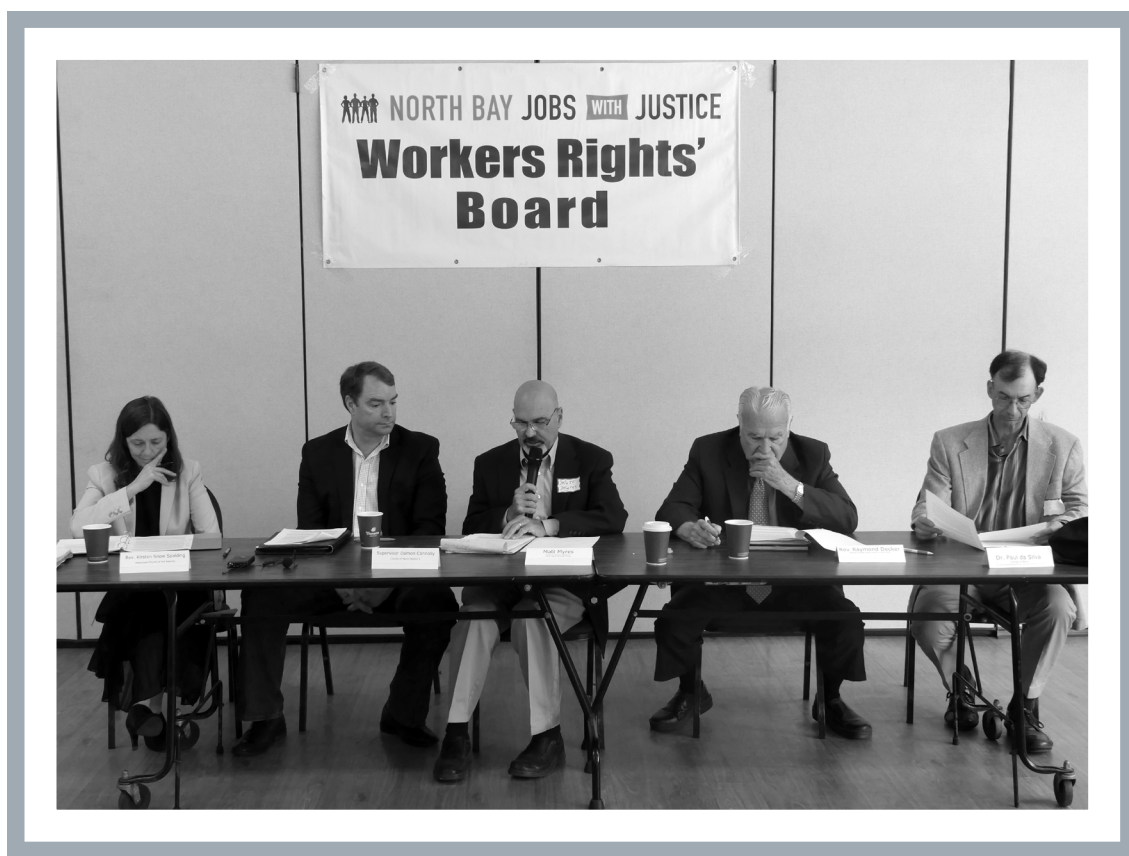


NORTH BAY WORKERS' RIGHTS BOARD

Report on the Hearing and Investigation of the Working Conditions of Employees at MARIN GENERAL HOSPITAL



**The North Bay Workers' Rights Board
is a community-based project of**

 **NORTH BAY JOBS WITH JUSTICE**

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Members of the Hearing Panel

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Marin County Board of Supervisors

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*Rector, Episcopal Church of the Nativity,
San Rafael*

(Organizational affiliation for identification purposes only.)

Testimony

The Workers' Rights Board received testimony from the following Marin General Hospital Workers and Union Representatives:

Virginia Currie, Registered Nurse

Deborah Savino, Radiology Technologist

Wendy De La Luz, Patient Admitting Representative

Edward Silva, Certified Surgical Technologist

Luz Ramirez, Environmental Services Aide

Lynn Warner, Registered Nurse

David Wallace, Monitor Technician

Brandon Taylor, Senior Environmental Services Aide

Janis Smith, Environmental Services Aide

James Taylor, Certified Nursing Assistant

Matthew Mullany, Teamsters 856 Business Representative

Tim Jenkins, Teamsters 856 Researcher and Business Representative

Susanna Farber, Attorney, Teamsters 856

Introduction and Background of the Report

The North Bay Workers' Rights Board (WRB) is a community-based organization comprised of 26 leaders from faith, labor, academic, and community organizations in the North Bay. It is a public forum to which workers can bring their concerns about violations of their rights in the workplace. The North Bay Workers' Rights Board is affiliated with North Bay Jobs with Justice, a labor-community coalition of 17 unions and community-based organizations.

Marin General Hospital (MGH) is a 235-bed district hospital and Marin County's only trauma Center. Marin General is a non-profit whose stated mission is "to provide exceptional health care services in a compassionate and healing environment." The hospital is a highly regarded and valued institution among residents of Marin County.

The governance structure of the hospital is two-tiered. The Marin Healthcare District, a government entity that has a publicly elected board, owns the land and hospital facilities. The board leased the operations of the hospital in 1985 to a nonprofit, Marin General Hospital Corporation (MGHC). In 1996, MGHC affiliated with Sutter. In 2006, Sutter agreed to terminate its lease 5 years early (by 2010), as part of a settlement agreement to resolve litigation between the District and Sutter concerning the construction of a new seismically sound facility. After almost a decade of operating under Sutter Health, the District severed its ties with Sutter, and control of the hospital reverted to the District in June 2010. The District kept the two-tiered structure and again leased the operations of the hospital to the newly created non-profit entity known simply as Marin General Hospital (MGH). The District is the General Member of the nonprofit MGH. The District and MGH together planned and financed a new wing of the hospital (with the help of a \$394 million-dollar public general obligation bond measure that was approved by the voters in 2013) that will meet state seismic safety standards and is now under construction.

Since Sutter left, the hospital has been doing well financially. The CEO of MGH, Lee Domanico, reported at the February 2017 Board Meeting that the hospital finished 2016 financially strong and exceeded its budget expectations. The latest available Internal Revenue Service 990 filing for Marin General (2015) reveals total program service revenue of \$376 million with a net of \$22 million after expenses, including salaries, benefits, and equipment.

But the hospital has other problems. In order to achieve such robust profits, MGH has reduced staffing



and consolidated positions. There has also been a turnover of many department managers at the hospital and the new managers have implemented new procedures without consulting employees. Consequently, many practices and relationships established under Sutter have been lost. Management's treatment of workers, according to employees, has become punitive. This has led to worker dissatisfaction and declining employee morale. Representatives from the Teamsters Local 856 and the California Nurses Association have attempted repeatedly to communicate their members' concerns to management.

According to union representatives, grievances and unfair labor practices have been filed, but resolution can often take up to two years. Union representatives and veteran employees both report that hospital management has refused to address widespread dissatisfaction and concerns about working conditions — particularly the impacts of systematic understaffing.

Therefore, workers represented by the Teamsters and the California Nurses Association approached the North Bay Workers' Rights Board to request an investigation into their working conditions. The WRB conducted a public hearing on Saturday, May 6, 2017 in San Rafael. The following report includes the testimony from the hearing and the WRB's Findings and Recommendations.

A CULTURE OF FEAR AND INTIMIDATION AND LACK OF RESPECT FOR WORKERS

Virginia Currie is a Registered Nurse who remembers the hope that employees had when MGH severed ties to Sutter. But working conditions and employee morale are actually worse under the hospital board's management.

My name is Virginia Currie, I am a Registered Nurse in Marin General's Cardiac Specialties Unit. As you can see I am just getting off of my night shift! I live here in Marin County; as an RN, I care for our community's elderly population.

Marin General is a 235-bed district hospital overseen by a publicly elected board. Many of you might be familiar with how MGH became the only stand-alone hospital in the area. In 2010, after almost a decade of operating under Sutter Health, many local residents became displeased with the hospital's leadership alleging, among many things, major financial mismanagement to the tune of \$180 million.

In June 2010, Marin General severed ties with Sutter returning it to public control over the Marin Healthcare District Board. Community members and MGH employees were thrilled when Sutter was kicked out. They were a bad employer engaging in bad faith bargaining, disciplining leaders, and bleeding the hospital dry of money.

MGH staff was ready for a change in leadership. We were all hopeful that with public oversight and transparency, our working conditions would improve. Unfortunately, the culture of the hospital has gotten much worse. Marin General hospital has brought onto their Executive Team individuals who have made a career out of union busting in the hotel and hospitality industry. This has created a culture of fear and intimidation.

We have come to expect this kind behavior from big behemoths like Sutter. Unfortunately, our stand alone community hospital engages in the

Virginia Currie

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Marin General went ahead and severed ties with Sutter returning it back to public control over to the Marin Healthcare District Board....MGH staff was ready for a change in leadership. We were all hopeful that with public oversight and transparency; our working conditions would improve. Unfortunately, the culture of the hospital has gotten much worse. Marin General Hospital has brought onto their Executive Team individuals who have made a career out of union busting in the hotel and hospitality industry. This has created a culture of fear and intimidation."



same tactics. Our staff works as a team; everyone you will hear from today, either at the bedside, in environmental services, or in the cafeteria, ensures that the patients get the best possible care. We hope that the hospital will return to what the community had always envisioned: a true healing place for those who receive and provide care.

Thank you for your time.

Deborah Savino

“It troubles me to see my brothers and sisters, members of the Teamsters and CNA, having to fight so hard simply to get respect on the job...We join our co-workers in calling on Marin General to do the right thing by all its workers, because we are the ones who work day in and day out to serve and protect our patients and whose hard work has made this hospital what it is today.”



