CARE CRISIS
HOW LOW STAFFING CONTRIBUTES TO PATIENT CARE FAILURES AT HCA HOSPITALS
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ABOUT SEIU

More than one million healthcare workers across hospitals, in-home care, and in nursing homes are united in the Service Employees International Union (SEIU), the nation’s largest union of healthcare workers. SEIU is an organization of nearly 2 million members united by a belief in the dignity and worth of workers and the services they provide. SEIU is dedicated to improving the lives of workers, families, and communities to create a more just and humane society.
HCA Healthcare is the largest hospital company in America and is widely regarded as an industry leader, with more than 180 hospitals in some 20 states and more than 280,000 total employees.

As this report documents, HCA routinely engages in practices that maximize profits at the expense of patient care, working conditions, and responsible corporate behavior. HCA staffs its hospitals at very low levels, typically about 30% below the national average, according to analysis of Medicare cost report data. This trend of low staffing at HCA hospitals reflects an intentional corporate strategy that long predates the COVID pandemic. In particular, Medicare cost report data shows staffing levels routinely and precipitously drop after HCA acquires a hospital.

Short staffing saves HCA billions each year. These billions are costs borne by patients, as lower staffing levels are associated with inferior patient care. The accompanying report includes an extensive review of hospital inspections and lawsuits, which reveal patient safety failures and quality concerns linked to low staffing at HCA’s hospitals. HCA safety and quality failures include examples of outright inadequate staffing, such as low staffing in telemetry units leading to patient deaths.

The costs from short staffing are also borne by people working in HCA hospitals, who are overstretched and often in dangerous situations because of HCA’s low staffing levels. According to a January 2022 survey of over 1,500 frontline nurses and healthcare workers at HCA hospitals, nearly 80 percent reported witnessing patient care being jeopardized due to low staffing.

Many hospitals—especially smaller, independent rural hospitals—find themselves needing to cut staffing in order to remain solvent. This is not HCA’s story. HCA is the largest hospital system in the country, with nearly $60 billion in annual revenue. The company has been consistently profitable since its most recent public offering in 2011. HCA, founded in 1968, has gone through periods of being both publicly traded and privately held. The most recent public offering was in 2011, following a mammoth leveraged buyout in 2006.

Rather than invest in its workforce, HCA uses its profits to line the pockets of investors through share buybacks. In 2021, HCA earned close to $7 billion in profits, its highest profits since the 2011 IPO. HCA chose in 2021 to repurchase $8 billion worth of the company’s stock from their shareholders. This is a regular theme for HCA: Since the company’s IPO in March 2011, HCA has paid to its investors more than $4.9 billion in dividends and $26.9 billion in share repurchases, a total of over $32.2 billion in payouts.

While share repurchases are common in many industries, HCA stands out for having the highest share repurchases in the healthcare industry and the 17th highest among all publicly traded companies in the U.S. in 2021. This volume of share repurchases is even...
more concerning given that roughly 40% of HCA’s revenue ($24 billion in 2021) comes from the taxpayer-funded Medicare and Medicaid programs—a staggering use of public funding to facilitate the transfer of wealth to private shareholders.

HCA could use these billions of dollars to invest in its workforce rather than reward shareholders. Instead, HCA has trotted out what it calls “new models of care,” which include sending nurses to the bedside without adequate training (such as being asked to insert a feeding tube into a patient without training on that specific task) and requiring nurses and other employees to perform out-of-scope duties (for example, security guards being expected to serve as patient sitters, or EMTs performing the duties of ER staff). Moreover, when HCA’s own employees express concern about the safety of staffing levels, they often experience retaliation. In one notable example, a nurse expressed concern that ICU nurses were being assigned more patients than the monitoring equipment could handle. She was fired, and she reported in an online blog that at least two patients from her hospital died in the ICU because of unsafe staffing and insufficient monitoring.

The staffing crisis in HCA’s hospitals has also long predated the COVID-19 pandemic. COVID made the situation even worse, as HCA refused to provide adequate PPE. One hospital in California was fined by the state OSHA department for withholding N95 masks. Yet, rather than prioritizing the needs of its employees in dealing with an unprecedented, highly transmissible disease, HCA focused on returning to business as usual with elective surgeries as quickly as possible. It should come as no surprise that HCA has been highly profitable through the pandemic—$3.8 billion in profits in 2020, and close to $7.0 billion in 2021. HCA even returned $6 billion in federal CARES Act funding in October 2020 because the company did not need it. These profits could have been used by HCA to invest in its frontline workforce and address its ongoing staffing crisis, rather than to reward company shareholders.

A thorough examination of a wide variety of data on quality of care—from hospital inspection reports, CMS’s Care Compare website, and countless lawsuits—reveal strong evidence of staffing-related quality breakdowns in HCA hospitals. This includes higher death rates from pneumonia, higher readmission rates for certain conditions such as heart failure and pneumonia, and very troubling evidence concerning bedsores suggesting that HCA may be avoiding Medicare financial penalties by engaging in practices that discourage employees from documenting the most severe hospital-acquired bedsores. It also includes multiple concerns about staffing levels in HCA’s telemetry units, where monitor techs are routinely required to be responsible for dangerously high numbers of patients. Additionally, this report documents patterns of avoidable patient care failures and patient harm linked to low staffing levels such as missed nursing assessments, delays in patient treatment, patient falls, and other instances of the endangerment of patients.

Given these facts, HCA hospital workers across the country are calling on the company to put patients ahead of profits and address its staffing crisis:
- **Raise staffing to safe levels.** HCA’s facilities need safe staffing—inclusive of all care and services jobs.

- **Pay living wages for all workers.** Tens of thousands of HCA’s workers make poverty wages, and rising inflation has squeezed the budgets of households across the country. All HCA workers deserve wages that allow them to provide for their families and get ahead.

- **Provide safe workplaces.** Policies must prioritize protecting health workers from workplace violence and ensure that they have sufficient personal protective equipment.

