

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

NURSES UNITED OF THE NATIONAL
CAPITAL REGION,

Plaintiff,

and

Civil Action No. _____

WASHINGTON HOSPITAL CENTER
CORP.,

Defendant

DECLARATION OF SUSAN P'HEUREUX

I, Susan L'Heureux, do hereby depose and state as follows:

1. I am a Registered Nurse ("Nurse" or "RN"), MS, CCRN, Clinical III Staff Nurse, employed by Washington Hospital Center Corp. ("WHC" or "Hospital") in the Hospital's 4G Surgical Intensive Care Unit. I have worked on that unit since 1985. I was first hired as a RN by the Hospital in February 1981, and I have been a nurse for nearly 30 years, since June 1980.

2. I am also a member of Nurses United of the National Capital Region ("Nurses United" or "Union"), the certified collective bargaining representative for over 1,500 Nurses at the Hospital. I have been actively involved as a Union member for many years, and I have served as a Shop Steward for the past three years. My role as a Steward involves participating in interpreting and administering the Collective Bargaining Agreement ("CBA" or "Agreement") between the Union and the Hospital on a day to day basis. This includes investigating and processing grievances and disputes under the CBA's grievance-arbitration provisions, responding to inquiries from Nurses, and representing Nurses and the Union in dealing with the

Hospital.

3. I have voluntarily taken the 2009-2010 seasonal flu vaccine, and I have cooperated in administering the vaccine to recipients who want to take the vaccine based on truly voluntary and informed consent. But I respect the personal right of patients, Nurses and Hospital staff to decline vaccination and not to be forced to receive unwanted medical treatment or bodily intrusion. After receiving consent forms and disclosures about the vaccine's potential side effects and risks, some Nurses have expressed sincere personal fear and concern to me about Guillain-Barré syndrome, for example, which can cause serious and even permanent disability. As a professional healthcare provider, I can see and understand that for an individual contemplating whether or not to take a medical treatment, even a small chance of suffering a drastic consequence may cause great personal anguish. Nurses have raised these doubts and worries with me, asking questions such as, who will take care of my children and family if I'm disabled and can no longer work as a result of taking the vaccine?

4. Based on my experience as a Nurse at Washington Hospital Center, I am greatly concerned that the Hospital's imminent suspension and termination of unvaccinated Nurses will cause serious and irreparable harm to Nurses and patients. The sudden elimination of experienced, healthy Nurses from our workforce would be disruptive, would create unnecessary difficulties, and would undermine our ability to provide high quality patient care under any circumstances. But that course of action is even more alarming given that the Hospital is already suffering from staffing problems and personnel shortages that are straining our capacity to deliver even adequate care. In these circumstances, problems that arise on a given shift are magnified, and the loss of even a few Nurses can be disastrous.

5. In our surgical ICU, for example, we are chronically understaffed and have been for many months. Our unit serves a varied and challenging population of surgical critical care patients who need close monitoring and intensive caretaking, including serious acute trauma victims, open heart surgery and heart transplant patients, neurosurgical patients, and other unstable post-operative patients. We have not had a regular Head Nurse for the past year; and the Hospital has apparently had difficulty filling the position, as a series of Acting Head Nurses have rotated through. We used to have three Clinical Managers assigned to our unit, who would help ensure adequate patient care and who could assist in emergencies. But during 2009, the Hospital eliminated all of the Clinical Managers. Approximately 20 Nurses from our area have quit in the last year, complaining of inadequate conditions. We have been depending heavily on temporary agency nurses who report to the Hospital and are “floated” all over the premises. Over the past six months or so, there has been a growing perception among Nurses that this has become an unsafe environment in which to work. We struggle to provide proper patient care even when things are relatively calm. However, when a medical crisis occurs, as can be expected in a unit such as ours, the system seems to break down because even the most diligent efforts by Nurses, physicians and other medical personnel cannot make up for inadequate staffing. Now, the Hospital has targeted six critical care Nurses from our unit 4G to be suspended and fired because they are not yet vaccinated; and we understand that other surgical and medical ICUs (e.g., 3G, 4H, 3H and 2G) are also facing removal and termination of unvaccinated Nurses.

6. The unfortunate experience in our unit just last weekend illustrates the kinds of problems that the Hospital will be creating and exacerbating if it goes ahead with deliberately

suspending and firing unvaccinated Nurses. I was working a weekend night shift on 4G, from 7:00 pm on Sunday, January 24 to 7:00 am on Monday, January 25, and there were seven other Nurses working with me on the unit. The Acting Head Nurse was absent from work that shift, but on any given shift, one of the staff nurses is assigned as Resource Nurse (similar to a charge nurse, but with a patient assignment). Our unit has a 14-bed capacity, and we had 13 surgical intensive care patients that night. Four of those patients were very acute, assessed as needing a 1:1 Nurse staffing, leaving the remaining four Nurses responsible for the other nine patients. During the course of our shift, medical crises with three of our patients overwhelmed us; while we were scrambling to try to keep up, our supervisor requested additional Nurses from throughout the Hospital but none could be spared; and by the end of the shift, two patients were dead, and one had been resuscitated after a “Code Blue,” i.e., cardiac arrest (I do not know the subsequent outcome).