Deborah Savino has been a Radiology Technologist for 15 years at MGH and while she feels the managers in her department are fair-minded, she knows the struggle that her fellow MGH workers are experiencing and she supports them in their fight for respect on the job.

Hi, my name is Deborah Savino and I have worked for the past 15 years as a Radiology Technician at Marin General Hospital. I have been the secretary for almost 12 years of our Radiology Association, which just merged with National Union of Healthcare Workers (NUHW). I am here standing in solidarity with my co-workers, the nurses, CNAs, EVS workers, dietary workers and others who contribute so much to Marin General.

I understand the struggle that these folks are going through trying to get the respect and compensation they deserve from the management at Marin General. As Radiology technicians we used to have our own independent association but we saw that it was going to be more and more of a fight to secure ourselves a good contract. In the past we have had long, tense negotiations with management and we have even had to do an informational picket one year to pressure the company. We decided to merge with NUHW so that we would be

stronger and better prepared to fight in the future for a good contract.

It troubles me to see my brothers and sisters, members of the Teamsters and CNA, having to fight so hard simply to get respect on the job. We are fortunate in our department that our managers generally treat us fairly, and Marin General owes the same to all its employees. We join our co-workers in calling on Marin General to do the right thing by all its workers, because we are the ones who work day in and day out to serve and protect our patients and whose hard work has made this hospital what it is today.

Janis Smith, Environmental Services Aide was unable to attend the hearing but submitted her testimony to the panel in writing.

My name is Janis Smith. I have worked in the Environmental Services Department at Marin General Hospital for about 7 years. My work includes getting discharge rooms ready for the next patient. Management expects us to clean 10 or more rooms in a shift of 7 hours (excluding our ½ hour lunch and 2-15 minute breaks). If all rooms were non-infectious disease rooms (non-CDIF) this may work. However, this is a hospital setting where we deal with highly infectious diseases (CDIF rooms) and also highly soiled rooms like birthing rooms. We thoroughly clean and disinfect the bathrooms, pull the soiled linens, pull the trash, mop and disinfect the floors, wipe down and disinfect all surfaces. We need to take the proper time to thoroughly clean and disinfect a room to get it ready for the next patient. I can complete my entire assignment but I can't do it thoroughly at 100% like it should be done. We need more support. Nurses get upset because trash and linen are overflowing. But we can't be everywhere at once. We work hard and are diligent but we can't keep up with everything especially when we get in on Monday after having a weekend off. The new manager Gerald thinks that if an area is closed on the weekend, like main admitting in the east lobby and bathrooms over there, and the unit offices, it does not need to be assigned to a worker on the weekend. But those areas are still used by staff and guests, especially the bathrooms. This leads to us always playing catch up. We are burnt out. Even the brand new per diems are getting burnt out. They are tired. They need more training but are put on assignments by themselves after just three days of training.

Gerald also changed how to prioritize cleaning rooms. If 2 of the high priority rooms are next door to each other in the same unit, if another high prior-

ity room has been on the board longer in a different department, even if it's on the complete other side of the hospital, we are instructed to go to clean that room and then return to the original unit. It results in a lot of unnecessary time spent traveling back and forth throughout the hospital. We should use our judgment if the rooms have all been on the board for approximately the same amount of time, but with the intimidation tactics Gerald uses many employees are fearful of doing anything against his directives and so will do it in straight chronological order for fear of being written up or yelled at and belittled.

Gerald started at MGH about a year ago. While he got a sense of each unit, he never walked each position with us. Instead he just came in and changed our process without ever really understanding the work or how long work assignments and tasks truly take. If he had taken the time to really understand the work flow, I think there would be less issues now, and the work assignments would be more reasonable and realistic. He has also made it more difficult to do our jobs by removing all the supplies from the housekeeping storage closets in each unit forcing us to go all the way back to the EVS department to restock our carts several times throughout the day. He has also told us at times that we cannot have clean linens when we are asked by a charge nurse to get more linens for a patient room. He's gone by 3 PM every day the majority of the time which means we don't have management support on the PM shift.

We all want to clean the hospital efficiently and thoroughly. However, it feels like Gerald is simply concerned about how things look on the surface, like the dot program. The dot program doesn't result in a cleaner room; it just tests a few specific areas in the room. At times EVS staff can't get to the spot behind the patient's head until discharge - as the patient is in the bed and doesn't want to be disturbed. But Gerald will go into the room while the EVS staff member is there while the patient and patient's visitors are in the room and test that area. It doesn't seem to be done to teach the staff, it seems to be done to embarrass and belittle the staff especially because he does it in the presence of coworkers and patients. He also doesn't talk to the staff, he barks and yells at us or simply ignores us. He tends to pick on employees that he thinks won't speak up. He avoids those of us that will speak out but that isn't right. He won't listen or engage in conversation about work flow or if you have an idea about

a process. He simply cuts you off. He's told a couple of employees when they came to him with concerns and he responded that he was a sniper in the military. There is a constructive way to help people do better to make sure the work is being done correctly. I welcome constructive criticism. I welcome learning new ways to make the hospital better for the community. But I don't want to be yelled at. I don't want to be belittled in front of patients and coworkers. I don't want to be told it's my way or the highway. I don't want to hear about a manager's sniper skills as a form of intimidation.

I was hired when the hospital was under Sutter. The manager, Aaron, ran a tight ship and was strict. He disciplined when necessary. But he was fair. He wanted what was best for the hospital, the community, and he treated the employees with respect. We felt heard. We could discuss our concerns with Aaron without fearing for our jobs or fearing intimidation tactics. He was very engaged with the staff and was hands on with the work. He knew us by name, greeted us in the hallways, and knew our work. He was present and respectful.

The hospital wants to be known as a "healing place." But for us, the workers, it doesn't feel like a healing place. Our staffing is at an all time low. Morale is low. I have never seen this many people out on medical leaves at the same time. I don't know if it's related to Gerald or not but it seems connected with the stress and anxiety he's creating in employees. Even though the department has hired per diems, they are not helping with the short staffing because they are all already scheduled 10 days per pay period so we still don't have any coverage for when we need to use PTO for medical appointments or to take a much needed day off. We're told that the staffing issues are our fault due to employees out on leave. We shouldn't be made to feel responsible for employees taking protected medical leave. Instead of addressing the issue we're just made to carry the burden. Even with all the employees back we still would not have enough benefitted staff.

With the help of our Union we approached the CAO of the hospital with our concerns about Gerald and our work environment. Unfortunately, the hospital never shared with us whether he was addressed or spoken to regarding these items. There was no follow up to 30 employees going to speak with the CAO regarding his behavior and how he treated and continues to treat staff. I love my work and being of service to patients but it was important that I share these issues with the community. Thank you.

*"[Gerald's] told a couple of employees, when they came to him with concerns about work flow and assignments, that he was a **sniper in the military...**"*

Brandon Taylor, a Senior Environmental Services Aide for 18 years, relates how the managerial culture has changed from being more 'personable and friendly' to one of threatening and bullying behavior.

Distinguished panel: My name is Brandon Taylor and I have worked for 18 years at Marin General Hospital in the EVS unit.

One year ago, MGH hired Gerald Lynch as a manager of the EVS department. In the year since he was hired, he has not done anything to foster good relationships between the workers and management. He has berated employees in front of patients and visitors.

One example, and this employee would have been here to speak but she is at the hospital working today, is when one of our veteran staff members returned to work in June of 2016 after taking time off to the grieve the death of her husband. Instead of introducing himself to her or welcoming her back to work, he came into a labor and delivery room that was patient-occupied that she was cleaning. He started asking, in front of the patient and the family, whether she had cleaned all of the different access points. He instructed her to reach over the patient and the newly born baby to access a point to clean behind the patient's head. The patient seemed uncomfortable with this; it would have been best to do it at a later time when she and the newborn baby were not in the bed.

He has threatened employees with termination and has threatened veteran staff as if they are an impediment to the hospital. Gerald has made several employees cry due to his bullying tactics, going so far as to tell one staff member that "he's a better housekeeper than you," in the presence of patients and visitors. He has made inappropriate comments to the staff, asking one woman "what's up with your hair, it looks a mess."

He has told staff members that he was a sniper in the military. His approach is always in front of people to try and show his power. If he thinks an employee won't speak up he will yell at them about their work performance in front of other staff and in front of patients and their families.

When Sutter was here, the directors and managers were more personable and friendly with us. I've always been able to talk with my managers and directors. Now, we feel like just a body. We do not feel valued and we feel our work isn't valued. Morale has sunk to an all-time low, thus leading to an inordinate amount of call-offs and medical leaves. Gerald's continuing lack of direction and ability to work with his staff has a negative effect on patient care.

Brandon Taylor

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UNDERSTAFFING LEADS TO REDUCED PATIENT CARE AND SAFETY CONCERNS

Edward Silva is a Certified Surgical Technologist who has worked at MGH for 10 years. He raises concerns about cost-cutting measures that affect patient care and safety, such as an inferior quality of supplies, and chronic understaffing, and he also points to excessive management turnover as a cause for turmoil that can affect patient care.

My name is Eddie Silva and I work as a Certified Surgical Technologist at Marin General Hospital. I have worked at MGH for about 10 years. My work consists of assisting nurses and physicians during surgery, with everything from setting up the instruments for each procedure to assisting with the surgery itself—basically everything aside from cutting tissue. This means we need to have detailed knowledge of each surgical procedure, anticipate the course of each procedure and also know about each physician's preferences for procedures.