- **Not retaliate for expressing safety concerns.** All healthcare workers need to be able to advocate for staffing levels and other conditions that are safe for patients and workers. Workers should not be retaliated against when they advocate for their patients and themselves.
In August 2019, Norma Mae Fittsgill was admitted to HCA Houston Healthcare Clear Lake for surgery to remove a mass in her brain, after which she stayed in the hospital and experienced multiple, severe quality of care failures due to low staffing levels according to a lawsuit filed by the patient’s family. In the lawsuit, Ms. Fittsgill’s family alleges that HCA Houston Healthcare Clear Lake staff told them that the floor where Ms. Fittsgill was being treated was “severely understaffed.” This allegedly led to Ms. Fittsgill not being provided “proper toileting and continence care, which resulted in her laying in her urine and feces for hours at a time and caused her to develop a bladder infection and sores to her genitalia and bottom.” When her family requested that staff assist Ms. Fittsgill with such activities, their complaints were ignored due to staffing shortages.4

According to the suit, Ms. Fittsgill also suffered the withholding of her pain medication “for hours at a time while at the facility due to nursing staff shortages.”5 She experienced numerous falls because, her family claims, the hospital failed to follow fall prevention protocol despite her high risk for falls. Additionally, Ms. Fittsgill developed pressure ulcers due the alleged failure of hospital staff to reposition her in accordance with standards of care.

After complaints, Ms. Fittsgill’s family claims that Texas Health and Human Services conducted an inspection of HCA Houston Healthcare Clear Lake and cited the hospital for deficiencies concerning Ms. Fittsgill’s care.

The lawsuit asserts that the understaffing at HCA Houston Healthcare Clear Lake was a purposeful business decision with disastrous consequences:

“Based on information and belief, Defendant [HCA Houston Healthcare Clear Lake] engaged in a systematic process of ensuring that their medical facility maintained the highest acuity levels possible while at the same time providing insufficient capitalization and staff to meet the individual needs of their patients during the time that Norma Fittsgill was a patient in the facility. This purposeful undercapitalization and understaffing directly resulted in the failure of their facility to provide the necessary and basic services that Norma Fittsgill needed to prevent her from sustaining the injuries pleaded herein.”6

Ms. Fittsgill’s ordeal is not an isolated incident. Sadly, hers is just one of many patient quality breakdowns due to low staffing levels seen across HCA’s entire health system.
Short-staffing also has a profound impact on frontline worker health, safety and well-being at HCA-owned hospitals. For example, Michelle Harvey is a surgical tech at HCA’s Del Sol Medical Center in Texas who is concerned that HCA’s low staffing levels are jeopardizing worker and patient safety.

“People are leaving HCA because they believe their licenses are at risk due to under-staffing. The possibility of patient care failures due to short-staffing is a constant concern for us. We often don’t get adequate breaks. We regularly miss lunch breaks. We might have just a couple of 10-minute breaks during a 12-hour shift.

Those of us who stay feel like we are pushed to the breaking point by short-staffing. When we are short-staffed, we don’t get relieved at the end of our shift, even if we’ve been working 12 hours – we are just left in the room. No one comes to ask or inform us. I believe the longest shift I have worked at Del Sol was 26 hours straight.”

Erika Watanabe, a surgical technician at an HCA hospital in Nevada also has to stay long past her shifts to compensate for the hospital’s insufficient staffing. Often, no one is scheduled to replace her at the end of her shift, so she is pressured to stay and continue working to ensure that patient surgeries can keep being conducted safely. This leads to her sometimes working an extra 12 hours on top of a scheduled shift meaning a 20-hour work day in total. She says, “it’s hard to remain at my sharpest on the 19th or 20th straight hour of working.”
1.1 STAFFING OVERVIEW

With over $58 billion in revenues and approximately $7 billion in profits in 2021, HCA Healthcare (hereinafter “HCA”) is the nation’s largest for-profit hospital system and one of the most profitable in the world. HCA is also one of the largest employers of healthcare workers in the country, with approximately 284,000 employees as of December 31, 2021. With an estimated 5.6 million hospital workers in the entire United States, this suggests that around 1 in 20 hospital workers in the USA currently works for HCA.

HCA’s relentless focus on holding down labor costs is a big driver of the company’s high profits. HCA pays tens of thousands of its employees poverty wages, and has significantly lower than average staffing levels despite the fact that higher staffing levels are associated with better patient care.

As shown in Figure 1 below, our analysis of CMS cost report data shows a concerning and consistent pattern of lower-than-average staffing ratios at HCA’s facilities nationwide. In 2020, HCA had about 30% less staff per adjusted occupied bed than the national average for acute care and critical access hospitals.

This metric of full time equivalent staff (FTE’s) per adjusted occupied bed represents the number of staff at a hospital compared to the number of patients. (In this report, we refer to this metric as the "FTE ratio" or "staffing ratio.") A higher FTE ratio indicates more staff per patient, and a lower ratio indicates fewer staff per patient.

Figure 1 shows HCA’s system-wide staffing ratio compared to other hospitals broken down by ownership type. The HCA system, which includes 3.5% of hospitals in the analysis, has a system-wide staffing ratio average significantly lower than the average for any type of hospital. Non-profit hospitals, which represent 61% of hospitals in the analysis, have an average staffing ratio very close to the national average. For-profit hospitals excluding HCA (representing 14.6%, of hospitals in the analysis) have an average staffing ratio lower than the national average, but on average still 1.0 more FTE’s per adjusted occupied bed than HCA.

Figure 1. Staffing Ratio (Full Time Employee per adjusted occupied bed)
In 2020, HCA's weighted average state staffing ratios were lower in 19 out of 20 states in which they operated.

HCA's low staffing ratios have a huge impact on healthcare workers and the patients in their care. According to a January 2022 survey of more than 1,500 frontline nurses and healthcare workers at HCA hospitals, 83% agreed or strongly agreed with the assertion, “I feel my floor or unit does not have the right level of staff for the patients I care for or
Low staffing ratios impact the physical, mental and emotional health of frontline caregivers at HCA hospitals.

- Michelle Harvey, an HCA surgical tech in Texas, explains the toll short-staffing has taken on her health, "Once at the end of my fourth straight 12-hour shift, I got out of a case, and I nearly passed out. I ended up in the ER for severe dehydration. My blood pressure spiked, and my blood sugar plummeted. I needed IV fluids." While she loves her job, she fears for her patients, coworkers, and herself. HCA management seems less concerned. During the incident, her manager came to check on her in what she initially believed to be an act of concern. Instead, the manager left immediately when told she would be unable to work her shift that night.

- Rublas Ruiz, an ICU nurse at HCA’s Kendall Hospital in Florida, said, “Constant short-staffing makes our work so difficult. When we are constantly short-staffed, the risk of delay of care and patient care failures goes way up.”

- Even in California, which passed mandated minimum nurse to patient staffing ratios years ago, patient care is still jeopardized by short staffing.
  
