



Nurse Conference Committee (NCC) Meeting Minutes

Date: June 14th, 2023

Time: 1:00-3:00 PM Location: WebEx

Name	4/5/23	5/3/23	6/14/23	6/28/23
Bonnie Fryzlewicz	Present	Present	x	
Danica Pytte	Present	Absent	x	
Dinarte Viveiros	Absent	Present	Present	
Holly Beauchene	Absent	Present	Present	
Calli Komban	Absent	Absent	x	
Kara Yates	Present	Present	Present	
Kelsey Gellner	x	x	Present	
Kristie Page	Present	Present	Present	
Linda Burbank	Present	Present	Present	
Lindsey Kirsch	Present	Present	Present	
Lori Chudnofsky	Present	Present	Present	
Maureen O'Brien	Present	Absent	Present	
Molly Aaseby	Present	Present	x	
Nic Maurice	Absent	Absent	x	
Sam Forte	Present	Present	Present	
Sandy Kellas	Present	Present	x	x
Tammy York	Present	Present	Present	
Annika Hoogestraat	Absent	Present	Present	
Stefanie Chandos	Absent	Present	x	
Katie Podobnik	Absent	Present	Present	
Te'onna Adams	Absent	Present	Present	
Therese Hill	Present	Present	Present	

Guest(s): Chris Patin, Jim Sawyer, Sue Anderson, Maya Scott, Melissa Cary, Ashley Hopkins, Ian Johnson, VaLiesha Brown , Jonathan Jones

Notetaker: Sarita Wall

ITEM NO.	AGENDA TOPIC	DISCUSSION	COMMITTEE ACTION
I.	Approval of May 03, 2023	Motion to approve 5/3 NCC Meeting Minutes	1 st Dinarte 2 nd Tammy
II.	<p>WPV/Safety Issues: update Guests to provide real examples of WPV on their units and to them: Melissa Cary, Ashley Hopkins Security to speak to issues raised in separate previously held meeting. Emphasis on but not limited to risk assessments, interventions for workplace violence prevention, tripled assault rates</p>	<ul style="list-style-type: none"> • Melissa read a personal statement to show impact on staff safety (see attached). • Sam read the below ADO to show impact on staff safety, including gaps that result in harm. <p><u>ADO 1147</u></p> <p>A patient became extremely physically violent with the PBMU sitter, another charge nurse, and me. This patient has had, on many previous occasions, been physically violent with staff and injuring staff. Today the patient punch and kicked the sitter multiple times, pulled the charge nurses hair, and put her in a chokehold. I was the other charge nurse trying to loosen the patients grip. I got kicked in the lower abdomen. I am currently 11 weeks pregnant with twins. I needed to leave work to get medical attention. Staff is not protected from this patient’s violent outbursts. No one feels safe to be around this patient and situations continue to escalate with no actual change happening to protect staff.</p> <ul style="list-style-type: none"> • Sam started the discussion on behalf of the nurses about workplace violence and safety issues with questions for Sue, the security team, and VaLiesha from legal. <p><u>Q&A</u></p> <p>Q: The Safe Work Environment Policy is intended to satisfy the legal requirement our 49.19 RCW, is that accurate? A: Yes</p> <p>Q: Is Sue the only person that makes changes to that policy? A: No, changes to the policy come from different areas, which include the Employee Health and Safety Committee and Security.</p>	<ul style="list-style-type: none"> • Sue to do research on WPV interventions data and communicate back to the group • Jim to follow up with the team about signage recommendations by early August • Continue discussion at another time

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		<p>Q: Since the policies were last approved in January, has there been any revisions? (see policies 12791 and 12912)</p> <p>A: Revision information is in PolicyStat under the policy</p> <p>Q: The 49.19 RCW states that an annual review of the frequency of incidences or incidents of workplace violence, including identification of the causes for, and consequences of violent acts at the setting, and any emerging issues that contribute to workplace violence is required. Where is this work done or kept?</p> <p>A: The environment of care program encompasses a very large area. Things such as hazardous materials, fire life, safety, etc. Two of those sections are also security and safety. And safety encompasses not only workplace violence, but I want you to think about things like making sure that we have fire drills and other things of that nature. Each year the safety and security management plan is reviewed and updated. Those are available on PolicyStat. The requirement for CMS and other groups, including the 49.19 RCW, specifies that SC has to do annual evaluations of each management plan. Those are conducted with the owners. Then, they're presented to the Safety Leadership Committee, and that goes up through the QISC program.</p> <p>Q: The part that was missing when we reviewed it, is that it doesn't include interventions or actions that are workplace violence specific.</p> <p>A: The workplace violence is included in all of the numbers that are reported up through those programs.</p> <p>Q: Is there specific data regarding frequency of incidents of workplace violence with the identification and causes for, and consequences, of those acts?</p> <p>A: No, we give an overview for all the different report outs. They're very similar to the ones that we have with the Employee Health and Safety Committee, where we look at the dashboards and use that information to discuss what we've done in response to them. It doesn't get down into the granular level that you're looking for with that question, however, it covers the requirements.</p> <p>Q: Has there been any reprioritization of that with the crippled assault rates?</p>	