I started here when Sutter was running the hospital. When Sutter was here the policies were consistent and clear. Expectations for patient care were understood. Since Sutter left we have had a revolving door of management. In the last 8 years we've had approximately 8 directors. Some are interim and stay only a few weeks. We had one stay 2 years, but that was the longest. Most stay between 6 months to 15 months. The mid-managers also have a high turnover rate. We've gone several months without direct managers over the surgical department. Each new Director comes in with ideas to change care standards, but without any real plan for implementation. We aren't opposed to bettering standards of care, but it has to follow the process. One Director came in and just issued policies without going through the MGH internal review board process. The changes were not rolled out formally and the techs were not formally educated on the changes.

The management also has a disciplinary style of approach instead of a collaborative, educational one that would help us provide better patient safety and care without being in fear of being disciplined as we learn new skills and new protocols. One example of this is the new gel in/gel out protocol. This applies to our classification even though it's not applicable to the OR. When I go into the operating room, I scrub pursuant to national hospital standards. If I am scrubbed I cannot gel in with a hand sanitizer as that would interfere

Edward Silva

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with the scrub process. The tracking system will still note this as a failure to gel on my part and I could be subject to discipline. The managers have not told us how this will be addressed and corrected. There is very little communication from our managers and Director regarding new policies and the culture is one where most of my coworkers are afraid to ask questions regarding these new protocols and procedures.

The inconsistent management leads to more than just new policies every 6-10 months. It also makes it difficult to hire scrub techs at MGH. It's difficult to even get registry scrub techs at MGH as the registry staff rates MGH very low and not a good place to work on the employee forums. Some of that is because the phy-

sicians don't want to use registry/temporary staff on surgeries but a lot of it is due to the inconsistent policies and the general feeling of unease for employees at MGH. The hospital has had a surgical technologist position available that they have been unable to fill for over 8 months, since August of 2016. There is another vacancy they just posted and 2 per diem positions they've had posted since January. This lack of staffing affects our ability to take much needed PTO. It also leads to burn out. If the hospital wants to have three cases going during the day, which it generally does, that means at least 1 tech has been held over on overtime. Of course the overtime rate is a good incentive, but we should be staffed in a way to allow employees to really rest and recover between shifts as we are on our feet all day and it's physically difficult work. We are

also exposed to bovie smoke during procedures. The hospital has provided us with education and training on how this bovie smoke may cause health issues for us and how physicians can reduce our exposure by using smoke evacuation devices. However, the hospital won't push or require the physicians to use these devices to reduce the health risks for the workers in the OR.

Another issue is the reduced quality of our supplies. When Sutter was here, our gloves, and masks were a better quality. Now they tear very easily exposing us to possible infection.

I really enjoy my job at MGH and I enjoy patient care. I want to help the hospital take the best care of our patients. I hope the hospital can listen to and address our concerns.

Lynn Warner

"We are frequently asked to decrease the number of staff when patient census decreases. Rather than staff up, to account for a fluctuation of patients, the hospital will send us home to save a few dollars.... It is recommended that telemetry patients (patient's wearing a cardiac monitor to observe heart rhythm) would be in a 4 patients :1 nurse ratio. This means one RN would have only 4 telemetry patients under their care. Due to bed availability, some patients wearing a telemetry monitors are on the medical or surgical units. According to Title 16 or 22, these patients should be a 4:1 ratio. Our professional practice committee has contacted administration about this repeatedly. This ratio is the Bay Area standard. Why doesn't MGH follow this? Is it too costly to hire experienced cardiac nurses or is it costly to train current nurses? It is unsafe."



Lynn Warner has been a Registered Nurse for 30 years, the last 13 at MGH. Lynn's testimony details the potential for serious problems to occur and the ongoing loss of good patient care due to staffing and other cost-cutting decisions made by management. Nurse-to-patient ratios are routinely not met, turnover rate is high, and there is a lack of nursing assistants to help with patient care.

My name is Lynn Warner. I have worked at MGH for 13 years but am approaching 30 years as a registered nurse. I am also a proud member of the California Nurses Association.

Marin General Hospital has always been known as Marin's community premier hospital for quality best care. RNs are patient advocates; all of the staff attempt to provide the best possible care to our patients under a challenging administration.

Nursing care is impacted by cost cutting measures. In the supply arena, the quality of the gloves is so cheap we repeatedly put our fingers through the ends. This can cause infections that could otherwise be prevented. We run out of critical supplies at the end of the week and are told by management that the item is on back order for a month.

We are frequently asked to decrease the number of staff when patient census decreases. Rather than staff up, to account for a fluctuation of patients, the hospital will send us home to save a few dollars. For example, if at 6pm the census decreases by 2 patients, an RN is sent home. Why not check the census in ER to see if there is possible admission for the critical care areas? Then, at 7 pm, we are asked to admit 2 patients to the critical care area. We cannot admit them because it will

cause us to be out of compliance with state mandated nurse-to-patient ratios. This is a critical safe patient care standard my union fought for. As a result patients are held in the emergency room for long periods of time because the hospital understaffs. This situation could have been avoided by letting the nurse stay for one more hour.

The hospital is a well-oiled machine. Every staff member plays a critical role in patient care. Certified nurse assistants (CNA) provide that extra set of hands for care and to complete tasks. The RN staff may be busy suctioning a patient or passing meds. The CNA can make time to wash a patient's hair and that patient will feel psychologically better. Management feels it is okay to send them home mid-shift. The time may be 1pm or 3am. We are having trouble recruiting and maintaining these invaluable hands because they are losing hours, and find work elsewhere.

In the critical care patient areas, we have lost over 40 nurses in two years. They wanted to stay but management has used intimidation tactics to push them out. The hospital uses its "CARES" program to police behavior and discipline nurses for anything from not smiling enough to speaking up about patient safety. Nurses should expect to have an open communication with their manager. An RN may wish to discuss an issue regarding patient care, safety or policy. The critical care manager has told RNs "if you do not like it, leave."

Most recently, management has attempted to outsource a set of our Nurses to a handful of at-will non-union positions. This has caused a major disruption in the way we take our breaks and receive assignments.

Nurses are governed under a set of rules to provide safe patient care. It is recommended that telemetry patients (patient's wearing a cardiac monitor to observe heart rhythm) should be in a 4 patients:1 nurse ratio. This means one RN would have only 4 telemetry patients under their care. Due to bed availability, some patients wearing telemetry monitors are on the medical or surgical units. According to Title 16 or 22, these patients should be under that 4:1 ratio. The nurses have fought this for over two years. Our professional practice committee has contacted administration about this repeatedly. We have placed calls to the state board and public health department. This ratio is the Bay Area standard. Why doesn't MGH follow this? Is it too costly to hire experienced cardiac nurses or is it costly to train current nurses? It is unsafe.

Our working conditions were at an all-time low between 2015–2016 during our contract negotiations. Management sought to take away critical patient safety provisions of our contract and began disciplining union leaders. We went on a historic one-day strike and in an

act of retaliation management opted to lock us out of our jobs for an additional four days. During this time our union filed multiple unfair labor practice charges through the National Labor Relations Board. One was based on an incident involving me. I was written up for walking through the hospital updating RNs on negotiations on my day off. Luckily the board found in our favor which resulted in a good settlement for the nurses with the hospital.

I love my job as a registered nurse and patient advocate. We ask ourselves...is it safe to work in an environment of fear and intimidation? and being bullied by administration? Is it unsafe to change rules on a weekly or monthly basis? We will continue to advocate for our patients and profession.

David Wallace, (photo next page) a Monitor Technician at MGH for 15 years, discusses how understaffing causes workers to be pulled in too many directions—and frequently workers are asked to perform tasks that take them away from their own work and leaving patients at risk.

My name is David Wallace and I work as a Monitor Technician at Marin General Hospital. I have worked at MGH for about 15 years. My work consists of monitoring EKG rhythms, blood pressure, and oxygen levels of cardiac patients. We watch the monitors for irregularities. It's really important to have a dedicated monitor tech to watch these monitors. We're the first set of eyes that sees any irregularities in blood pressure, oxygen saturation, and other patient vitals so we can immediately get the patient what they need.

We watch between 14–18 monitors per monitor technician. It used to be about 12 monitors per technician when Sutter was here. After Sutter left, the hospital decreased our staffing and also eliminated the monitor tech for the night shift in the step down unit. This means that this work falls on the nurses. The nurses are upset about having to do this in addition to their work. It's unsafe for patients because it takes the nurse away from patient care, increases the nurse's patient load, especially if there isn't a resource nurse staffed on the night shift. The nurses take remote monitors with them while performing care of other patients. The monitors are supposed to sound alarms when there's an irregularity. They don't work perfectly. Sometimes they go off and nothing needs to happen. You can get alarm fatigue so you may not be as responsive. When we sit and watch the monitor as opposed to having a nurse carrying the monitor with them we can spot a pattern that wouldn't sound an alarm but can be an early indicator that something is going wrong with the

David Wallace

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patient care or safety, we fear retaliation and discipline. They announce changes and tell us to take it or leave it—as in, find a new job elsewhere if we don’t like it.

The constant understaffing of certified nursing assistants since Sutter left has caused us to take on additional roles. Now we’re having to answer patient call lights because the nurses and nursing assistants are busy with other patients. That takes us away from our role of watching the monitors and impacts patient safety. If the hospital census is right on the cusp of needing another nurse or nursing assistant, when Sutter was here, the management, charge nurse, and staffing office would work together and say hey, let’s get that extra nurse or tech so we have support in case we get a few more patients. That doesn’t happen anymore. They determine call off based on the hospital census at that exact moment without anticipating how that will affect patient ratios if an extra patient were to be admitted to our unit.