  - CNAs and other non-nurse patient care staff in that state do not have mandated staffing ratios. “Patient and worker safety is not there due to the lack of staffing,” said Xochitl Gonzalez, a certified nursing assistant at HCA’s Los Robles Medical Center in Thousand Oaks, California. Gonzalez noted she is currently expected to cover up to 30 patients throughout the day.
  
  - Monique Hernandez, an ICU nurse at HCA’s Riverside Community Hospital in Riverside, California, said said understaffing in her hospital’s laboratory is so severe that staff struggle to perform essential tests.

HCA workers in multiple states have attempted to push back on unsafe staffing assignments through a number of avenues when speaking up to management, but it has been a struggle to win lasting improvements. Hospital staff have used public actions, informational picketing, and Assignment Despite Objection (“ADO”) reports to raise their concerns. According to Rublas Ruiz, an HCA nurse in Florida, just in the HCA hospitals where 1199SEIU caregivers work, his union has compiled over a thousand ADO reports, with “truly disturbing outcomes.” Registered nurses (“RNs”) from SEIU 121RN in California went on a 10-day safety strike over short-staffing at Riverside Community Hospital in June 2020. Monique Hernandez, who took part in the strike says, “every nurse will come together for one purpose and that’s for safe staffing. We know what can happen if you don’t staff us correctly. That means somebody’s family member is getting lesser care.”
Comments from HCA executives suggest that low staffing is a deliberate strategy by HCA to keep costs down and profits up. HCA’s CEO Sam Hazen has said, “Our productivity is at a very efficient level when it comes to employees per patient.” This suggests that the ratio of healthcare staff to patients is a metric that HCA management follows closely.

Indeed, in addition to having lower staffing ratios than non-profit and for-profit averages, HCA-owned hospitals are remarkably consistent in their FTE per adjusted occupied bed ratios. While our analysis showed a wide range of staffing ratios at U.S. hospitals, HCA’s hospitals are clustered more tightly around the system average of 3.9 FTE’s per adjusted occupied bed. This is illustrated in Figure 2 below.

Figure 2. Distribution of FTE ratios at HCA vs. Non-HCA hospitals

That HCA’s FTE ratios are so heavily clustered in the 3.0-4.5 range suggests that HCA’s stated intention to keep the number of staff per patients at “a very efficient level” has been quite successful at the facility level.

Another illustration of HCA’s corporate strategy is that FTE rates have gone down at recent HCA acquisitions, especially those that were previously operated by non-profit organizations.

In Georgia, HCA bought two hospitals in 2017 and 2018 — Memorial Satilla Health in Waycross and Memorial Health University Medical Center in Savannah. As shown in Figure 3 below, staffing levels in both of those hospitals dropped after HCA took over, and in 2020, both Memorial Satilla Health and Memorial Health University Medical Center had significantly lower FTE ratios than the Georgia average.
In North Carolina, when HCA acquired the Mission Health system in the Asheville region in early 2019, staffing decreases were raised as major reasons for concern about the sale.\textsuperscript{22} Indeed, cost report data for Mission Health hospitals confirms that from the year before the sale (2018) to the year after the sale (2020), there was a \textbf{26\% drop} in the total number of full-time equivalent employees ("FTE’s") on the payroll of Mission Health hospitals.\textsuperscript{23} That’s approximately 1,950 fewer staff than the system’s hospitals had before it was bought by HCA. Figure 4 below illustrates that between 2018 and 2020 the FTE ratios of facilities within the Mission Health System fell significantly lower than state average.\textsuperscript{24}

After these hospitals joined the HCA system, their staffing per patient dropped to the "efficient" level favored by HCA’s corporate organization. This further indicates that HCA’s operating practices include controlling the staffing levels at hospitals it owns so that they match the corporate strategy.
However, “efficient” staffing levels come with a huge price. In February 2020, approximately one year following HCA’s takeover of Mission, local and state officials signed an open letter to the independent monitor overseeing HCA’s compliance with the Mission Health sale terms because “concerns have been pouring in from distressed patients, practitioners and HCA employees.” The open letter goes on to say:

“With HCA heavily focused on the bottom line, there have been numerous, aggressive staff cuts over the past year, putting patient safety at risk. Certified nurse assistants and unit secretaries have been cut dramatically or eliminated, putting new pressure on nurses. Patient to nursing staff ratios have also increased and some departments have seen an exodus of nurses, further stressing the remaining nurses.”

Kelley Tyler, a 37-year Mission employee, testified earlier this year at a joint FTC/DOJ hearing to shed light on how this short staffing impacts her day-to-day work and to “share the devastation our community has experienced since HCA Healthcare, the world’s largest and wealthiest health care system, bought Mission.” Tyler notes that prior to the sale, her trauma care unit had 13 RNs and 5 CNAs to care for 36 patients. Now that unit has 44 patients but only 9 RNs and 4 CNAs, with “a one-to-five ratio on a good day.” She adds, “The reality is more than often a one-to-seven ratio,” and “This only allows eight minutes per patient each hour with little to no assistance. We’re not able to give the best quality care in the situation. Nursing under these circumstances is more like factory work.”

Mission nurses overburdened, patients suffer

Thirty-year nurse veteran Amy Waters saw support staff being cut after HCA took over Mission Health, including certified nursing assistants (CNAs), housekeeping, and food service staff. Nurses also departed, often replaced by part-time or traveling nurses, if at all.

But as the pandemic has raged on since March 2020, HCA’s continued practice of understaffing has only exacerbated the strain and burden placed on our nation’s frontline healthcare workers. As NPR reported, “During the pandemic, [Waters’s] fears only worsened. At times, nurses cared for seven patients at once, despite research indicating four is a reasonable number.” Mission nurses also note that “short staffing has become a daily occurrence,” with RNs being asked to do more with less and to work with no meal or rest breaks. For example, nurses have taken on other tasks as HCA cut back on support staff, including housekeeping and blood draws because of a phlebotomist shortage.
1.3 **FINANCIAL ANALYSIS**

**PROFITS, NOT PATIENTS**

The result of HCA’s quest for “efficient” staffing levels has been remarkable financial success. HCA is the largest health system in America\(^{33}\) and one of the wealthiest health systems in the world\(^{34}\) with unprecedented financial dominance. In fact, the company generates more revenue and more than three times as much profits as the three other leading publicly traded acute-care hospital systems combined. (See figures below.) It is essential to keep in mind that labor costs are the largest expense item for hospitals by far,\(^{35}\) typically representing over half of hospital expenses according to Healthcare Financial Management Association.\(^{36}\)