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		<p>A: There is a new subcommittee that met on Monday. The subcommittee discussed classifying the data and having the committee give recommendations on steps to take to help make a difference with some of these assaults. Moving forward there will be differences in the data and with reporting. The subcommittee worked with us during some investigations on serious injury and illness investigations that we complete. We've been able to take some steps to help make some changes for specific incidents that have happened. Those are reported out at the Employee Health and Safety Committee. We don't share identifying information on the people or the persons that were involved, to protect their own privacy, however we can look back at some of those and see that we have made some steps to make improvements as well.</p> <p>Q: How recent were those changes made? A: That information is available on the Employee Health and Safety Committee dashboard. There have been some dips in the numbers after some of the work that Maureen has done in the PBMU. That doesn't necessarily mean there's correlation or causation. That was part of the committee's discussion on Monday. In regard to assaults, which are very wide-ranging term, we are reporting out on at the Employee Health and Safety Committee meetings. When we're not getting the better classification of it. For example, the term assault could mean that I've called you a name or that I struck you. So, we're working to get the data cleaned out by putting them into different categories. The committee is deciding what those categories are going to be, so that we can determine what the worst/least serious incidents are. Then, we will be able to tell what changes have been effective and in what areas.</p> <p>Q: How decreased is the PBMU patient census at this point? A: Census is restricted to 32 beds right now, based on construction.</p> <p>Q: What was it previously? A: Prior to construction or remedying tragic sewer breakages, etc., the bed capacity was 41.</p> <p>Q: In regard to the safe work environment policy, when were the response pathways rolled out? Was it with the new additions? Or was it something that was there prior?</p>	

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		<p>A: Those were added on last year. That goes along with the training that was rolled out for nursing. after nursing is complete, eventually it will roll out throughout the organization.</p> <p>Q: Is it a little too soon to do any sort of analysis on where it falls apart? A: we're looking to see if we can look at the data and see if there has been a change made because of those trainings and pathways. That work is being undertaken now.</p> <p>Q: Where in this policy does it points out prevention plans and strategies that address security considerations and factors that may contribute to or prevent the risk of violence? A: If you take a look in the security management plan, you're going to see where we have our security risks where we do security vulnerability assessments for different areas to help determine some of the needs for those different areas. There's a list of the different areas that are considered to be security vulnerable.</p> <p>Q: Has there been any other are risk assessments done since it rolled out in 2022? Is there any prioritization to these areas? Or are they just all considered the same level of sensitive areas? A: Security does annual RVAs (risk vulnerability assessments) and SVAs (security vulnerability assessment) for main campus and regional sites, which includes include sensitive areas.</p> <p>Q: Is there any prioritization to sensitive areas? A: No, we just wait to identify areas of concern in the RVAs</p> <p>Q: What is done in terms of security plans, regarded to those RVAs or SVAs? Is there a reallocation of security staff is there increased rounding? A: We embrace and focus on philosophy of zero incidents. If we find a high-risk area (external or internal), we will prioritize prevention strategies to address that area. On a macro level, one of the great challenges for health care institutions across the country is to validate, authenticate, and know who is inside your building, which is why we have about 3000 badges per day. Everyone over the age of 12 gets badged. That's one of the strategies that we have in place to help safeguard these sensitive areas as we move into the future.</p>	

