Specific cases of illness and death

Massachusetts: A family filed a lawsuit in January 1999 against a Beverly Health and Rehabilitation Services, Inc.-owned Hermitage Health and Rehabilitation Center in Worcester, for causing the death of their father by intentionally engaging in a practice nationwide, of understaffing their facilities. The suit specifically alleges that the licensed practical nurse (LPN) in charge of the patient's care had only two-and-a-half weeks experience as an LPN when she was placed in charge of 62 patients in two of Hermitage's three units. (An LPN's training usually consists of a 12- to 18-month post-high school course that focusses on basic nursing care.)

The facility ignored her concerns that she was incapable of supervising two units, when the patient—who was suffering from respiratory depression, pneumonia, seizure disorder, dementia, and pernicious anemia—died (*Worcester Telegram and Gazette,* Jan. 30, 1999).

Massachusetts: In 1997, at one major Boston teaching hospital where nurses had gone through two years of staff "downsizing," use of unlicensed personnel, increase of patient assignments to unsafe ratios, and a dramatic rise in mandatory overtime to cover for a lack of registered nurses (RNs), a concerned hospital manager provided the nurses with a confidential report from the hospital's quality assurance department.

As described by a representative of the Massachusetts Nurses Association to *EIR,* the report "contained the hospital's own data on patient outcomes related to nursing issues. What the report showed was that patient falls had increased, medication errors (and nosocomial infections) had been increasing, patient satisfaction had been declining, and sponge counts in the operating room were routinely incorrect," that is, surgical sponges were left inside of patients after surgery. The manager saw a direct and unmistakable connection between poor RN staffing and poor patient care in the hospital's own data.

Ohio: In 1994, Christ Hospital of Cincinnati was one of the first and most aggressive hospitals to use unlicensed technicians as nurse aides. In August 1994, their patient, Rebecca Strunk, died after untrained aides missed all the tell-tale warning signs (falling blood pressure, pain) of a massive infection after Strunk's surgical hysterectomy. Aides had never reported her condition, nor the family's complaints made to the overworked nursing staff. There was a failure to order blood cultures. The infection was finally so widespread, that nothing could be done. After a $3 million settlement against the hospital in 1996, Strunk family attorney Richard Lawrence said that what killed Mrs. Strunk was the hospital's policy of "replacing educated minds with uneducated ones that can't appreciate subtle signs and symptoms before they become deadly." (This case was reported in *The American Journal of Nursing,* November 1996.)

being driven out of hospitals because of impossible working conditions—"speed-up" (routinely having to do the work of several workers), unsafe circumstances, such as caring for far too many acutely ill patients without an adequately trained staff, and so on.

In nine Minneapolis/St. Paul hospitals, where RN positions were reduced by 9.2%, one study found a 65.2% increase in injuries to RNs, who were forced to move patients and heavy medical equipment without help. In contrast, nurses have worked—unharmed—for 20 years, using the "buddy-system" to move patients. Now, staff cuts "are crippling a whole generation" of nurses, according to researcher Elizabeth Shogren. At hospitals that refuse to replace RNs lost through attrition, nurses are ordered to work double shifts several times a week and work 55 to 60 hours a week, for weeks or more, or face disciplinary action for "abandoning their patients," a charge for which they can lose their nursing license, or lose their job.

Typically, hospital RNs work round the clock in cases of major accidents or natural disasters, and they regularly provide overtime on a voluntarily basis. But hospitals now utilize mandatory overtime to meet *regular* staffing needs. In many Massachusetts hospitals, for instance, when the four-week nursing schedules are posted, there are as many as 40 to 60 unfilled shifts, or holes in the schedule; the hospital does not have enough nurses to staff the facility. Nurses ordered to work double shifts end up working 16 to 24 hours a day in some cases, and then put in another 12 hours caring for their own children.

The practice of mandatory overtime is a dangerous trend, in which overtired nurses might not be alert enough to catch subtle changes in a patient's condition. The problem is especially serious in an intensive care unit, where nurses give a lot of vasoactive drugs intravenously. A drug miscalculation can kill a patient.

An account of the problem in *The American Nurse,* in an article titled "Fighting the Clock" (May-June 1998), cited many other instances:

- One nurse at Ohio State University Medical Center was ordered, under threat of disciplinary action, to report to work