Rochester General Hospital Registered Nurse Staffing Report – Q1 2025

The Top-Level Numbers

There was not a single full twelve-hour shift between January 1 and March 31 in which RGH had enough Registered Nurses (RNs) for the number of patients hospital-wide. Only on the night shift on January 20th were (barely) enough nurses scheduled, but sick calls brought the actual number below the minimum. On all other shifts on all other days, sufficient nurses were not even scheduled. Hospital-wide, RGH was understaffed 100% of the time in the first quarter of 2025.

As explained below, this report also includes unit-by-unit staffing numbers. These vary greatly, so that, for example, in March, 53.23% of twelve-hour shifts were understaffed on Labor & Delivery, whereas 93.55% of twelve-hour shifts were understaffed in the Adult Emergency Department. That means that on any given shift, there could have been some units that had the appropriate level of staffing and others that did not, but, in the aggregate, there were never a sufficient number of nurses hospital-wide to provide safe patient care according to the RGH clinical staffing plan filed with the New York State Department of Health.

The Purpose of this Report

The over 1000 Registered Nurses at Rochester General Hospital who make up RUNAP are proud to serve our patients and our community. We love our jobs, our coworkers, our patients, and the work that we do. We believe that Rochester Regional Health should be adequately supporting bedside staff in that critical patient care work.

When we formed our union in July 2022, the number of staff RNs at RGH had reached a low point of 838. Since settling our union contract with significant improvements to working conditions in October 2023, recruitment and retention have turned around and, as of May 2025, that number has reached 1,006 staff RNs. We are finally moving in the right direction. However, the hospital is still short hundreds of RNs, and RRH administration is reneging on commitments to end unhealthy shift rotation patterns (where nurses are made to rotate between both day and night shifts), compensate preceptors (experienced nurses who orient new hires), ensure charge nurses can work free of patient assignments to provide critical support on their units, and adequately staff the hospital.

This report triggers a $100,000 fine assessed against the hospital under the 2023-2027 RGH/RUNAP contract for Q1 2025, which is to be paid out directly to the nurses forced to work under these unsafe conditions. The fines will continue to be assessed quarterly until at least 90% of twelve-hour shifts are adequately staffed under the clinical staffing plan filed with the New York State Department of Health.

We are releasing this report publicly because the Rochester community has a right to know about the conditions in the hospital, and we hope that greater public awareness will compel Rochester Regional Health CEO Richard “Chip” Davis and the members of the RRH Board of Directors to act.

The Scope of this Report

This report covers Registered Nurse (RN) staffing numbers in RGH's two Emergency Departments (Adult and Pediatric) and twenty-five in-patient units. It does not cover perioperative or procedural units, which do not yet have clinical staffing plans filed with New York State, nor does it cover Licensed Practical Nurses (LPNs) or other staff equally important to patient care.

Only RN staffing is covered under the RUNAP contract, but we know that conditions are often even worse for non-union groups at RGH. On several Medical/Surgical floors, RNs and LPNs work hand-in-hand to provide patient care, so the RN numbers provide only half the story.

The Data and Analysis

All data was provided to the union by RGH administration, pursuant to the RUNAP contract. The analysis is based on comparing the actual nurse and patient numbers on a given shift against the clinical staffing plan that sets the minimum safety numbers. It was performed by a computer program commissioned by RUNAP for this purpose.

Each hospital unit covered by the clinical staffing plan has a "staffing grid," which sets the appropriate number of RNs and other staff according to the census (number of patients) on the unit during that shift. For example, if there are 18 patients on the Medical Intensive Care Unit (MICU), then there are supposed to be 13 RNs working on the unit. If, instead, there are only 10 RNs for that number of patients, as there were on March 27, then the unit is short 3 RNs and counted as "understaffed" for that shift. In practical terms, that means nurses may have to take more patients than is safe for the level of care expected of such a unit, and many studies have shown that patient outcomes worsen when nurses are understaffed.

The clinical staffing plan is set, and can be amended, by the clinical staffing committee, a joint labor/management committee created by the 2021 New York State hospital staffing law. Half of the committee is made up of bedside staff and half is made up by management. Each side gets one vote, and ties are broken by the hospital president. This advantages management, and, in practical terms, it means there are several unit staffing grids that nurses believe are not actually sufficient for minimum safety standards. This report uses the existing clinical staffing plan, however, which has been submitted by the committee to the New York State Department of Health, and which the hospital is both legally and contractually obligated to follow.

The staffing grids are set in eight-hour increments for the in-patient units (7a-3p, 3p-11p, 11p-7a) and four-hour increments (11p-3a, 3a-7a, 7a-11a, 11a-3p, 3p-7p, 7p-11p) for the Emergency Departments. We received staffing data in four-hour increments from RGH for all units. The underlying four-hour blocks are included in the report, but the contractual language that triggers the financial penalty deals with twelve-hour shifts, defined as "the full duration of 7 AM to 7 PM and 7 PM to 7 AM." We have therefore combined the six daily four-hour blocks into two daily twelve-hour shifts for the top-level numbers.