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		<p>Q: People are getting into the building without being properly authenticated.</p> <p>A: It's an enduring challenge we take very seriously. Our goal is to authenticate and validate everyone who enters the building. because we have seen increase in external activity that kind of thing. We want to ensure that every person who enters the building belongs, have been given and badge, and have the appropriate permissions to be where they're at. That's not only going to grow in importance. We want to do that while maintaining high levels of customer service to support the families. I would also add that if that does occur, we need the support of the staff to let us know so we can address it to figure out what happened in the moment. It could be a coaching opportunity that we have to address with our team.</p> <p>Q: In regard to risk assessments, is this work that is multidisciplinary on any level or is this strictly done by the security team?</p> <p>A: Usually, two to three people from Security Services (officers, supervisors, and managers) are assigned to conduct annual risk assessments.</p> <p>Q: Is there any feedback elicited from frontline staff?</p> <p>A: Yes, we do take feedback from staff.</p> <p>Q: In regard to zero incidents, our incidents is now into the 300 numbers, which is lofty given that we've had tripled rates of assaults. Where does that come from? And how is that reevaluated?</p> <p>A: Part of the issue is support. When we're talking about patient aggression versus family aggression.</p> <p>Q: What type of reanalysis work is done when a patient or a family member has become escalated over a period of time? We are aware of initial assessments on whether or not they are high-risk when coming into the facility. If they continue or start aggression while they are in the facility, are they reworked into a high-risk category, or do they maintain for the length of their stay?</p> <p>A: if we have we have a family member that presents challenges we will work with social work leadership and the care team to try and understand</p>	

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		<p>what this situation is to come up with a support plan that will hopefully work for the family and support the staff. When we have a situation where there's a protracted set of behaviors, we will collaborate with social work to mitigate or improve a situation. We won't accept status quo for the duration.</p> <p>Q: Are they flagged on entry, going forward, if they've proven that they need an increase presence of support for the nurse?</p> <p>A: We have the Casper program that is used to share historical information with the care team, social work team, BST team, and the security entrance team. The security team also has a watch list at every entrance. The watch list is a list of people we will not allow into the building or if they do arrive, we will have an escort for them. There's linear of reasons to be on the watch list.</p> <p>Q: Is someone added to the watch list if they bring a weapon onto campus?</p> <p>A: If there is any kind of history of threatening or there was any kind of vested concern, it could be a Casper situation and could lead to restriction, restricted hours, and/or criminal trespassing. It's situation dependent.</p> <p>Q: Are there any exclusion criteria for belonging searches? Is there a policy?</p> <p>A: No. We are sensitive to the realities of a weapon culture and we're surveying, both, internal and external areas for the hospital where we can post "no weapons" signage in the hospital where we think we can strategically install signage. Standard areas for weapons science is usually parking lot entry points and building entrances. We hope to have the survey done during the month of July. And the report complete by August 1st.</p> <p>Q: Is what you're looking at strictly signage? It's</p> <p>A: This is this is just for signage recommendations, advising people that we are no weapons facility both internally and externally.</p> <p>Q: Extra effort towards putting up signage is appreciated, but if someone would want to bring a weapon into the house, which doesn't stop them from doing that. We don't trust that the perimeter of the hospital is</p>	

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		<p>secure, and people still have the opportunity to bring weapons in. The main concern is that it sounds like we are waiting for something to happen and that we're not being preventative.</p> <p>A: We make those considerations and evaluate on an annual basis. That is part of the RVAs that is escalated to the decision-making parties of the organization at all levels. We do encounter weapons on an occasional basis. We have direct conversations with individuals who have weapons. Sometimes they check those weapons with us in the Security Department, and sometimes they are asked to remove them off property. The escalation portion of prevention is building relationships with individuals as a prevention tool. Detecting a weapon and asking someone not to use it, does not stop someone with intent. It might prevent it in the moment, but that's not the prevention strategy. The prevention strategy is based on the zero-incidence part, which comes from relationship building. The strategy is to build trust and stability with individuals and bring them closer, making them a part of our community, as opposed to turning them into someone that has a feeling of rejection or animosity, which is actually unsafe.</p>	
III.	<p>PHP: updates Maureen: Clarification on how vacation, sick call, breaks are covered How? 25:33</p>	<ul style="list-style-type: none"> • The group requested clarification from Maureen on how vacations, sick time, sick calls, and breaks are covered, and if it had been communicated to leadership that when nurses move from location to location, they get float and NCF pay. <p>Maureen let the team know she received an update from Carly Von Hoffman that that team is working on some different strategies on a voluntary basis from a variety of different groups including the PBMU nurses, outpatient side nurses, ambulatory RN float pool, and float pool. There are several requests out for voluntary cross training. Recently, another nurse was hired. Now, there three nurses on the schedule. They are 0.60 FTE, so there's at least two nurses on any given day. The nurses are good about moving their schedules around where possible to cover each other. Also, Laura Knapp, VP of Behavioral Health joined the team recently. Laura has been working with the team on strategy.</p> <p>Maureen was asked if there was better or improved communication between nurses and leaders about changes and</p>	<ul style="list-style-type: none"> • Nothing further needed