![Figure 5. Publicly Traded Acute Care Hospital Systems 2021 Revenues\(^{37}\)]

![Figure 6. Publicly Traded Acute Care Hospital Systems 2021 Net Income\(^{38}\)]

Additionally, unlike many health systems that struggled financially during the pandemic, HCA’s profits soared, jumping from $3.5 billion in 2019 to close to $7 billion in 2021.\(^{39}\)

HCA’s sky-high profits are unsurprising given the company’s low staffing levels, again because labor is the largest single cost center for hospitals. However, instead of investing in its workforce and patient care, HCA has chosen to prioritize its investors. Since the company’s IPO in March 2011, HCA’s has paid out over $4.9 billion in dividends and $26.9 billion in
share repurchases, or over $32.2 billion to investors. Dividends are cash payments directly made to investors based on how many shares of stock they hold. Share repurchases are transactions where companies use cash to repurchase their stock from the marketplace. By reducing the number of shares publicly available, share repurchases benefit investors by boosting stock prices and per share financial metrics like earnings per share (“EPS”).

In 2021, during the height of the pandemic and fueled by its $7 billion in profits, HCA made over $8 billion in share repurchases alone. HCA’s share repurchases were so high, that out of thousands of publicly traded companies, HCA had the 17th largest share purchases that year. (See Figure 7 below.) Additionally, HCA had the most share purchases in 2021 of any company in the US healthcare industry. (See Figure 8 below.)

**Figure 7. Top 20 US Companies: 2021 Share Repurchases ($ in billions)**

<table>
<thead>
<tr>
<th>Company</th>
<th>Share Repurchases</th>
<th>Market Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Apple Inc. (NasdaqGS:AAPL)</td>
<td>$88.3</td>
<td>$2,494.0</td>
</tr>
<tr>
<td>2    Alphabet Inc. (NasdaqGS:GOOGL)</td>
<td>$50.3</td>
<td>$1,423.9</td>
</tr>
<tr>
<td>3    Meta Platforms, Inc. (NasdaqGS:META)</td>
<td>$50.1</td>
<td>$473.4</td>
</tr>
<tr>
<td>4    Microsoft Corporation (NasdaqGS:MSFT)</td>
<td>$29.2</td>
<td>$1,947.2</td>
</tr>
<tr>
<td>5    Oracle Corporation (NYSE:ORCL)</td>
<td>$28.0</td>
<td>$199.6</td>
</tr>
<tr>
<td>6    Berkshire Hathaway Inc. (NYSE:BRK.A)</td>
<td>$27.1</td>
<td>$631.3</td>
</tr>
<tr>
<td>7    Bank of America Corporation (NYSE:BAC)</td>
<td>$25.1</td>
<td>$268.6</td>
</tr>
<tr>
<td>8    JPMorgan Chase &amp; Co. (NYSE:JPM)</td>
<td>$18.4</td>
<td>$336.5</td>
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<tr>
<td>9    Charter Communications, Inc. (NasdaqGS:CHTR)</td>
<td>$15.4</td>
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<tr>
<td>10   The Home Depot, Inc. (NYSE:HD)</td>
<td>$14.8</td>
<td>$315.1</td>
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<td>11   Wells Fargo &amp; Company (NYSE:WFC)</td>
<td>$14.5</td>
<td>$163.7</td>
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<tr>
<td>12   The Procter &amp; Gamble Company (NYSE:PG)</td>
<td>$13.5</td>
<td>$343.1</td>
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<tr>
<td>13   Lowe’s Companies, Inc. (NYSE:LOW)</td>
<td>$13.0</td>
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<td>14   Morgan Stanley (NYSE:MS)</td>
<td>$12.1</td>
<td>$142.0</td>
</tr>
<tr>
<td>15   Visa Inc. (NYSE:V)</td>
<td>$11.1</td>
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<td>16   Walmart Inc. (NYSE:WMT)</td>
<td>$9.8</td>
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<tr>
<td>17   HCA Healthcare, Inc. (NYSE:HCA)</td>
<td>$8.2</td>
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<tr>
<td>18   Citigroup Inc. (NYSE:C)</td>
<td>$7.9</td>
<td>$100.5</td>
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<tr>
<td>19   Cigna Corporation (NYSE:CI)</td>
<td>$7.7</td>
<td>$85.4</td>
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<tr>
<td>20   American Express Company (NYSE:AXP)</td>
<td>$7.7</td>
<td>$114.7</td>
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</table>

*Source: CapIQ, Market Capitalization as of July 22, 2022*
Many experts agree that share repurchases are a problematic, short-sighted use of company capital. In 2020, the Harvard Business Review published the article "Why Stock Buybacks are Dangerous for the Economy" which notes that stock buybacks make no contribution to the productive capabilities of a company, lead to increased income inequity and employment instability, and enable senior executives to manipulate their companies' stock prices.  

Given the already problematic nature of share purchases, it is egregious that in a list dominated by technology and financial industry giants, HCA stands out for being a healthcare provider who receives over 40% of its revenues from taxpayer funded Medicare and Medicaid programs (see Figure 9 below).

Figure 8. Top 10 US Healthcare Companies: 2021 Share Repurchases ($ in billions)

<table>
<thead>
<tr>
<th>Company</th>
<th>Share Repurchases</th>
<th>Market Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCA Healthcare, Inc. (NYSE:HCA)</td>
<td>$8.2</td>
<td>$59.7</td>
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<td>Cigna Corporation (NYSE:CI)</td>
<td>$7.7</td>
<td>$85.4</td>
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<td>Bristol-Myers Squibb Company (NYSE:BMY)</td>
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<td>UnitedHealth Group Incorporated (NYSE:UNH)</td>
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<td>Amgen Inc. (NasdaqGS:AMGN)</td>
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<td>$131.4</td>
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<tr>
<td>Johnson &amp; Johnson (NYSE:JNJ)</td>
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<tr>
<td>Regeneron Pharmaceuticals, Inc. (NasdaqGS:REGN)</td>
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<td>$63.2</td>
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<td>Abbott Laboratories (NYSE:ABT)</td>
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<td>McKesson Corporation (NYSE:MCK)</td>
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<tr>
<td>Quest Diagnostics Incorporated (NYSE:DGX)</td>
<td>$2.2</td>
<td>$15.3</td>
</tr>
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</table>

Source: CapIQ, Market Capitalization as of July 22, 2022

Figure 9. Tax payer funded government programs made up 41% of HCA's revenues in 2021
HCA’s Low Staffing Strategy Is Not Sustainable

After many years of keeping labor costs low by tightly controlling the staffing levels in its hospitals, HCA faced a cataclysmic staffing emergency during the COVID-19 pandemic. Following larger healthcare industry trends, HCA saw skyrocketing labor costs due to staffing shortages connected to surges in COVID-19 cases and higher than normal workforce turnover. These staffing surges in turn caused an increase need to use expensive contract staffing. According to HCA’s CEO Samuel Hazen, “the challenging labor market pressured margins as the cost of labor increased more than we expected ... we experienced higher levels of contract labor expenses than planned. ... In some situations, the challenges in the labor market also constrained our capacity, preventing us from delivering hospital services to certain patients.”