The management feels more removed now. Management doesn’t know the staff; they don’t say hi to us. No one knows who is on the board of the hospital or who is running it. When Sutter was here, the CEO would come greet us, directors would come through, our management valued us and our opinions. Now we feel like a number to them and not part of a community.

Thank you for taking the time to listen to our concerns.

James Taylor, a Certified Nursing Assistant was unable to attend the hearing but submitted his testimony to the panel in writing.

My name is James Taylor and I work as a Certified Nursing Assistant at Marin General Hospital in the medical unit. I have been in patient care for the last 15 years, and have been at Marin General Hospital for 3 years. My work consists of helping to care for patients such as bathing, ambulating patients, oral care, helping to feed patients, turning patients in bed who are not able to turn themselves, answering call lights to respond to patients’ needs, and responding to bed alarms that indicate that a patient that is unable to get out of bed unassisted is making an attempt to get out of bed alone and is at a risk of falling.

I really enjoy working at the hospital and I enjoy patient care. I enjoy being a part of this community. However, I’ve seen first-hand how inadequate staffing impacts patient safety and care. I work the night shift, from 7 PM to 7 AM. Nine out of ten patient falls occur

patient. For example, blood pressure can be stable in 140s and start to slowly decrease or doing some wide fluctuations that won’t sound an alarm until the blood pressure hits 90 but we can alert the nurse and doctor of the issue earlier.

The culture of the hospital has changed since Sutter left. Before they would notify us and roll out policy and standards of care changes over a period of time now they just email policy changes and standards of care changes and expect us to just read our work emails on our own time and hold us to the new standards immediately.

We used to feel that management was collaborative with the staff and sought out our ideas and thoughts. Now, most employees don’t want to speak up about

during the night. A night CNA should have a maximum of 12 patients to care for; ideally 8–10 patients. Best practices call for hourly rounding on patients and we attempt to meet that, but with increased patient census we are sometimes caring for as many as 15 patients at one time. This makes it very difficult to complete our roundings, answer call lights in a timely fashion, and respond to patient needs. It also increases the burden on our nurse staff who must assist us with patient care work in addition to their own work of giving medications, changing dressings, and consulting with physicians. The patients' number one complaint that I have heard is delayed responsiveness to call lights and overflowing garbage.

We do our best but we cannot be everywhere at once. Many times we have to help with overflowing garbage, dirty linens, and cleaning of CDIF infectious rooms because our brothers and sisters in Environmental Services are similarly understaffed and overworked. When we have to help clean out an infectious CDIF room we have to gown up, remove the garbage and dirty linens from the room, and then take off the gown and place everything in the dirty utility room before we go disinfect to continue caring for our patients.

Marin General uses a staffing matrix that provides a third CNA only when the patient census reaches 32 patients, meaning that each CNA can have between 14 and 15 patients to care for at one time. If a patient requires what is called a sitter, a CNA whose sole responsibility is to sit with that 1 patient due to patient safety reasons, the hospital counts that CNA as part of the 2 required CNA staff. So there could be 28 patients, with 1 CNA for the specific patient in need of a sitter and 27 patients for the other CNA. The hospital also does not do any predictive staffing, meaning if the census is at or below 32 they will staff with 2 CNAs for the entire night without taking into account anticipated increases to the patient census. This is especially hard during the winter flu season as it is incredibly hard to get someone to come in to assist in the middle of the night. It



makes more sense to call someone in in the evening instead of trying to get staff at 2 AM since the CNAs are not on call.

While the hospital has attempted to fill in the needed staffing with registry employees, the hospital should hire more benefited part time and full time positions that would have more of a sense of loyalty to the hospital and should use more benefitted positions to fill the times that are of need to the hospital. The hospital has hired per diems but these employees do not have set schedules and do

not receive benefits. We have discussed needed more staffing of CNAs with our management, but it appears to fall on deaf ears as nothing changes with respect to the staffing levels.

We have had 2 Directors in the 3 years I have been here at the hospital; my coworkers tell me that since Sutter left it's been a revolving door of managers. The hospital sends us to training to provide better customer service, but doesn't invest in staffing which would better alleviate these patient safety issues and lead to better patient satisfaction. Management has told us that they want to promote a program based on relationship based care. We can only succeed at providing relationship based care if we have the staffing resources to care for patients.

"We have had 2 Directors in the 3 years I have been here at the Hospital; my coworkers tell me that since Sutter left it's been a revolving door of managers."

USE OF TECHNOLOGY TO REPLACE UNIONIZED WORKFORCE

Wendy De La Luz has been a Patient Admitting Representative for 10 years. She was not able to attend but a coworker read her testimony into the record. She relates the special importance of human contact when hospital patients are arriving at the hospital—and explains why kiosks cannot perform the same functions. Technology, she explains, will not solve the understaffing problem and seems aimed at replacing unionized staff.

My name is Wendy de la Luz and I have been a Patient Admitting Representative at Marin General Hospital for 10 years, working in the main admitting area, registering patients for surgeries and other inpatient and outpatient procedures.

I am a bilingual patient admitting representative; the patients I see are predominately senior citizens who utilize Medicare, as well as Hispanic patients that do not speak and/or read English. When we register patients, we enter and verify demographic information, including name, address, and emergency contact information, register and verify the patient for the services they are obtaining at the hospital, and verify and explain insurance information, including explaining what services and costs are covered by insurance. We collect copays and are also able to show the patient a sample bill to show them what they can expect to see after their surgery so there are no surprises.

The most common negative feedback I've received from patients is when they get unexpected bills or if they didn't understand whether a certain service was covered under insurance or not. Most of the patients I see are happy to have a person to ask questions of regarding the services they are obtaining and about the costs and what insurance will cover. We are the first face and contact that the patient sees and we provide a comforting and reassuring hand during a stressful time for the patients. Even though we are so short staffed that we cannot take PTO days, our admitting staff throughout all inpatient and outpatient facilities continues to get recognized for excellent service.

Here is a sampling of the comments patients routinely leave about the admitting staff:

"She goes beyond by helping and making me feel comfortable. She calls the doctor's office when an order

was not faxed to the Lab."

"When I came into the ER with a head injury, you were so kind to me. Your speedy assistance got me into triage quickly. You were reassuring and thoughtful. I knew I was in good hands. You showed genuine interest in my time of need."

"When a lab order was not at the outpatient lab [the admitting representative] followed up by calling the doctor's office to have it immediately faxed over. She had a lovely attitude and was very gracious."

"[She is] always such a pleasure...good care and goes beyond to help."

In spite of our hard work, the hospital has notified us that they want to take our work away by implementing patient self-registration kiosks and employ non-union kiosk coordinators to replace our Admitting Clerks in Main Admitting (East and West Lobby), the Lab, and Radiology. The hospital has told us they expect that these kiosks will reduce the number of benefitted staff in our department by over 7 benefitted positions. We are already short staffed as it is. The hospital stated to us that it wants to implement the kiosks and kiosk coordinators to save time and allow patients to register more quickly.

However, the hospital has also told us that legally, the patient will still need to obtain a wrist band from a Marin General Hospital representative prior to obtaining services at the hospital. This means that the reduction in union benefitted staff members will actually increase wait times for patients, as those patients will still need to see a patient admitting representative to obtain the wrist band.

When we provide a wrist band, we need to go through the many screens in our system Paragon to verify information. The wrist band tells other departments that the patient has been checked by one of our staff to ensure that demographic information is correct and that they are there for the correct procedure. The majority of the patients are already pre-registered when they arrive, whether through our staff that does the pre-registration process over the phone a few days before the procedure or through online pre-registration process. Adding an electronic kiosk to verify this information upon arrival only to again have to verify the same information with a patient admitting representative does not make sense. If the hospital is stating that a Kiosk Coordinator can do the wrist banding then it is clear that the hospital is merely trying to reduce the

number of union employees.

The real issue with wait times for patients is the lack of adequate patient admitting representative staff to wrist band patients, as well as the ineffective system that our hospital uses. We use Paragon, a system that requires us to click through 6–7 screens to register and verify information for the patients. This system is slow and tends to freeze on click through.

The system used at SF General, EPIC, has fewer windows and fewer screens to click through. There are also HIPPA concerns with using this system, such as what happens with similar names or if a patient leaves their information up without effectively closing the screen. The system Marin General has selected, Patient-Works, is not in use in any other major Bay Area facility and is only in use in two California facilities. Califor-

nia has heightened medical privacy requirements that we are trained on.

We are not opposed to technology and/or making the wait times shorter for our patients. But we need more staff for that, not less. We have raised the idea of having floater patient admitting representatives with tablets to go out into the waiting area to get the patient wrist banded while they sit in the waiting area instead of having to wait in line. The real priority for the hospital seems to be decreasing our staff which is going to impact patient care.

I love my job and helping members of our community. It's important to me that we continue to be able to assist patients during a stressful time and I believe that's best met by increased staffing of patient admitting representatives.

FAILURE TO TAKE APPROPRIATE ACTION REGARDING A SEXUAL HARASSMENT EVENT

Luz Ramirez, an Environmental Services Aide, describes a disturbing incident of sexual harassment, and an even more disturbing tale of management's failure to properly address the situation and take the appropriate action to protect workers.

My name is Luz Ramirez. I started working at Marin General on August 9, 2009. I work in housekeeping. When I come to work, I move my supplies cart to the department I'm working in. Lately I've been in the emergency room, but I have experience working throughout the entire hospital. I do everything in general, from cleaning patients' rooms, the waiting rooms, and other rooms. We make sure everything is clean and sterilized for patients.