The contract also specifies that staffing be calculated on "a hospital-wide basis." We have included the underlying unit-by-unit staffing numbers, though it should be noted that the percentage given as "understaffed" for each of these is an underestimate, as it counts a nurse who was scheduled to work but called out sick as still being present in the staffing numbers. The

hospital has the obligation to account for sick calls, but the enforcement mechanism in our contract provides that sick calls exceeding 3% of scheduled RNs hospital-wide not be removed from the numbers. As this was not relevant for the underlying unit-by-unit numbers, all scheduled nurses are counted in the staffing calculations for the unit-by-unit numbers.

Using the above example of the MICU on March 27, we are crediting the hospital with the 10 scheduled RNs from 3pm to 7pm, even though one was sick, causing the actual number of working RNs to fall to 9, when 13 were required for minimum safety in the hospital's clinical staffing plan.

Hospital-wide, the sick calls make a difference on whether the hospital was understaffed or not on only a single shift: from 7pm on January 20 to 7am on January 21, a sufficient number of nurses were initially scheduled, but sick calls caused the hospital to fall below safety minimums. Sick calls are a normal part of a 24/7 healthcare setting, and if even three RNs out of 160-170 scheduled can disrupt the staffing plan, then the hospital is not sufficiently staffing to account for basic facts.

On all other shifts during the quarter, the number of total RNs scheduled failed to meet the number of RNs required to meet the clinical staffing plan's safety minimums hospital-wide. As patient census fluctuates shift by shift, it is important for a hospital administration to schedule enough nurses to respond to changing patient care needs. A hospital falling below safety minimums frequently is a sign that staffing practices should be adjusted; a hospital falling below safety minimums on every single shift is a sign of dangerous mismanagement.

Both the clinical staffing plan and the actual staffing numbers are included in this report, along with the analysis performed by the program and then manually checked.

The file titled *RGH Clinical Staffing Plan* contains unit-by-unit staffing grids. These represent the minimum staffing numbers each unit requires for the number of patients; they were set by the RGH Clinical Staffing Committee and filed with the New York State Department of Health.

The files titled *RGH Staffing Dashboard* contain unit-by-unit staffing numbers for each month provided by RGH administration.

The files titled *RGH Monthly Staffing Analysis – January 2025, February 2025, and March 2025* contain the output of the program commissioned by RUNAP to compare these numbers. It combines the different rows for bedside RNs (excluding orientees) and compares the actual number of RNs working on a shift to the minimum required by the clinical staffing plan for the present number of patients (the "census"). There are pages for each unit, for the hospital-wide numbers, and for a monthly summary.

The file titled RGH Staffing Analysis – Q1 2025 Summary is a one-page worksheet summarizing the hospital-wide numbers for the entire quarter.

Note on dates: a day is tracked in the numbers provided by RGH as beginning at 7am. So, the first shift in the quarter begins at 7am on January 1, 2025, and the date doesn't roll over until 7am on January 2, 2025. The four-hour block listed as 3am to 7am on January 1, then, actually occurred in the early morning of January 2.

Missing or Erroneous Data

Certain units covered by the clinical staffing plan have no data for some or all of the quarter. For instance, B7 (a.k.a. 7000) was closed in December 2024, so there is no data for the quarter. Another unit, 4500, operated only in January.

However, there are other units missing data for days when we believe patient care was being provided. RGH administration has yet to provide clarification on these cases. We are concerned that the hospital may not be correctly keeping records of important patient care information.

Further, during a preliminary analysis, we discovered that, on at least one unit, erroneous numbers were being reported. 3800, an Orthopedic/Surgical unit, currently uses an off-site “virtual care” nurse on Monday-Friday day shift, who is not supposed to be counted in the bedside staffing grid. Even if they can help with documentation remotely, a virtual nurse cannot catch a falling patient. However, the numbers provided for at least some shifts on that unit did, in fact, count that nurse as if they were working on the floor providing direct patient care, rather than being in another facility a mile away. We brought this to hospital administration’s attention and they apologized for the error, but they have not confirmed how often these numbers were misreported or if this practice has stopped altogether.

For now, we are using the numbers provided by the hospital, as that is what is called for in the union contract. Calculations have also been repeatedly complicated by inconsistent and changing formats for the staffing reports provided by hospital administration.

RRH Administration’s Response

We met with RRH and RGH administrators to discuss this data twice—once in a preliminary meeting on March 10, when we discussed data for Q4 2024 and the beginning of Q1, and once during a class-action grievance hearing on April 28.

On March 10, RUNAP and RGH compared methods of staffing analysis. RGH’s team called the meeting to a halt when they discovered that one of their administrators had been calculating the staffing numbers incorrectly. They had been counting a “shift” not as a shift on a unit or in the hospital, but as an individual nurse’s shift. So, for example, if there should have been 10 RNs for safe patient care and there were only 9, RUNAP counted that as one understaffed shift, while RGH counted that as 9 “staffed shifts” and 1 “unstaffed shift.” This was clearly problematic, causing RRH’s lawyers to pull their team into a private caucus until the end of the meeting. However, we have never received confirmation that they have corrected their method of analyzing understaffing.