While good pay and safe working conditions are the foundation of any sustainable business, HCA’s response to a tighter labor market appears to be doubling down on its existing strategies. Here are some of the problematic and unsustainable strategies to reduce staffing costs touted by HCA management on recent calls with investors:

**STRATEGY #1: MANAGING THE NUMBER OF STAFF PER PATIENT**

“Our productivity is at a very efficient level when it comes to employees per patient. So we’re managing on that front as well as we possibly can.” - HCA CEO Samuel Hazen

HCA may tell its investors that its staffing levels are efficient, but in practice this emphasis on “efficiency” translates to low staffing levels. By keeping staffing levels “efficient” (low), HCA has been able to drastically boost company profits. This might sound like a great strategy for rewarding investors. However, there are huge consequences to prioritizing profits over patients. Many burnt out HCA workers feel underpaid, undervalued, understaffed and unsafe, making them consider whether it is worth it to stay with the company. As seen in Figure 10 below, almost half of recently surveyed HCA workers in Florida were considering leaving their job.

**Figure 10. Worker Burnout**

<table>
<thead>
<tr>
<th>Considering Leaving your Job at HCA hospital</th>
<th>Top Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1. Not Paid Enough</td>
</tr>
<tr>
<td>47%</td>
<td>2. Not Feeling Valued</td>
</tr>
<tr>
<td>53%</td>
<td>3. Unsafe Staffing</td>
</tr>
<tr>
<td>No</td>
<td>4. Unsafe Working Conditions</td>
</tr>
</tbody>
</table>
HCA workers have noticed high turnover and unfilled positions at their hospitals that further contribute to short staffing.

- Rublas Ruiz, an HCA Florida nurse, said that “nurses and other caregivers are leaving now because they don’t want to work where they don’t feel supported, or where their license is not safe.

- Monique Hernandez, an HCA California nurse, noted that ancillary staff are scarce at her hospital, which makes it hard for her and her coworkers to ensure that patients get timely tests and scans. As for RN’s, she says “the relentless shortcomings and stressors put on nurses are causing the system to break down from the inside out. The new generation of nurses have healthy boundaries and will fight anything. They are quickly noticing nursing in these conditions is not for them. They plan to do this for a short time and then go out to travel. We’re losing the experience and knowledge from a long-time nurse because younger nurses aren’t going to stay. When they are pushed too hard they leave, and so we are becoming a revolving door.”

- Erika Watanabe, an HCA Nevada surgical technician, says HCA has given two market-adjustment raises to nurses recently, but none for ancillary staff, which makes it hard to fill positions as the cost of living rises. The lack of recent raises makes it hard for the hospital to recruit for important support positions that ensure quality patient care such as patient care technicians, surgical technicians, and environmental services workers.

- Michelle Harvey, an HCA Texas surgical tech said, her hospital’s COVID unit was so short staffed, “that management is offering huge bonuses for a two-year contract, but working conditions are so bad that people end up quitting within a few months, knowing that they’ll have to pay that bonus back.”

It is no surprise, then, that as many of its workers find employment elsewhere, HCA has resorted to using short-term contract employees to maintain operations at its hospitals, and still has had to turn away some patients because of a lack of staff.48

STRATEGY #2
NEW MODELS OF CARE

Towards the end of 2021, HCA started telling investors that the company was experimenting with “new models” of care to support nurses given the fatigue nurses were facing during the pandemic. Initially, it was described as “hiring more ancillary support to take some of the burden off of clinical nurses.”49 However, in subsequent calls, HCA has expanded on these “new models of care,” and the details are concerning.

“...And then looking at new models of care, can we support our nurses with patient care techs? Can we utilize paramedics in the emergency room? Can we utilize other service lines to take the burden off the nurses? So that helps ease the dynamic and even the cost burden that may occur over time.”

- HCA CFO William B. Rutherford
We are concerned that these “new models of care” require existing employees to perform out-of-scope duties for which they are neither trained nor qualified. HCA is effectively putting too much patient care responsibility on workers who are not properly equipped to do the work. By doing so, workers may be exposed to certain liabilities or hazards as a result. One example is a paramedic who was terminated after assisting in the ED of HCA Florida Ocala Hospital. He alleges in his employment retaliation suit that workers at the facility felt unsafe because security was “extremely lax” and “there is rarely any police or security presence.” Thus, “male staff, particularly paramedics ... are often forced to deal with violent and unruly patients.”

He alleges that in one such incident, he assisted one of the ER nurses with bringing a patient experiencing a psychotic episode to a more secure room, during which the patient became irate and threatening. He claims he put the patient in a physical hold because he feared for his life and it took several other ER staff, including another paramedic, to subdue the patient.

We are also concerned when we hear about efficiencies by sharing services through the alignment of departments:

“Many of these [resiliency programs] are advancing efficiencies through our next generation of shared services. Examples of these include a consolidation and alignment of laboratory operations, facility management, environmental and food and nutrition support areas.”

— HCA CFO William B. Rutherford

Combined with “new models of care”, these efficiencies sound like more unsustainable shortcuts where unqualified existing employees are asked to step up and fill in the gaping holes in care caused by HCA’s understaffing model. Unfortunately, these can lead to huge breakdowns in patient care.