When I started, the hospital was run by Sutter. It was a lot better, because management was good to everyone. The director was an excellent person. Aaron, the past housekeeping director, treated everyone equally and with respect. He was always attentive to what the employees needed to do our job. Now, when the director calls us, it's to make us feel less than

[human]. About a month and a half ago, Gerald, the new director, called me in to his office only to tell me that he is the most valuable employee the hospital has. I was surprised that he called me in just to say that. I told him, although you feel you are the best, I've been

here 8 years, I've been employee of the month, and you can see the email references from nurses and doctors about the work I do. They fight to have me work in their department. That is what it means to be a good worker. He had no reason to call me in to tell me that. A director should not behave that way.

"As I was leaving I started crying. I did not feel support from my director. When I got back, I was told that the lead security guard wanted to talk to me. I told him what was happening. I was shaking. I've worked here for 8 years. Before, I used to feel that in my hospital, my home, I was protected, but what happened that day did not make me feel that way."

The director has consolidated many permanent positions that had defined responsibilities; now there are fewer full time positions. Now I have to bring down all of the supplies I will be using for the day, everything from liquids to large paper towel rolls, and anything we use to clean. This has caused injuries because for a woman, this is very heavy.

Additionally, we have to bring down the linen carts and they are very heavy. With Sutter, there were two men who came in the mornings to do this work, but

not anymore; all of these positions that helped us are being cut.

When Sutter was here there was harmony in the hospital. Now we do not have the same unity, the same community between departments.

Before, all of the equipment that we needed for patients was available. Now, that isn't so. I had a situation where Jonathon, the charge nurse, gave me a paper specifying the linen he needed for the ER, because it had run out. I ran up to get the linen and I came across Gerald. He did not let me retrieve the linen. He told me that the excess use of linen was costing him \$4000 a week and that I would not be using it up. He told me all of this very angrily; yelling in front of patients and other co-workers. I told him to speak with the nurse because I did not want any problems in my department. Gerald said he would not do that and that I did not understand him. He made me seem ignorant in front of the people who were there, including patients.

On April 5th, I started work around 7:30 a.m. and I was called to clean room 9. I saw a man watching me from room 11. He was there with a patient. He was looking at me very strangely. The patient's clothes were on the floor so I gave them a bag for the clothes. From that moment on, I noticed that the man started following behind me in the hallway, and he was touching himself. I ignored him, but he kept trying to get my attention. When he continued following me and touching himself, I felt intimidated. I spoke with Caro, a Chaplin for the hospital, and she told me to be careful. She told me to talk to the charge nurse.

In that moment, a patient in room 9 came in with a security guard, and Caro told the guard to keep a watch out for me. I went to the office to report what was happening and Gerald was there with Jose Diaz, a manager. I was very nervous and anxious, and so I started speaking to Jose in Spanish. Gerald interrupted me to tell me to speak in English, even though Jose could understand me.

I explained again what was happening in English. Gerald told me, if the nurses in the ER have big chests and can ignore these situations, why couldn't I? I told him his response made me feel bad and scared. I was nervous, but he laughed at me and mocked me. He told me to return to my floor. He did not care what I was



feeling.

As I was leaving I started crying. I did not feel support from my director. When I got back, I was told that the lead security guard wanted to talk to me. I told him what was happening. I was shaking. I've worked here for 8 years. Before, I used to feel that in my hospital, my home, I was protected, but what happened that day did not make me feel that way.

He told me he would write a letter to human resources and told me to go home if I didn't feel well. Regardless, I stayed and did my work, but I was nervous and nauseous. The security guard had to follow me in the areas I cleaned for the rest of the day. All of this caused me a lot of anxiety. With a director like Gerald, what protection do employees have if something happens to us?

I wrote a statement to human resources, explaining what happened; they already knew from the security report. Human resources told me that they would speak to Gerald, and that they would let me know what happened with the situation. But since then, they haven't been in communication with me.

Since the date of the hearing, Ms. Ramirez received a letter from the hospital informing her that a "full investigation was conducted and concluded" and that the hospital has applied "appropriate discipline to parties involved where appropriate." The letter further instructed Ms. Ramirez to report further instances to her same supervisor and Director; and that she must at all times behave in a manner characterized by respect and professionalism and adhere to the CARES (Communication, Accountability, Respect, Excellence, Safety) standards.

MANAGEMENT'S UNWILLINGNESS TO RESOLVE THE ISSUES

Labor representatives gave testimony reflecting the negative effects of the ongoing intimidation of employees and management's failure to address the issues and to meet the terms of the contract.



Matthew Mullany

"... I've been the business agent for Teamsters 856 members at Marin General Hospital for over 10 years. In my time as a business rep for Teamsters

856, I've represented primarily hospital and health care workers...I've never seen a health care environment like the one that currently exists at Marin General right now. I've never seen workers with such low morale and management that acts with such disregard for our contract and with such disregard for the employees. Linda Lang, the VP of HR, is not interested in settling disputes. She creates conflict and engages in delay tactics. After 15 months of negotiations, the longest in our history at MGH, we reached a tentative agreement and then ratified our 2013-2017 collective bargaining agreement in June of 2014. When we got the edited contract for signing, we realized that the hospital had rewritten and edited several sections of the contract that were not changed during negotiations. We thought it might be a mistake but when we raised the issue, the HR staff told us that Linda Lang wanted those changes. Linda Lang never sat in one day of our bargaining sessions. So for her to rewrite entire sections of the contract, after we had ratified the tentative agreement with our members, was shocking. We eventually had to get the assistance of a federal mediator to get the contract back to the agreed upon language changes roughly 10 months after ratification."

Matthew Mullany, Teamsters 856 Business Representative says that despite dangerously low morale, management seems uninterested in resolving the issues.

My name is Matthew Mullany and I've been the business agent for Teamsters 856 members at Marin General Hospital for over 10 years. Teamsters 856 has represented the clerical and ancillary support staff at Marin General Hospital for over 30 years. In my time as a business rep for Teamsters 856, I've represented primarily hospital and health care workers, including clinical and nonclinical workers at Marin General Hospital, Eden Medical Center, Washington Hospital and St. Rose Hospital.

I've never seen a health care environment like the one that currently exists at Marin General right now. I've never seen workers with such low morale and management that acts with such disregard for our contract and with such disregard for the employees. When Sutter left in 2010, we thought it would get better being a community focused and run hospital but it has gotten worse. When Sutter was there, we had disagreements but issues were resolved. Linda Lang, the VP of Human Resources, is not interested in settling disputes. She creates conflict and engages in delay tactics. After 15 months of negotiations, the longest in our history at MGH, we reached a tentative agreement and then ratified our 2013-2017 collective bargaining agreement in June of 2014. When we got the edited contract for signing, we realized that the hospital had rewritten and edited several sections of the contract that were not changed during negotiations. We thought it might be a mistake but when we raised the issue, the HR staff told us that Linda Lang wanted those changes. Linda Lang never sat in one day of our bargaining sessions. So for her to rewrite entire sections of the contract, after we had ratified the tentative agreement with our members, was shocking. We eventually had to get the assistance of a federal mediator to get the contract back to the agreed upon language changes, roughly 10 months after ratification.

Since Linda Lang took over HR at MGH, there's been about 8-10 different HR staff that we've been told to work with on grievances and employee issues. Six of those people are now gone; it's a revolving door of HR

staff, which makes it difficult to build relationships.. Linda also does not give the HR staff authority to resolve and settle grievances. The HR staff always has to check with her. It's a good employer strategy because the person that says no is insulated behind a closed door. It doesn't allow for the parties to actually resolve issues prior to having to go to costly board hearings and arbitrations, which is the whole point of the grievance procedure. As we approach our upcoming contract negotiations, we need the person making the decisions to be at the bargaining table.

MGH takes unreasonable positions and backs managers that make bad decisions. We never had to take a grievance to arbitration when Sutter was here, now we've had 4 arbitrations since 2012. We've won each arbitration and had grievances that have resulted in hundreds of thousands of dollars awarded in back pay to employees. We just returned a terminated employee to work after being out for nearly a year, under the exact same terms and conditions as we originally proposed the week after the termination. We had a grievance whereby our Sterile Processing employees got over 1200 hours of extra hour and overtime pay due to the management failing to schedule pursuant to the collective bargaining agreement and continued to do so because HR didn't correct them once we filed the grievance.

When there were bio-burden issues in the sterile processing department, I went and did a walk-through of the department with Lee Domanico and we reached agreement on several procedures and processes to follow. Instead of holding its management accountable to these procedures and staffing the department at adequate levels, the hospital retaliated and terminated two of our members and suspended another 8 for alleged minor documenting errors that occurred prior to the roll out of the new documenting procedures. We got the terminated members back to work and reduced the suspensions with the help of our chief shop steward who was able to provide evidence that all the documentation policies from Sutter had been thrown out by the new Director and had never been replaced with anything. So then the hospital, instead of holding the Director accountable, went after the chief shop steward, suspending him for 5 days-- a 17-year employee that had never had a verbal warning in his file. We still have his grievance pending resolution. The hospital finally agreed to arbitrate this case in December.

Then the hospital tried to outsource our work in the sterile processing department. We were under our 2010-2013 contract at the time and the contract had not yet been opened for negotiations. The hospital violated the outsourcing language and we were able to

prevent the outsourcing with assistance from our labor community. The hospital again tried to outsource the department immediately after an SPD worker reported to HR and went to the District Board about concerns over the sterilizers in the sterile processing department being out of compliance with national standards. We again prevented the outsourcing but this has stayed with the employees. They are fearful of reporting unsafe conditions for fear of retaliation and discipline.

These are but a few examples of the difficulties we've had with Marin General. We see day in and day out how the culture of intimidation and discipline affects patient care, employee health and satisfaction, and the ability to recruit and retain experienced staff. We are hopeful that the hospital can work with us in good faith to resolve these issues.