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		<p>expectations to float and cover the area. Maureen informed the team that currently, no one is being required to float to that area.</p> <p>Maureen was also asked which alternative classifications or positions would be covering in lieu of the nursing home. This question stems from a previous meeting where Maureen said there's a model that doesn't require nursing. Maureen informed the team that there are ways to run PHP per regulations that doesn't involve nursing staff. The way that can happen is creating structures for observed medication self-administration, if needed, from the patients (based on their home supply). The observations are done by unlicensed personnel. They're done by frontline staff, mental health specialists, and etc. within the regulations. The observation of self-administration is to protect against risk of overdosing and inappropriate use of medications. Laura has some experience working in facilities where they've done this and some of those facilities have shared some policies with us that's currently in review to see if the policies are feasible in our environment as well.</p> <p>The question was raised, what would happen with the current three nurses if PHP can be ran without them? Maureen ensured the team that there are no plans to eliminate positions. It would only allow the opportunity for more coverage, and to expand PHP in the future (possibly to a lower acuity version of the program) to have more capacity.</p>	
IV.	<p>Incentive: updates Kristie Page: Why and when the change occurred for tier 3 incentive?</p>	<ul style="list-style-type: none"> The group asked Kristie what changes were made to the tier 3 incentive and if the union was notified of the changes. Kristie responded that no changes have been made to the tier 3 incentive and that she sent out clarification around 5/31 to the SAs. Tier 3 is available, however, the team wanted to be thoughtful about using as need. The reason Kristie sent out the clarification communication is because of an escalation received that a team was short staffed that evening and the staff was requesting the manager to initiate tier 3. However, there was staff available in the PICU with that skillset at the time. The manager felt that those people should be moved with those skills over to the team, rather than initiating tier 3, which is correct. Teams should use available 	<ul style="list-style-type: none"> Kristie, Annika, Kara, and Dinarte to discuss incentive changes at a later date

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		<p>resources first and if there is a deficit, then initiate tier 3. The question was raised if there was a move towards leaving all of the HOCs in the hospital in the green in order to initiate tier 3. Kristie reiterated that the teams need to think about using resources appropriately and also consider the financial state of the org. Kristie mentioned there hadn't been previous discussion on the topic.</p> <p>A point was made that it seems as if some teams get tier 3 when others don't. Kristie advised the group that it's based on each individual division.</p>	
V.	<p>Addendum D: update Any updates on the changes in Ambulatory. Prepared in ETM for OT</p>	<ul style="list-style-type: none"> The group asked Tammy if payroll is prepared in ETM for the overtime that may happen to prevent backtracking to fix paychecks, what kind of messaging has gone out to the teams, and what kind of work has been done with UBSC? Tammy informed the group that for overtime, ETM will calculate it, but will defer the question to the Payroll team. The last time the team discussed Addendum D, a concern was raised about six to nine-hour shifts being scheduled. Tammy reached out to GI and confirmed those shifts aren't being scheduled in current state nor future state. Tammy requests that if there are specific nurse that are saying this, to escalate to her. Tammy did reiterate with Danica and still waiting to connect with Mike about the language (clarifying "calling the negotiation") in Addendum D. <p>Linda reiterated to Tammy that the union is receiving feedback that management (in different areas) is incorrectly communicating to staff about changes to schedules. And that it's causing concerns in regard to the six to nine-hour shifts. Holly's team was going to send out some communication to leaders to ensure they weren't misrepresenting the changes. A PowerPoint slide deck was shared from the GI leadership team to Holly that spoke to the six to nine-hour shifts. Linda notes that there needs to be prior notice and collaboration with Housewide Staffing. Neither has happened, however, it is needed to do effective bargaining. Tammy assured Linda and the team that she did reach out to the GI manager, and no one is past six or nine hour shifts now or in the future and</p>	<ul style="list-style-type: none"> Invite Payroll to an upcoming meeting Still waiting to hear back from Mike Holly to send clarifying communication to leaders Holly/Tammy/Di narte to prepare payroll for August update and follow up with Lindsey