On April 28, RUNAP presented a preliminary version of the report being released today to RGH/RRH administrators. Some unit-by-unit numbers were not yet final due to inconsistencies in RGH’s documentation, which have since been corrected by RUNAP. We presented the top-level number - 100% of shifts were understaffed hospital-wide between January 1 - March 31- as well as the raw data analysis showing our calculations. Administrators who have long attempted to blame understaffing on workers calling out sick seemed surprised by the fact that they were not even scheduling enough nurses in the first place. They asked us

questions about what the underlying staffing data counted, despite the fact that they were the ones who provided it.

This time, they did not present any argument or analysis of their own, despite our pressing them. It gave the unsettling impression of a hospital administration completely out of touch and unaware of what is happening in their facility, even after years of bedside providers sounding the alarm on the reality of unsafe staffing at RGH.

On May 6, hospital administration informed us that they did not agree with our analysis or interpretation of the contract but did not give any reason. The only time RGH/RRH administration has substantially laid out their position was in the March 10 meeting where, in addition to incorrectly calculating understaffing, they put forward an incredible claim about their obligation to properly staff the hospital.

RGH's contract with RUNAP states that a shift is defined as the full duration of 7am to 7pm or 7pm to 7am. This clearly means that they are obligated to staff the hospital for the full duration of each shift. However, on March 10, they suggested that if they had the proper staffing for even four hours out of twelve, then the shift "wasn't understaffed for the full duration." Not only is this a tortured reading of the contract language, but it is an unconscionable claim coming from a hospital administration. If a patient suffers a bad outcome because there aren't enough nurses at 11am, that isn't undone because an extra nurse arrives at 3pm.

This erroneous interpretation would not fundamentally change the facts: even looking only at four-hour blocks, 91.94% were understaffed hospital-wide in January, 98.21% in February, and 93.55% in March. Overall, even if RGH administration incorrectly counted a "partially" staffed twelve-hour shift as safely staffed, that would leave 90% of shifts fully understaffed, well in excess of the 10% understaffing trigger for the financial penalty.

Ultimately, the fact of RRH administration being fined is only important insofar as it draws attention to the unacceptable conditions in the hospital. There is no way to slice the numbers that do not paint a frightening picture of patient care in our community.

The Way Forward

By organizing our union and fighting for improvements, RUNAP nurses have already begun to turn the tide on staffing. However, the impact has been uneven across units, and the hospital continues to cut travel nurse contracts and ignore nurses' concerns with their working conditions and management environments that drive turnover. By filing for arbitration on RGH's denial that they've triggered the financial penalty, nurses are prepared to fully defend the reality of unsafe staffing and demand that RGH prioritize meaningful patient care. In addition to filing for the financial penalty, on May 1 we presented RGH President Tammy Snyder with the following demands in a petition signed by almost 1000 bedside providers:

- Not cutting the staffing minimums for 5400, 5500, or any other unit.
- Following the grids when scheduling and not floating nurses away below grid.
- Not taking nurses or other staff away from the bedside and forcing them behind an off-site "virtual care" screen against their will, as administration has repeatedly proposed.

- Updating all in-patient unit grids to include a free charge nurse without an increase in nurse-to-patient ratios.
- Entering into expedited bargaining with RUNAP on staffing incentive programs and a comprehensive retention program.

Additionally, RGH has recently reneged on commitments to end unhealthy shift rotation practices - where nurses can be required to frequently rotate between day and night shift - and compensating preceptors, experienced nurses who orient new hires.

Shift rotation is a significant driver of turnover which many other hospitals have long since ended, and in our October 2023 contract, RGH committed to ending shift rotation on half of all units within a year and then continuing beyond that. Now, they're saying there's never been an agreement and refuse to meaningfully engage in solving the problems that will help recruit and retain nurses.

Similarly, they committed to compensating nurses for precepting new hires, which is an industry-standard practice. Other than an unworkable proposal that would have seen one nurse training two new hires on the same shift, they have refused to move on this. This causes fewer experienced nurses to be willing to precept, making new nurses train new nurses.

These are issues that RGH administration can solve immediately to improve nurse recruitment and retention, while working with RUNAP nurses on longer-term solutions like reinstating a hospital-wide float team, which could cover daily holes from sick calls (a team that did exist for many years until RRH administration chose to end it for reasons that remain unclear).

We delivered our petition to Tammy Snyder because she was the highest-level administrator in the building. However, we know from dealing with administration for years now that neither she nor anyone else at RGH makes financial or other staffing decisions. Rochester Regional Health micromanages everything from their system-wide finance office, with decision-making many layers away from the nurses, doctors, therapists, technicians, and other staff actually providing patient care.

We ask the Rochester community to stand with us in calling on RRH CEO Richard "Chip" Davis and every member of the RRH Board of Directors to treat these staffing conditions as the emergency that they are and sit down with us to find solutions. Rochester deserves better!