Tim Jenkins, (photo next page) Teamsters 856 Researcher and Business Representative, provides facts and information that demonstrate how MGH's workplace culture can lead to medical errors and adverse outcomes that could be easily prevented.

My name is Tim Jenkins and I am a labor representative and strategic researcher for Teamsters Local 856. Previously I worked for the California Nurses Association and the San Francisco Department of Public Health where I conducted management training on creating a culture of safety.

Marin General Hospital is a non-profit whose stated mission is "to provide exceptional health care services in a compassionate and healing environment." Marin General Hospital is a 235-bed district hospital and Marin County's only trauma center.

Since Sutter left, the hospital has been doing well financially. The CEO of MGH, Lee Domanico, provides the Healthcare District Board with a financial report at the monthly Board meetings; at the February 2017 meeting he reported that the hospital finished 2016 financially strong and exceeded budget expectations. He went on the state that 2017 was beginning strongly as well with high patient census counts, particularly for inpatient Medical Unit and Emergency. The latest available 990 for Marin General (2015) shows total program service revenue of \$376 million dollars and a net of \$22 million in revenue after expenses, including salaries, benefits, and equipment. MGH paid the board members over \$6.5 million in 2015.

That is the good news. The bad news is that while finances are up, indicators of quality patient care have gone down.

The California Department of Public Health is a



Tim Jenkins

The California Department of Public Health is a state agency that licenses and inspects California hospitals. They collect data on

various indicators of patient care at hospitals, and the trend at MGH is troubling. Since Lee Dominico became CEO at MGH, there has been an increase in survey deficiencies and administrative penalties. Survey deficiencies are violations of one or more specific licensure or certification requirements. Under Sutter, between 2004–2010, there were a combined 149 survey deficiencies reported for Marin General Hospital. Looking at the six years since Marin General Hospital Corporation took over, from 2011-2016, there have been over two times that amount, 306 survey deficiencies.”

state agency that licenses and inspects California hospitals. They collect data on various indicators of patient care at hospitals, and the trend at MGH is troubling. Since Lee Dominico became CEO at MGH, there has been an increase in survey deficiencies and administrative penalties.

Survey deficiencies are violations of one or more specific licensure or certification requirements. Under Sutter, between 2004 – 2010, there were a combined 149 survey deficiencies reported for Marin General Hospital. Looking at the six years since Marin General Hospital took over, from 2011-2016, there have been over two times that amount, 306 survey deficiencies. In the last 2 full years alone (2015 and 2016) there were 85 survey deficiencies.

Under Sutter, from 2004-2010, there were 8 state administrative penalties assessed against MGH. From

2011-2016, that has increased to 12 state administrative penalties. In 2014, more than three years after taking over from Sutter, the hospital was cited and issued a \$100,000 penalty for failing to develop, maintain, and implement written policies for the surgical department. As you just heard from the tech, Eddie Silva, it seems not much has changed.

So, why is this happening?

To answer this question, I have been studying the workplace culture at Marin General Hospital through employee interviews and a written survey. My conclusion is there is a lack of leadership in supporting a culture of safety. Specifically, this can be seen in three ways:

1. Hospital management’s failing to take action to stop intimidating and disruptive behaviors.
2. Short staffing leading to possible practice drift.
3. A punitive environment where people feel their mistakes are held against them.

First, you have heard today about a failure in leadership to stop intimidating and disruptive behavior. The Joint Commission, which is the hospital’s accrediting body, has solid research demonstrating how damaging this can be to patient care. As they wrote in their publication, Sentinel Event Alert, on July 9 2008:

“Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.”

The second reason is short staffing. Sixty-five percent of our surveyed members say they do not have enough staff to safely do their work.

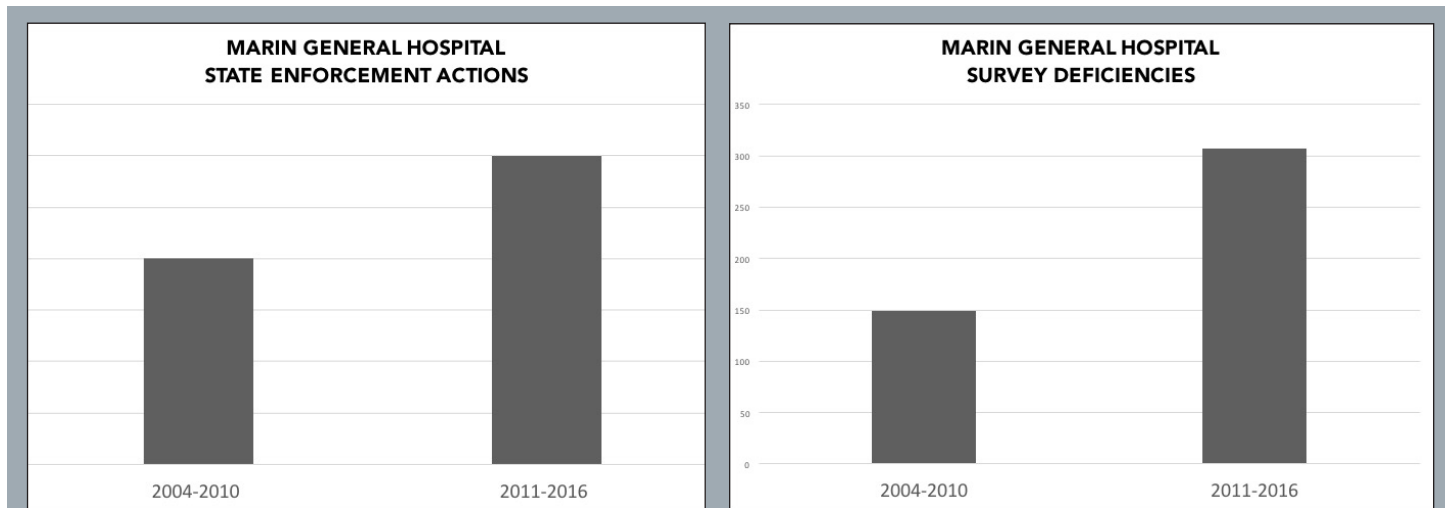
Short staffing is not only stressful to employees but can lead to taking shortcuts, leading to dangerous “practice drift.” Practice drift is a term used in safety sensitive environments where employees must find shortcuts or rule bending to get the work done each day. The North Carolina Board of Nurses Published an article in the Fall of 2016 describing this: “It is not uncommon for any one of us, when faced with having to do more with less or when pushed for time, to find ways to use work-arounds and take shortcuts. They often seem like the only solution to fixing what is wrong. They become part of the culture and the need

to identify and address the root cause of the issue is hidden. We fail to see that we have institutionalized a temporary, inadequate fix. In many cases, it is not until an adverse event requires deeper examination that the underlying conditions that led to unsafe “practice drift” are identified.”

The third area of concern is a punitive culture: 51.4 % of our surveyed members say their mistakes are held against them. When staff feel like they will be punished for their mistakes, they are less likely to report them. The problem is that many times mistakes are signs of systemic problems (such as short staffing or improper training, etc.) and without mistakes being

reported, there is no chance to fix the root cause of the problem.

In closing, let me quote from the March 1, 2017 publication from the Joint Commission, titled “*The Essential Role of Leadership in Developing a Safety Culture*”: “Competent and thoughtful leaders contribute to improvements in safety and organizational culture. In essence, a leader who is committed to prioritizing and making patient safety visible through every day actions is a critical part of creating a true culture of safety.” Leaders must commit to creating and maintaining a culture of safety; this commitment is just as critical as the time and resources devoted to revenue and financial stability, system integration, and productivity.



Marin General Hospital’s lease with Sutter terminated June 30, 2010.

Our own survey results reinforce the state’s findings and demonstrate generalized trends present at MGH:

- Employees at MGH believe their units/departments are inadequately staffed, and
- The culture of intimidation has led to employees being fearful about speaking up about safety concerns

Employees who completed the survey were asked questions about staffing and reporting safety concerns.

Overall, the responses showed a common trend of understaffing and concerns about retaliation across various departments and classifications.

When asked whether employees “have enough staff to safely do the work”:

- 65% of the employees disagreed or strongly disagreed that they have enough staff in their unit or department to safely do their work.
- 7% of the employees were neutral, and
- 28% agreed or strongly agreed that they have

enough staff in their unit or department to safely do their work.

When asked whether employees should have a say in determining safe staffing levels for their departments:

- 90.41% agreed or strongly agreed they should,
- 5.48% were neutral, and
- 4.11% disagreed or strongly disagreed that they should.

When asked whether employees felt that mistakes were held against the reporting employee:

- 51.39% agreed or strongly agreed that mistakes were held against them,
- 26.39% were neutral, and
- 22.22% disagreed or strongly disagreed that mistakes were held against them

Communication with Mr. Lee Domanico, CEO of Marin General Hospital

The CEO of Marin General Hospital, Lee Domanico, communicated with the Workers' Rights Board on a couple of occasions. Mr. Domanico was formally invited to attend the Workers' Rights Board Hearing. In response, Mr. Domanico sent a letter, through an email from Thomas Asiano, to the Workers' Rights Board Chairperson, Matt Myres. The following is the content of the letter.

"I received your email dated April 27 regarding your scheduled hearing on Saturday, May 6 about working conditions at Marin General Hospital. As you probably know, we employ clinical, technical, and administrative employees who are represented by four different unions; each of which we are currently under contract with. We have a well-staffed Employee and Labor Relations Department which meets regularly with union representatives and employees. I will not be able to attend your meeting on Saturday. However, anytime there are concerns about employee or patient health or safety, I want to be informed of specific issues so we can appropriately address them. At present, I am not aware of any issues that are not currently either under discussion with our unions or in the formal grievance process outlined in our collective bargaining agreements. In all cases, those issues will be addressed in the proscribed manner. Please send me any questions that arise at the meeting. I or one of our staff will be glad to answer any specifics so that your report will include responses to concerns raised."