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		<p>they've been instructed that negotiation needs to happen for Addendum D.</p>	
VI.	<p>Management layoffs: new What roles involved? How does this affect bedside nurses? Any executive leadership roles?</p>	<ul style="list-style-type: none"> The group voiced concerns about the recent layoffs of 135 people/leaders in regard to the lack of transparency on what the roles are, why those particular roles were chosen, are any of the on-hold positions RN positions, and how nursing will be affected overall. In response, Dinarte informed the group that the roles were supervisory and above across the health system with an understanding of what the needs were within those specific teams. Communication is still trickling out within teams as there were roles where people were offered other positions and had until last week to decide. That's why the information hasn't been fully shared. Leaders were asked to cascade information to their teams with those changes this past week. <p>Holly added, leadership tried to be transparent with the emails sent by Dr. Sperring to the entire workforce. There was a lot of consideration about the right way to communicate and when to communicate. Leadership wanted to take a different approach than other organizations, not wanting staff to show up and swipe their badge and it doesn't work. The new definition of transparency includes having compassion and the message Dr. Sperring sent on May 30th was really intended to do that. Comparatively speaking, it is unusual to even provide the level of communication that was provided, knowing it created some anxiety across the organization as people were thinking about it. Balancing that sense of compassion and being transparent is a challenging task. Holly assured the team that the intent wasn't to push any additional work on to frontline staff members, but to restructure leadership more effectively (comparable across other organizations that are similar to SC).</p> <p>Lindsey and the team voiced concerns that frontline workers won't have the same support. For example, if the MA supervisors are gone, "who will keep the MAs going?". Also, the question was raised, why executive leadership was not affected by the layoffs? Holly reiterated that not all information and this was not about</p>	<ul style="list-style-type: none"> Tammy and Linda to collaborate on workload and working conditions plans and communications

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		<p>just eliminating roles but transitioning work.</p> <p>In response to the question about executive leaders, Dinarte informed Lindsey that there have been changes around the VP level over the past few months. When evaluating cost structure by roles across the system, from a leadership perspective, relative to FTE and the size of the organization, SC was at the 100th percentile (there was only one other hospital that was pretty close to us in Children's Hospital Association that had the same amount of FTE). When evaluating looked at it by role, the VPS relative to our size was around the 50th percentile.</p> <p>In response to the question about how nurses will be affected, Dinarte added that there is no intention on laying off frontline staff at this point (for the rest of the fiscal year). Dinarte is not saying there will be layoffs next fiscal year, just thinking about planning in regard to timelines.</p> <p>In response to on hold positions, Ian advised the group that the Workforce Optimization Management Council (WOMAC) did go through a process froze some positions. They were primarily support roles in terms of administration and services versus director patient contact areas. Nursing is getting preferential treatment by WOMAC and are allowed to go against higher benchmarks, unless their numbers are trying to add additional headcount without a justification for it. Ian couldn't recall any direct patient care facing nursing role that is 3105 that has denied in the clinical area.</p> <p>The nursing team requested a list of the interdependent roles that were eliminated (names aren't required), specifically RTs and Mas, to help with planning the day and knowing expectations as to the support that teams may or may not be able to get in a timely manner. Holly let the team know that the intent is to communicate so that there's a better understanding of the structure at some point, however, it's still early and leadership is prioritizing honoring the activities that happened last week with those impacted individuals, ensuring they're best taken care of as</p>	