For example, multiple HCA facilities have been cited for significant patient care failures due to having security staff provide direct patient care. TriStar Southern Hills Medical Center in Nashville, Tennessee, was placed into Immediate Jeopardy status by CMS after a patient who was being monitored by a security guard attempted suicide. The patient required immediate admission to the Critical Care Unit to treat their medication overdose. At Eastern Idaho Regional Medical Center, CMS found that while security officers were involved in patient safety incidents such as restraining patients, they did not submit incident reports in the hospital’s electronic health record. Consequently, officers had records of restraint incidents they performed that had not been entered into the hospital restraint log. Relying on non-clinical support staff such as security guards to fill gaps in clinical staffing has consequences for direct patient safety as well as for proper documentation and tracking of patient safety incidents.
STRATEGY # 3: RELYING ON INEXPERIENCED NURSES AND NURSING STUDENTS TO ADDRESS SHORTAGES

“We continue to be extremely excited about the strategic implications of having that nursing school. Our goal is to develop a Galen College of Nursing in every one of our major markets, and we’ve got expansion plans and sites for that. And if you think about it, it just makes perfect sense. They’re one of the largest educators of nurses. We’re one of the largest employers of nurses. So you can obviously see a natural fit for that...”

– HCA CFO Bill Rutherford

HCA presents its recruitment and in-house training of new RN nurses as a way to address the staffing crisis. HCA’s Galen College of Nursing advertises the opportunity for students to earn a 4-year BSN degree in only 3 years. However, there are significant consequences to staffing hospital units with nurses who have little experience. Studies have shown that “patients get the best care when treated in units staffed with nurses who have extensive experience in their current job,” because “[r]elative to novice RNs, experienced RNs are likely to be more adept at identifying complications and unexpected changes in patient conditions sooner and respond appropriately.” Studies have also found that experience is invaluable in a patient setting because experienced nurses “make clinical assignments that better match the knowledge and skills of nurses with the needs of the patient, serve as role models and mentors, and deal effectively with physicians, administrators, and others to assure the well-being of patients and their families.”

What’s more, HCA CEO Sam Hazen has said that the company is utilizing student nurses and externs to help alleviate its labor pressures and staffing shortages:

“We also believe that we have an opportunity to integrate those [Galen College of nursing] students into our organization to support current needs as well as hopefully create synergy as they graduate the program and want to come to work for HCA Healthcare... there will be some short run [gain] with nurse externs and rotations and so forth that we can utilize, hopefully effectively, to support current day needs.”

– HCA CEO Sam Hazen

HCA’s plan to rely on inexperienced nursing students and new nurses puts both workers and patients at risk of costly errors, especially given HCA’s questionable track record of ensuring proper competencies and training of its nursing staff as illustrated in the examples below.

Two lawsuits from families of former HCA patients in South Carolina claim that hospital staff failed to place breathing tubes correctly due, in part, to training and supervision failures. In one case, staff “utilizing an improper technique to intubate” led to the patient not receiving enough oxygen and ultimately dying. The other suit alleged that the hospital’s failure “to properly train, supervise and hire their employees,” led to an improper intubation which precipitated the death of an infant patient.

A former patient of HCA Florida Palms West Hospital in Florida sued the hospital for negligence after he developed gangrene in his hand. The patient had received emergency
hand surgery to treat compartment syndrome which was preventing blood flow to his fingers. After the surgery, the patient’s wounds were covered by vacuum-assisted closure (VAC) dressings which should reduce the swelling in the patient’s fingers. According to the suit, “The proper use of VAC dressings is complex and requires specialized training practice.” The lawsuit claims that the patient’s “VAC dressings were not applied by nurses who had had the requisite training and practice in applying VAC dressings.” The untrained nurses allegedly constricted the VAC dressings with bandages, impeding blood flow to the patient’s fingers, which led to the patient developing gangrene in his fingers. The patient required partial finger amputation to prevent the gangrene from spreading.

CMS cited HCA Florida Trinity Hospital for unqualified staff performing complex care procedures which led to a patient being placed on a ventilator. A patient was ordered to be fed using a Dobhoff feeding tube, a type of small-bore feeding tube. However, the RN who placed the tube did so incorrectly, placing the tube through the patient’s trachea (windpipe) and into their lungs, rather than down their throat and into their stomach. This fact was unknown to an RN on a later shift who used the tube to push a bolus feeding into the patient’s lungs after which “the patient subsequently developed significant abdominal pain and had to be given pain medication (Dilaudid).” Eventually, a CT scan showed that the Dobhoff tube had been placed incorrectly, staff removed it, but the patient’s breathing continued to deteriorate. The hospital’s quality management staff “confirmed RN #A did not have a competency for insertion of a Dobhoff feeding tube.” A nurse conducted a complex procedure without training and precipitated the dangerous deterioration of a patient’s respiratory functioning.

For more examples of training failures, go to page 50.
1.5 **HCA’s Anti-Worker Retaliation**

HCA’s management has worked hard to ensure HCA maintains a good public image. In this public image, staffing isn’t “low.” It’s “efficient.” HCA isn’t putting inexperienced caregivers in dangerous situations; it’s launching innovative new models of care and integrating its nursing school students into its hospitals. From the investor and public perspective, everything is going great. However, as discussed, our research indicates that this staffing model is neither sustainable nor safe for workers or patients. Many workers are afraid to publicly raise concerns about their workplace because of the extreme retaliation that their peers have experienced in the past.

A recent story from an HCA hospital in Colorado sheds light on how HCA workers bear the consequences of the company’s staffing model. DonQuenick Joppy, a Black nurse formerly employed by HCA’s The Medical Center of Aurora (TMCA), alleges in a lawsuit that the hospital retaliated against her for raising issues of workplace racism by creating a dangerous work environment and ultimately had her prosecuted for manslaughter in 2019.

Joppy claims that she was subject to “humiliating and demeaning” treatment from supervisors in a racially discriminatory way. After reporting this racist treatment, nurse Joppy was retaliated against, in part, by being “given assignments that she could not be successful at” such as being left to care for three critical care patients by herself. The lawsuit alleges that the racist retaliation against Joppy culminated in her being incorrectly and unjustly blamed for a patient death.