Following the hearing, Matt Myres sent an email to Mr. Domanico through Thomas Asiano as well as an email to the MGH Board of Directors' Executive Assistant, Louis Weiner (since Mr. Domanico had not responded directly from his own email address). The email from Matt Myres shared the Workers' Rights Board Preliminary Findings that were developed from the testimony given at the hearing. Mr. Domanico was provided with 1 week to respond. Matt Myres never received any written or verbal communication from Mr. Domanico.

However, Mr. Domanico did have a couple of telephone conversations with Supervisor Damon Connolly who served on the Workers' Rights Board panel for the hearing. The following information was a verbal response from Mr. Domanico communicated to Supervisor Connolly:

From 2011 to 2017, overall staffing at the hospital has increased from 1,583 to 1,759. Environmental

Services has increased from 48 to 65. Nurse Assistants have increased from 63 to 74. Teamsters 1 staff has increased from 316 to 363. Teamsters 2 has increased from 104 to 110.

Lee also stated that non-professional workers at the hospital average \$52,000/yr plus benefits (at no cost) and that Nurse Assistants are "not in the count" on staffing ratios.

Other than this verbal communication to one of the Workers' Rights Board Panelists, no written response was ever provided to the WRB from CEO Domanico or from any MGH staff.

In response to the staffing information communicated from Mr. Domanico to Susanna Farber who is the Teamsters' staff attorney, the following information was provided:

Mr. Domanico asserts that the overall staffing of the hospital has increased from 2011 to present by 176 employees. The majority of these increases are in non-patient care areas, such as administration and management. Further, the hospital has seen an increase in program revenues from 2011 to 2015 of approximately 25%, from \$299 million to \$376 million. The small increase in staffing is not keeping pace with the growth of the hospital nor is it seen in direct patient care areas.

Teamsters 2 is the Clerical unit which includes monitor technicians, unit clerks, and patient admitting representatives. Our records indicate 100 active benefited and per diem members and 5 members on leave for a total of 105, which has decreased since 2014 (107 total). Between 2011 and 2012, there was an increase of about 30 members due to organizing an existing 30 hospital employees into the Teamsters 2 unit in 2012.

Teamsters 1 is the technical unit which includes Environmental Service Aides, Sterile Processing Technicians, Certified Nursing Assistants, Emergency Department Technicians, and Surgical Technologists.

Contrary to Mr. Domanico's assertion, there has not been an increase in the staffing of Environmental Service (EVS) Workers. Mr. Domanico provided total employee numbers which can be misleading as it includes employees on a leave of absence as well as per diem employees who are not guaranteed work hours. Mr. Domanico stated there were currently 65 EVS employees. Our records show 62 total EVS employees. Of these 62 employees in EVS, 7 employees are on a leave of absence and 3 employees were terminated, bringing

the actual total to 53. Further, because per diem employees are not guaranteed work hours, it helps to look at the total number of employees that were actually scheduled to work. In EVS, the total number of workers scheduled to work in April of 2017 was 49 employees (35 benefitted employees and 14 per diem employees).

This is the same number of employees who were on the schedule in December of 2011, except there has been a decrease in benefitted employees and an increase of per diem employees (37 benefitted employees and 12 per diem employees (with 1 employee on a leave of absence). It's also comparable to October of 2015 where there were 50 employees scheduled to work (39 benefitted employees and 11 per diem employees), with 52 total employees (with 2 employees on a leave of absence).

Certified nursing assistants have seen a slight increase in per diem employees but not in benefitted staff with set hours. Because per diem employees are not guaranteed work hours at the hospital, the increase in

per diem staff has not assisted with the staffing shortage the workers face, especially during the night shift. Currently, the hospital calls in a third certified nursing assistant when the patient census hits 32 patients, pursuant to the hospital's internal staffing matrix (developed in accordance with Title 22).

The workers testified that the hospital does not use predictive staffing to account for likely increases in patient census. This leaves the certified nursing assistants short staffed.

The hospital also includes a certified nursing assistant assigned to the task of being a sitter (when a patient needs one on one care) in that internal staffing matrix. For example, if there were 30 patients and 2 nursing assistants, and 1 patient needed a sitter for one on one care, the hospital still would not add another nursing assistant. This leads to the nurses not having enough assistance for the call buttons and they get pulled away from their duties and also leads to the monitor technicians getting pulled away from their job duties to answer call lights and help patients.



Workers' Rights Board Findings and Recommendations

Finding #1:

There is systematic understaffing at Marin General Hospital (MGH) as a result of cost-saving practices and employee turnover due to worker dissatisfaction. Teamsters 856, the largest bargaining unit in the hospital, conducted a membership survey in 2017 in which 65 percent of employees surveyed indicated that there is not enough staff at MGH for workers to safely do their work. Understaffing has created a stressful work environment and eroded the quality of patient care.

- a) MGH Workers' testimony indicated that there has been a reduction in the staffing for Certified Nursing Assistants (CNAs). California Department of Public Health (CDPH) Regulations Title 22 requires that MGH provide staffing based upon patient acuity. MGH may not be in compliance with Title 22 Regulations whenever CNA staffing does not adjust to patient acuity on a particular hospital unit. When there is a lack of appropriate staffing, there is greater risk of patient falls, bedsores and other incidences of patient neglect. Since 2010, an increase in patient incidences at MGH has been reported to the California Department of Public Health (See the testimony of Tim Jenkins regarding data from CDPH).
- b) In addition, the number of Monitor Technicians (MTs) has been reduced during the night shift, which requires that Registered Nurses (RNs) must pick up some of their work — and RNs are subsequently challenged to complete their own work and less able to respond to emergencies. In addition, due to the reduction of CNAs, MTs sometimes have to leave their posts to help out with patients, putting patient safety at risk.
- c) At times, the hospital has failed to meet the required state mandated ratio of one Registered Nurse (RN) to every four telemetry patients, thereby placing patient safety at risk.
- d) Full-time Environmental Service (EVS) positions have been reduced through the consolidation of positions, and this reduction of staffing has affected the ability of EVS staff to do their jobs efficiently.
- e) Cost-saving practices have reduced the availability of proper and quality equipment, which

threatens worker and patient safety. For example, nurses report that MGH has purchased a lower quality glove that tears easily. Surgical Technicians report that there is a need for a bovie smoke vacuum to filter smoke in the surgical room resulting from catheterizing patients during surgery.

- f) The hospital has lost 40 RNs in critical care patient areas in the last 2 years due to turnover and the dissatisfaction of RNs with management practices. (See testimony of Lynn Warner.)
- g) Finally, according to MGH CEO Lee Domanico, there has been overall increase in staffing at the hospital since 2010. This overall increase, however, is due mainly to: 1) increases in administrative positions; 2) increases in Teamsters-affiliated positions as a result of workers joining Teamsters 856 already employed by the hospital; and; 3) increases in per diem workers replacing workers who have been out on stress leave. But there has been no significant increase in staffing in critical areas of patient care. (See the response of Teamsters Attorney, Susanna Farber, to CEO Lee Domanico's statement about staffing increases.)
- h) This pattern of understaffing in critical areas of patient care and other cost-saving practices threatens the quality of patient care at Marin General Hospital.

Recommendation #1:

The WRB recommends that Marin General Hospital increase staffing where needed to ensure that it is in compliance at all times with CDPH Title 22 Regulations. Marin General should change its practice of short staffing where it negatively impacts the ability of professionals to meet the needs of their patients and compromises patient care and patient safety. In addition, employees should have access to proper, quality equipment to ensure staff and patient safety.

Finding #2:

MGH plans to replace some of the Patient Admitting Representatives with kiosks outfitted with computers for patients to use when checking into the hospital. Patients who are admitted to the hospital often have anxiety about a surgery or other procedures they are scheduled to undergo, and they often have many ques-

tions that cannot be addressed by kiosks and the new technology.

Recommendation #2:

We recommend that the hospital set aside the plan to replace Patient Admitting Representatives with kiosks. Clearly, this plan to reduce staff in order to save money would also curtail critical human interaction with patients and reduce the quality of patient care that begins when patients are admitted to the hospital.

Finding #3:

At MGH there is a top-down approach to management that excludes workers from the decision-making process, compared to a collaborative model that invites worker suggestions and input. For example, nurses should expect to have open communication with their manager. RNs have tried to discuss with management issues such as patient care and safety policy. However, the critical care manager reportedly told RNs that if they don't like the way the hospital is run then they should resign. (see Lynn Warner's testimony). The Human Resources (HR) Director showed her disregard for employee involvement when she rewrote several sections of a newly negotiated contract just after ratification by employees (see the testimony of Matthew Mullany). The negotiation team represented by the Teamsters had to seek the assistance of a federal mediator to get the contract back to the original agreed-upon language, which took 10 months.

In addition, when workers have attempted to communicate their concerns to their supervisors, HR, and the CEO of the hospital, management has failed to address the issues raised. Although the CEO has indicated to the Workers' Rights Board that there are regular meetings between management, union representatives and employees, there is a gap between the perceptions of workers and the perceptions of management about what has been communicated and resolved.

This top-down management model has created a stressful work environment and undermined employee morale. Many employees do not believe they are respected and valued.

Recommendation #3:

WRB recommends that management implement a more collaborative model of staff supervision that encourages employee participation in key decisions, particularly regarding patient care. Management should schedule regular meetings between supervisors and workers in each department to foster a collaborative approach that recognizes employee expertise and encourages everyone to work together to meet patient needs

more efficiently and effectively.