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		<p>possible. Then later, the org will move forward with assimilating new teams. The group can expect to see more communication related to this in the coming weeks.</p> <p>Linda added that nurses are being trained to do some of the MA's, schedulers', and social worker's tasks and are vocalizing changes to working conditions without having clear communication. So, it does seem to be a communication gap. Linda also states that she heard there has been number of safety concerns. Tammy responded by offering to work with Linda directly on those concerns and request that Linda forward these instances to her for follow up.</p>	
VII.	<p>Facility updates: new Plans for Renton campus UC space/hours Medical/R3/NICU move timeline COVID vaccine cline PBMU construction timeline</p>	<ul style="list-style-type: none"> The group asked Dinarte for a brief overview of all the moves and changes on campus. In response, Dinarte informed the team that there's not a whole lot going on with the Renton location other than SC leasing the space out to different entities that currently reside in that space. River 3 and NICU is on schedule. Lifts are being install and expect to move into the space by November and that kicks off the work that needs to happen on Forest 3 to prepare for the NICU. That is on schedule for November 2024 move in date. For the PBMU, there is work happening that's closing PBMU beds to work on the new dialysis unit on RA6. Ceiling work is needed, so there are some beds closed for now. That work is anticipated to wrap up around July 10th. Following that there will be some work on the downstairs unit to complete the fire detection system installation and some other necessary for patient safety within that area. That will cause 16 beds to be closed. Some areas of the unit will be released to allow access to the outside for patients. That phase is anticipated to complete in late October. Then, 5-6 beds will be closing in River 5 for 2-3 months. Finally, there will be a fourth phase closing 10 beds, so there won't be beds for a capacity of 41 patients within the walls and in the PBMU until the fall of 2024. <p>For Urgent care, there's been approval to stay where they are at until November. There are no further updates as of yet.</p>	<ul style="list-style-type: none"> Discuss further in next NCC meeting

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VIII.	<p>Relocation/sign on bonus: update Bonnie: Vacancy numbers, Retention numbers with bonuses offered as compared to the market Travelers: number of them and plan moving forward</p>	<p>Ian joined the group to answer questions sent via email in regard to relocation and sign on bonuses.</p> <p><u>Q&A</u></p> <p>Q: What are the vacancy rates?</p> <ul style="list-style-type: none"> • Decreased 20% from 2/2022 for job code 3105 at 7.4% • Increased hiring pathways for experienced nurses is 5% • Through May 337 nurses have been hired (net increase of 190 nurses) • As of 5/31 1,899 nurses are employed at SC (including a few non-WSNA members) <p>Q: What are the retention numbers/turnover?</p> <ul style="list-style-type: none"> • In May there were 16 separations • 10 of the 16 separations were evening/night shifts • Top reasons were family obligations, relocations, job advancement, and job dissatisfaction • 2 of 16 separations • 5 of 16 separations were first year • No involuntary separations in May • 2 of 16 separations were per diem staff • 1 for NICU, 1 for PICU, 2 for R5, 2 for R6 (1 for different groups across the areas) • 40-45 traveler conversion so far this fiscal year <p>Q: What are the sign-on bonuses?</p> <ul style="list-style-type: none"> • Sign-on bonuses have been suspended across the org • There is a waiver for RN positions replacing travelers <i>(to reduce contract staff)</i> • Sign-on bonuses are monitored monthly comparable to the market 	<ul style="list-style-type: none"> • Dinarte and Lori to discuss PICU traveler information with Eli and report back • Ian to gather more information on the breakdown on the Pediatrics category and report back • Ian to follow up with Aya about the social media posts and report back via email

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		<p>Q: What is the RN travel usage?</p> <ul style="list-style-type: none"> • As of last week, down to 323 travelers (including Allied Health Professionals) from over 500 • 187 of 323 travelers are nurses • Highest traveler utilization is in PICU, <i>Pediatrics (Aya Healthcare)</i>, BHT, and NICU <p><u>Open Discussion</u></p> <ul style="list-style-type: none"> • Annika brought to Ian’s attention that there have been communications on people’s private social media accounts amongst the traveler groups warning each other no to come to SC. • Therese asked if SC are getting the same type of experienced nurses versus the nurses lost? Lori responded that they are getting experience applicants, but not at the level that we're hoping for. It is still challenge across the country with experienced applicants in both the NICU and PICU realms, but they are getting those experienced applicants. For travelers, they’re definitely getting experience applicants, however, the org is trying to extend the ones that are already integrated into the teams while the work is being done to replace the travelers, overall, with staff. 	

Committee Action Items: *Inform, Discussion/Feedback, Decision, Action*
Include: *Who, What, When*

Next Meeting: June 28, 2023, Virtual Meeting

Committee Action Items – Rolling Queue

Topic	Frequency	Next Agenda this would be on
Expense reimbursement	Twice per year	June 2023
Education Budget Metrics: <ul style="list-style-type: none"> ● Education leave hours (budgeted vs actual) ● Professional leave hours (budgeted vs actual) ● Total funds awarded (can report out on this 2x/year) ● Any denials of leave requests (and the nature of the denials) 	Twice per year	June 2023
WSNA Roster	Quarterly	June 2023