The criminal charges against nurse Joppy stemmed from a patient dying of natural causes in TMCA’s ICU. The patient was admitted to TMCA’s ICU with septic shock, multi-organ failure, and several comorbidities. Joppy, the nurse working the night shift, received the patient and then transferred care of him when the day shift started. However, since “TMCA was under staffed with an overflowing critically ill patient population,” Joppy did
not clock out immediately, but “**stayed to assist [the day shift nurse] in the understaffed ICU in caring for several critically ill patients,**” which was a common practice at TMCA.71

The other nurse was in charge of the patient’s care and when she received a physician order to begin end-of-life care, she delegated that care to Joppy. Alongside a respiratory therapist, nurse Joppy removed the patient from their ventilator and allowed the patient to die from natural causes.72

After the patient’s death, concerns were raised at the hospital about how the end-of-life process was handled. Ultimately, even though Joppy was not the primary RN assigned to the patient, she was blamed for the patient’s death and subsequently terminated. Joppy’s “termination documentation also stated as grounds that Ms. Joppy was ‘staying after her assigned shift continuing to provide care to the patient unnecessarily,’”73 despite, as noted above, it being “the customary and common practice at TMCA for nurses to stay past [an] assigned shift to assist with shift transition and patient care.”74

Joppy was fired specifically because she had stayed to provide patient care after her shift was over to compensate for understaffing in the TMCA ICU.

After her termination, Joppy was allegedly targeted by the hospital, which referred the case to the Colorado Attorney General’s Office and the Colorado Nursing Board. The hospital claimed Joppy had been criminally negligent in her care of the deceased patient.75 Joppy was formally charged with manslaughter and neglect charges in November 2020. However, the Attorney General’s Office dismissed all of the charges in September 2021 “in the interest of justice.”76

Despite the dismissal, Joppy’s attorney said that the nurse “hasn’t recovered since all of this happened.”77 According to Joppy, her life “has been turned upside down” due to these charges.78 An HCA nurse who tried to help her colleagues and patients by working longer than she needed to was allegedly punished and subsequently targeted by her hospital for something that did not even amount to a patient care failure. These allegations raise concerns that HCA may be shifting the blame for flaws in their staffing model onto their clinical workers, with potentially dire consequences.

Other stories of retaliation against workers by HCA include:

In Florida, a former ICU nurse at HCA Florida Westside Hospital sued the facility claiming that she was retaliated against for raising concerns about staffing and telemetry failures. She alleges that nurses in the ICU were assigned three or more patients even though the unit’s monitoring equipment could only monitor two patients simultaneously.79 If a nurse was assigned three patients, at least one patient would be unmonitored. The nurse claims that **ICU nurses being assigned three critical care patients was “standard practice.”**80 The nurse expressed that this practice was unsafe and raised the issue to her supervisors and the ICU Director. The nurse was terminated after filing written concerns about unsafe staffing and refusing to be assigned a third patient.81 In an online interview, the nurse claims that at least two patients died in the Westside ICU due to unsafe staffing and insufficient monitoring.82
In Missouri, Research Psychiatric Center has been accused in a lawsuit of retaliating against a nurse on its behavioral health unit after providing insufficient training on de-escalation techniques. The nurse was terminated for not using proper de-escalation techniques with an unruly and aggressive patient even though the only training available was allegedly only provided “approximately once every two years.” Moreover, the nurse argues that such trainings “do not address what to do when cornered and swung upon by a patient.” Instead, she claims she was fired in retaliation for reporting a patient safety incident.

In Florida, a former contract nurse of HCA Florida Largo Hospital alleged that the hospital retaliated against her for filing incident reports about patient abandonment and equipment failures. She was terminated one day after meeting with the hospital’s ethics department to discuss her incident reports.

In Florida, a former respiratory department employee sued the former Plantation General Hospital in for retaliation after she complained about racially disparate treatment from her supervisor. The suit alleges that after being terminated, the worker could not find employment because she had been placed “on a ‘do not hire’ list with HCA Hospitals worldwide specifying that she was a trouble maker.”
1.6 Pandemic Magnified the Negative Impact of HCA’s Short Staffing

“In July 2020, nurses went on strike at Riverside. At the height of the pandemic, we were sharing PPE, reusing PPE, or just going without. Nurses were calling out for help. We needed staff and equipment, and we didn’t have enough of either. We were down by more than 350 nurses at the facility at that time. Riverside was fined by California-OSHA for withholding N95 masks to frontline caregivers. Coworkers died of COVID. Working parents left. People with vulnerable family members left. The travel nurses went where the money went.” - Kerry Cavazos, a nurse at HCA’s Riverside Community Hospital

During the pandemic, HCA failed to adequately address workers’ mounting concerns about short staffing. In April 2020 – just one month after the World Health Organization declared COVID to be a global pandemic, a month in which 58,760 Americans died from COVID-19 – HCA’s CEO Sam Hazen told investors about plans to “reboot” certain suspended operations—notably elective procedures—across all their markets by June. Later, when hospitals across the country were dealing with the Delta-fueled surge, HCA hospitals appeared to resist suspensions of elective procedures. In August 2021, as some Florida HCA hospitals opened outdoor tents to address overflow of their Emergency Departments, HCA executives continued to stress that they had the capacity to continue to safely treat patient loads, even as nearby non-HCA hospitals paused their own elective surgeries.

This aggressive approach was good for HCA’s bottom line, netting the company $3.8 billion and $7.0 billion in profits during 2020 and 2021 respectively. At the same time, though, the health system was putting its workers and patients in jeopardy. In July 2020, nurses at multiple Florida HCA hospitals reported that the hospital was not regularly testing them for COVID-19 and that they were being told to come to work even when they were symptomatic. Others reported that HCA hospitals were not notifying them when co-workers who they had been in close contact with had tested positive. Throughout the pandemic, there have been numerous complaints of HCA hospitals failing to provide their workers with the Personal Protective Equipment (“PPE”) they need in order to perform their jobs safely – including complaints raised more than a year after the pandemic began. A critical care registered nurse at HCA’s Research Medical Center in Missouri testified before Congress in March 2021 that nurses on her unit were, at that point, “still caring for COVID-19 patients without adequate protection.” Amid this outcry, some HCA caregivers have reported being terminated or suspended for raising issues either internally or externally, and this may have deterred other workers from speaking out.

The pandemic, and HCA’s failure to adequately address workers’ concerns, exacerbated the already existing patient care issues caused by HCA’s 30% lower than average staffing levels. While hospital staffing ratios on average went up by 5% from 2019 to 2020,
HCA’s hospital staffing ratios only increased by 2%. As noted above, a January 2022 survey of over 1,500 nurses and other frontline healthcare workers at HCA hospitals showed that nearly 80 percent had witnessed patient care jeopardized due to low staffing.

“There is no more demoralizing feeling than when you run yourself ragged to do as much as you can for your patients, but 12 hours later leave your shift feeling like you didn’t do enough because you’re so short staffed,” said Jody Domineck, a registered nurse at HCA’s Sunrise Hospital and Medical Center. "Nurses are left to bear this emotional and physical burden on top of everything else now and it’s taking a devastating toll."