Workers can play a critical role in helping management understand the experience on the hospital floor and evaluate which practices could be improved to serve patients better and improve the quality of care. In this way, management could demonstrate that they are truly committed to improving the working conditions at Marin General Hospital.

Finding #4:

There is at least one department, the Radiology Department, where a more collaborative management model is utilized and in this department workers express greater job satisfaction. Employee-management relationships in this department demonstrate that it is possible to implement a collaborative approach that can achieve positive outcomes for patient care.

Recommendation #4:

Review the management practices in the Radiology department where a more collaborative model is utilized, and implement those practices in other departments. We also recommend that management consider relevant research such as that reviewed in the article by Allan S. Frankel, "Fair and Just Culture, Team Behavior, and Leadership Engagement: The Tools to Achieve High Reliability," <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955339/> published in the August 2006 Health Services Research which concludes, "It is increasingly clear that future improvements in health care will depend progressively more on our ability to promote excellent teamwork and effective communication across the spectrum of clinical care."

Finding #5:

A culture of intimidation and retaliation by hospital management prevails at MGH. The survey by Teamsters 856 indicates that 51.4 percent of their members believe they will be punished if they make a mistake and hence they are less likely to report errors. It was reported that the hospital uses its CARES program (Communication, Respect, Accountability, Excellence, and Safety) to police staff behavior and discipline nurses for anything from not smiling enough or for advocating for patient safety. The CARES Program provides standards for behavior for staff interaction with patients, but in practice the standards do not seem to apply to interactions between supervisors and workers. Such a management style inhibits workers' ability to take ownership for their work, and impairs communication by workers with their supervisors for fear of retaliation. Some supervisors are particularly at fault in this regard. For example, workers report that one supervisor, Mr. Gerald Lynch, intimidates work-



The worker reported the supervisor's comment to HR. It is unknown whether any action was taken by the HR Department with regard to Mr. Lynch's behavior.

Recommendation #6:

Hospital management should take appropriate action with regard to Mr. Lynch, who apparently did not follow appropriate procedures when an employee reported that she experienced sexual harassment. Sexual harassment prevention training should be provided to all

ers and does not understand their jobs. He dictates what should be done without listening to employee suggestions. Workers report that this supervisor tells employees that he is the most valuable person working in the hospital, informs workers that he was a former sniper in the military, and demeans workers in front of patients and other staff. This aggressive and egotistic behavior would certainly seem to be unacceptable in a hospital setting and might even lead to patient harm.

Recommendation #5:

The hospital should hold supervisors such as Mr. Lynch accountable when they engage in inappropriate behavior. The hospital should develop a plan to improve the treatment of employees and to ensure a positive work environment. Management should provide training to all employee supervisors on the use of collaborative management practices to improve employee training and morale. Management should build on their programs which reward employees for best practices and decrease its use of the CARES program which is experienced by employees as a form of intimidation.

Finding #6:

One worker reported that sexual harassment occurred in the hospital and that the supervisor's response to this employee's report was inappropriate. A female worker reported that a man visiting a patient at the hospital followed her around, touching himself and gesturing toward her in a sexual manner. This made her feel extremely uncomfortable and threatened. When she reported the man's behavior to her supervisor, Mr. Gerald Lynch, he allegedly told her that she should just ignore the man's sexual gestures.

hospital management and line staff. After an incident is reported, there should be a prompt investigation and recommendations to address an employee's complaints and to ensure policies are in place that will deter sexual harassment. Also, management should follow up with any allegation of sexual harassment and reassure the employee that the hospital is addressing their complaint.

Finding #7:

Marin General Hospital Corporation (MGHC) Board lacks transparency and accountability. The Marin District Healthcare Board is a publicly elected body that contracts with MGH to run the hospital. MGH is governed by a private board. The relationship between the public Marin District Healthcare Board and the private MGHC Board is confusing to the community and to hospital employees.

Although MGH is contracted to serve the public, the private MGH Board and its meetings are not open to hospital employees or the Marin County community. There is a brief public comment period at the beginning of each MGH Board meeting but the rest of the meeting is conducted in private. Employees of the hospital have been unsuccessful in their attempts to access the MGH Board to communicate their concerns about declining patient safety and lower quality healthcare at the hospital.

Recommendation #7:

MGH Board should become more transparent and accessible to the community and the employees. The

public board should provide more oversight to the private board to ensure that MGH: a) is providing high quality healthcare to all patients; b) is meeting the needs of employees, including their need for positive working conditions; and c) is fulfilling its mission to serve the public.

Finding #8:

The WRB concludes that Marin General Hospital routinely prioritizes cost cutting above the needs of its employees and in violation of the hospital's mission to provide quality healthcare to all patients. While it is reasonable to seek cost reductions when necessary, the hospital has had a significant budget surplus and its overall budget appears to be very healthy. At the same time, there have been increases in State Administrative Penalties since 2010 compared to State Administrative Penalties from 2004–2010. According to the CDPH, an administrative penalty is a civil monetary penalty in an amount not to exceed \$25,000 for a violation or deficiency constituting an immediate jeopardy to the health and safety of a patient. Since 2010, there has also been a doubling of Survey Deficiencies compared to 2004–2010. Survey Deficiencies are determined by an investigation or survey team that inspect for violations of state regulations. From 2011–2016, there has been also an increase of 200 self-reported incidents and complaints, including substantiated complaints of preventable falls, pressure sores, and improper incontinent care, and other quality of care issues. In 2014, MGH was fined \$100,000 for failing to develop, maintain, and implement written policies for the surgical department. It seems obvious, given this data, that the hospital is pursuing cost-cutting strategies that jeopardize the health and safety of patients as well as subjecting the workers' to unfair working conditions.

Recommendation #8: WRB recommends that Marin General Hospital align its budget priorities with improving the staffing needs for patients and the working conditions of employees in order to reduce State Administered Penalties, Survey Deficiencies and self-reported incidents and complaints, and thereby improve the quality healthcare to their patients.

Conclusion

It is the intent of the WRB that this report will facilitate positive outcomes for both MGH's employees and MGH management. The concerns expressed by workers are motivated by the desire to improve the quality of services at the hospital. By addressing understaffing, providing better equipment, and changing the punitive and negative management practices at Marin General Hospital, patients will be better served. By acknowledging worker concerns, management has an

opportunity to bring about a win-win-win situation for the workers, the patients, and the hospital.

The CEO of Marin General Hospital, Mr. Lee Domanico, was invited to attend the Workers' Rights Board Hearing and to provide testimony at the hearing. He declined this invitation. He was given the opportunity, following the hearing, to provide a written response to the preliminary findings of the Workers' Rights Board so that the WRB could consider his side of the story regarding the concerns of the workers. He declined to provide a written response. Mr. Domanico did communicate informally with one Workers' Rights Board panelist, Marin County Supervisor Damon Connolly, and this conversation was the extent of his communication with the Workers' Rights Board after he was invited to comment on the testimony. The limited information provided in an informal conversation and not in writing makes it difficult for the WRB to confirm the accuracy of information, especially when there are differences between the information by management compared to employee testimony. Moreover, in Mr. Domanico's letter to the WRB Chairperson, he stated, "Please send me any questions that arise at the meeting. I or one of our staff will be glad to answer any specifics so that your report will include responses to concerns raised." However, his lack of response to the preliminary findings are not consistent with his statement.

In response to a report in the Pacific Sun newspaper about the hearing, hospital spokesperson (MGH Director of Communications), Jamie Maites, stated that there "is no 'increase in service deficiencies' or 'short-staffing' at MGH." Yet 65 percent of the employees who were surveyed indicated that there was insufficient staffing for workers to safely do their jobs. In addition, the California Department of Public Health's data contradicts the spokesperson's assertions.

Finally, MGH management's lack of a formal and written response to the WRB invitation unfortunately reinforces the perception that management is unwilling to address the concerns of its employees, and that it lacks transparency and accountability to its workers, patients, and the public.

Therefore, we call upon the Board of Directors for MGH, the CEO of MGH, and the Marin Healthcare District Board to begin the process of addressing the findings and recommendations in this report. Given MGH's twin responsibilities to provide quality care to patients in Marin County and to maintain the good will and support of all Marin County residents, there is too much at stake for management and the governing boards to ignore the serious concerns and issues raised in this report.

The Workers' Rights Board



The Workers' Rights Board is a public forum where workers can bring complaints against employers for violating their human and legal rights in the workplace. The Board is particularly concerned with protecting the rights of low-wage workers, who are often women, immigrants, young workers, and workers of color as they strive for justice in their workplaces.

The Board is comprised of 26 community leaders who intervene with employers and the public to help resolve situations that threaten workers' rights. The Board believes that safe,

living wage jobs, where workers are not discriminated against for speaking up for their rights, are the backbone of any healthy community. To accomplish its goals, the North Bay Workers' Rights Board will at-tempt to resolve issues in a variety of ways.

Workers' Rights Board activities may include:

- Meeting with employers who have been accused of violating workers' rights or resisting efforts of workers to have a voice in the workplace.
- Holding public hearings or press conferences to expose injustices to public scrutiny.
- Supporting and strengthening the democratic rights of working people including the right to organize through community education.
- Establishing community standards about fairness in the workplace and corporate responsibility.

North Bay Workers' Rights Board Members

Matt Myres

Workers' Rights Board Chair
Retired Teacher, Principal K-12 Education

Sr. Dianne Baumunk, OSU

Program Director,
Public Relations Angela Center, Santa Rosa

Teresa Barrett

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Damon Connolly, Supervisor

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Rev. Raymond Decker

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