7. The shift began with 12 patients on the unit, three of them requiring 1:1 Nurse staffing. One of those critical patients “coded” repeatedly throughout the shift, and emergency open-heart surgery had to be performed right there in the patient’s room, at least twice that night. This patient’s medical crises required redeployment of Nurses – in addition to multiple doctors, there were two Nurses from our 4G unit, as well as two Nurses who came in from the OR, simultaneously tending to that patient. Eventually, toward the end of the shift, this patient died.

Meanwhile, one of the other 4G Nurses (I will refer to her as Nurse X) was caring for an acute neurosurgical patient who was assessed for 1:2 Nurse staffing but who needed close monitoring, i.e., regular hourly checking for brain changes, as well as a non-nurse “sitter” watching at the bedside because he had been agitated and confused. Suddenly, another difficult

situation arose: a woman who had suffered seizures at 35 weeks into her pregnancy was brought into our unit, in an unconscious state, after an emergency delivery to save the life of her baby. This new patient who needed 1:1 care was also assigned to Nurse X, who was already assigned to the sick neurosurgical patient. Nurse X was understandably concerned about capacity to care for both patients at the same time.

Almost as soon as the unconscious L&D patient was situated in the unit, under Nurse X's care, Nurse X's other patient "coded," creating a third crisis. A Nurse who was passing the room heard the alarm on the monitor and called the code; fortunately, there were physicians and nursing staff already present nearby due to the other situation. I understand that the patient was ultimately resuscitated.

Nurse X remained with her second patient, meanwhile, and that patient needed an emergency CAT scan. Nurse X took the unconscious woman to another unit for that procedure. As it turned out, that patient had suffered unsurvivable bleeding into her head. She did not regain consciousness, and by the end of the shift her family was told that she was brain dead. She is currently an organ donor.

In addition to the patients in crisis, the other patients in our area, and the numerous medical and support personnel on the scene during the shift, our unit was also dealing with patients' family members. This was especially challenging as two patients were nearing death, and relatives were gathering. At one point, the surviving infant was brought in from the NICU to be together with the comatose mother and her family. The strained and tenuous working conditions on our unit, and the concerns we have about not being able to provide adequate care, intensify the sorrow and emotional toll on Hospital staff.

While all of this was going on, I and one other Nurse were trying to take care of a group of seven patients, covering for Nurses redeployed elsewhere on the unit. One of those patients was designated for acute 1:1 Nurse staffing (assigned to the Resource Nurse who was trying to assist with the emergencies and staffing), and the other six were supposed to be cared for on the basis of two patients per Nurse. With two of us juggling seven critical patients, we knew that at any moment the situation could become life threatening. It was only a matter of chance that things remained quiet at our end of the unit; had these patients not remained stable, we would have been unable to provide safe care.

As it was, the nurses on duty that night had their licenses put in jeopardy, and the patients were placed at risk due to inadequate staffing. Our Resource Nurse was repeatedly calling the nursing Supervisor on duty that night, seeking any and all available assistance. Throughout the shift, the Supervisor – who had administrative responsibility for overseeing all the surgical ICU's and all the step-down units, or approximately half of the Hospital – tried to get additional Nurses from other areas of the Hospital, but she found that not a single Nurse could be spared. She was told by the Staffing Office that no additional Nurses were available from outside. At one point, the Supervisor herself came down to our unit and remained for about an hour. She acknowledged that she could not herself provide critical care functions, as she had not been performing these clinical nursing practices recently, but she offered to get supplies, help orchestrate care, and do whatever she could to assist the unit. Finally, we received some badly needed assistance from an experienced former 4G Nurse who was working in another unit (the MEDSTAR trauma receiving unit), and who volunteered to step away from her post temporarily while there were no trauma admissions in process and care for Nurse X's neurosurgical patient

for several hours after the resuscitation.

8. While emergencies of this magnitude do not arise every day on our unit, situations like this have been occurring on a fairly regular basis over the past six months. It is inconceivable to me and my Nurse colleagues that the Hospital would deliberately worsen the situation for patients and staff, by unnecessarily suspending and terminating capable Nurses who are willing to work and are so badly needed in our unit, and throughout the Hospital.

CERTIFICATION PURSUANT TO 28 U.S.C. §1746

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on January ~~27~~ 2010



Susan L'Heureux RN, MS, CCRN