports to the IRS as constituting community benefits.

Executive Compensation

Deborah Proctor, the outgoing CEO of the system, joined SJH in 2004. She was the first lay person to ever lead the system. As the CEO of SJH, Deborah Proctor has been among the highest-paid nonprofit executives in Orange County.⁴⁸ She earned \$2.05 million in compensation and benefits in the most recent tax filings with the IRS.⁴⁹

In addition to Proctor’s \$2 million dollar compensation package, four other executives within the system received compensation packages worth more than \$1 million each. While the system does not distribute profits to shareholders because of its not-for-profit status, it is allowed to pay its executives whatever it wants.

Investments Domestically and Abroad

The changing composition of the SJH board has resulted in a dramatic shift away from SJH’s historical mission to provide quality charity care. Instead, SJH has become a financial underwriter of for-profit healthcare incubators. One of the SJH executives reported as earning more than a million dollars is the president and CEO of the Innovation Institute, a for-profit healthcare accelerator company created by St. Joseph Health with an initial investment of \$40 million in January 2013. Currently, the Institute helps incubate companies which then sell their services to health systems, including SJH. In late 2013, Bon Secours Health System joined the Institute with a \$10 million investment.⁵⁰ As of June 30, 2014, SJH owned 71 percent of the company.⁵¹ Subsidiaries of the Innovation Institute include:

Company Name	Company Description
Petra Integrated Construction Strategies, LLC	Began as the in-house facilities, design, and construction department for SJH system based in Orange, California. Petra remained the internal division of the health system for over a decade until becoming independent in 2011. ⁵²
Tech Knowledge Associates, LLC	A company formed to save hospitals money by changing the way they maintain hospital equipment. It centralizes the clinical engineering functions of a service contract to consolidate cost centers. ⁵³
Far West Staffing Services	Provides technical and non-technical staffing. Uses full-time, part-time positions and subcontracting as a hiring methodology. "Positions range from office clerical work to senior construction manager." ⁵⁴
Total Health Environment	Specializes in "providing personalized customer service." Supports the design and layout of hospital equipment to maximize production. ⁵⁵

48. <http://www.ocregister.com/articles/health-652971-care-joseph.html>

49. 2012-2013 IRS Form 990

50. http://www.bizjournals.com/prnewswire/press_releases/2013/11/04/MM09318

51. <http://emma.msrb.org/EA648783-EA507735-EA903959.pdf>, p. 9.

52. <http://www.petra-ics.com/who-we-are.html>

53. <http://www.ii-techknow.com/who-is-tka/>

54. <http://ii4change.com/far-west-staffing-services/>

55. <http://ii4change.com/total-health-environment-llc/>

Healthcare Design & Construction A firm offering construction, architectural engineering, and planning services to the national healthcare market. HDC was formed through the acquisition of PDC West, a construction firm based in Orange County, California, which has more than 25 years of healthcare construction experience including acute care and outpatient medical diagnostic construction.⁵⁶

Healthcare Coding & Consulting Services Provides coding services for healthcare information management.⁵⁷

Healthcare Property Advisors, LLC A commercial real estate brokerage and developer with expertise in medical industry property management and leasing, construction management and engineering, and investment sales.

As some health industry researchers have noted, investing in technology often does not equate to cost savings for the patient,⁵⁸ and there are increasing concerns among physicians and registered nurses that much information technology actually interferes with effective patient care delivery.

Additionally, it remains unclear what role many of these companies play in providing direct quality patient care and healthier communities, or whether they instead divert patient care resources away from the bedside and from improving patient care. Why is money being put towards construction and real estate companies rather than reliably working equipment in the SJH hospitals? Why is SJH investing in cost-cutting technologies and financial opportunities when they are lacking in providing sufficient supplies and safe staffing for direct patient care?

In addition to investing in for-profit companies within the United States, SJH also invests in hedge funds and offshore accounts located in the Cayman Islands. According to its most recent tax filing, the system had more than \$59 million invested in these offshore accounts.⁵⁹ SJH RNs, whose experiences are the genesis of this report, believe that money would be better spent for SJH patients and communities by investing in direct patient care—not hedge funds and offshore accounts in the Cayman Islands, real estate companies, or high executive pay.

56. <http://ii4change.com/healthcare-design-construction/>

57. <http://www.hccscoding.com/about>

58. <http://www.technologyreview.com/news/518871/we-need-a-moores-law-for-medicine/>

59. 2012-2013 IRS Form 990

Recommendations

SJH is embarking upon a new era in its plan to merge with another hospital system. SJH nurses urge the SJH Ministry to use this as an opportunity to reaffirm a commitment to the highest standards of safe, dignified, and quality healthcare for our communities. SJH nurses believe the Ministry can do this in several ways:

- Support patients' rights and ensure the provision of the safe, therapeutic, and effective nursing care patients deserve, and fully comply with or exceed all applicable federal, state, and local health and safety laws at all times.
- Immediately cease all activity aimed at suppressing RN patient advocacy via collective bargaining, resolve all pending Unfair Labor Practice charges, and engage in good-faith bargaining over the needs and concerns of staff RNs.
- Support legislative efforts to improve reporting requirements for greater public transparency to ensure hospitals are meeting their charity care and community benefit obligation rather than just increasing revenues through marketing, cost containment, or other activities intended to generate profit.
- Invest excess revenue made by the system into patient care, not executive salaries or for-profit companies.
- Stop the unlawful campaign of fear and intimidation aimed at suppressing RNs' legal right to make a free and fair decision about union representation.
- Reverse sweeping cuts to employee disability benefits, needed medical leave, and retirement security—to help retain the most highly experienced nurses for the communities served by SJH hospitals.

The SJH system has shifted far from the morals that drove its founding Sisters. However, the registered nurses of SJH—backed with the information gathered in this report—believe that the above recommendations provide a roadmap back to truly healthy communities, perfect care, and sacred encounters. The patients cared for by SJH deserve no less.

*For more information, contact SJHinfo@calnurses.org.
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