Two and a half years after the start of the COVID-19 pandemic, HCA workers say they are scarred by the experience.

“I saw so much death during those two years. But it wasn’t the pandemic that broke me. It was my hospital’s response and how I was treated after. The system that was supposed to protect us abandoned us. That’s what broke me. Having to fight for what we needed and deserved.”

- Monique Hernandez, nurse, HCA’s Riverside Community Hospital

More than one HCA worker has compared the impact of working for HCA through the pandemic to the experiences of themselves and their family members who have been to war. They believe that this should not have happened to them, however, and would have been prevented if their hospitals prioritized their safety and staffing over profits. “As a respiratory therapist, I have seen firsthand the effects of both the Delta and Omicron variant can have on the vaccinated and unvaccinated. The high infection rate of Omicron is making all of us worry about the ability to do our jobs while being significantly short-staffed. This is not sustainable.” - Zavia Norma at HCA-affiliated Sunrise Hospital & Medical Center in Las Vegas.

In Nevada, staff at Mountainview Hospital reported: “There is concern that the employer is giving nurses an excessive workload due to an unbalanced nurse to patient ratio. As a direct result of this excessive workload, nurses may be cutting corners or violating safety precautions related to COVID-19.”
1.6 Pandemic Magnified the Negative Impact of HCA’s Short Staffing

On May 23, 2020, a COVID-19 patient died at HCA’s North Suburban Medical Center (Colorado) when no one was available to change the battery in their oximeter, a machine measuring blood oxygen levels. The malfunctioning oximeter was first noticed by a technician in the telemetry unit. Hospital telemetry units provide crucial care to patients who are in need of around-the-clock, remote electronic monitoring of cardiac conditions, oxygen levels and other vital signs. Techs must continuously monitor patient vitals because even subtle irregularities can reveal changes in the patient conditions.

At North Suburban, the first nurse called by the telemetry technician was already busy assisting a patient with COVID symptoms. The nurse was further delayed by having to safely remove all her protective equipment before moving rooms. The telemetry technician didn’t realize that no one had fixed the oximeter for more than a half an hour because she was already busy monitoring 46 other patients. By the time someone attended to the patient, the oximeter had been off for 47 minutes, and the patient was already unresponsive. The patient died shortly thereafter.

CMS inspectors found that when the patient died, the telemetry technician “was monitoring 47 patients and there were several pulse oximeter probes off and alarming.” Another technician who worked on the same unit reported that “monitoring 40 or more patients at a time can impact patient safety because when numerous alarms were alarming, it was easy to miss a change in a patient’s rhythm or an oxygen desaturation.” This 40-patient threshold was also noted by a 2015 academic study, which found that when the number of patients being monitored by one technician increased from 40 to 48 patients, technicians began to respond too slowly to simulated adverse patient events. According to the technician at North Suburban, she typically monitored anywhere from 40 to 60 patients at once as only one technician was scheduled per shift.

Unfortunately, North Suburban was not the only time that telemetry unit under staffing has led to patient death. For more examples of preventable deaths and other patient care failures related to understaffed telemetry units see page 37.
2.1 **HCA HOSPITALS SHOW DEFICITS ON QUALITY METRICS**

In order to help consumers make informed decisions about health care, the Center for Medicare and Medicaid Services (CMS) provides information on the quality of care at over 4,000 Medicare-certified hospitals in the United States.\(^{111}\) CMS Care Compare allows the public to access quality performance metrics at hospitals on a number of different measures. This information can be accessed at the consumer-oriented Care Compare website (https://www.medicare.gov/care-compare/) and CMS’s Data catalog (https://data.cms.gov/).

The most well-known component of CMS Care Compare is the hospital star ratings, with each hospital receiving a score of 1, 2, 3, 4 or 5. Ten out of 143 HCA hospitals that received a star rating for the year 2021 were given the lowest possible score of 1 star, of which seven are located in Florida. The HCA system as a whole had a lower average star rating than the national average in 2021, with HCA hospitals receiving an average star rating of 2.9. The average star rating for all hospitals nationwide was 3.2.\(^{112}\)

**Figure 11. Distribution of CMS Overall Star Ratings, HCA hospitals vs. National**

![Bar chart showing the distribution of CMS Overall Star Ratings, HCA 2021 vs. National 2021]

*Source: CMS Hospitals Data, 2021 Annual file – Hospital General Information, “Hospital Overall Rating.” HCA totals include hospitals currently owned by HCA.*

Because HCA is the largest private hospital system in the United States with more than 150 hospitals in a system that stretches coast to coast, one might expect HCA’s performance on CMS’s Care Compare quality metrics to mirror national averages, or perhaps exceed them. However, this is not the case when it comes to metrics researchers have flagged as being related to low staffing and, in particular, missed nursing care.\(^{113}\)

CMS has flagged 11% of HCA’s hospitals for having worse than expected 30-day mortality rates for pneumonia patients, more than double the overall rate of 5% for all U.S. hospitals, for instance. This measure is based on deaths from any cause within 30 days of the start of a hospital admission related to pneumonia.\(^{114}\) For this and other metrics, CMS designates each hospital as performing better than the national rate, no different than
the national rate, worse than the national rate, or as having too few cases to assess performance.\textsuperscript{115} The percent of hospitals in each category is different for each performance measure.\textsuperscript{116}

Similarly, while CMS has flagged only 2\% of hospitals for having a worse-than-average postoperative respiratory failure rate, 4\% of HCA’s hospitals have earned this troubling distinction.\textsuperscript{117} These results are troubling in part because HCA owns 6 out of only 50 hospitals designated as worse-than-average on this metric nationwide. They are also troubling because the consequences of these outcomes are extremely severe for patients.

**Figure 12: CMS Complications and Deaths Metrics, HCA hospitals vs. National**

<table>
<thead>
<tr>
<th>Measure</th>
<th>HCA % Outliers</th>
<th>National % Outliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death rate for pneumonia patients</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Postoperative respiratory failure rate</td>
<td>4%</td>
<td>2%</td>
</tr>
</tbody>
</table>


In addition to these mortality measures, HCA hospitals underperform on CMS’s re-admissions measures, which measure additional hospital visits for patients who have been discharged from the hospital. The chart below shows the percentage of HCA hospitals which have been found to be national outliers in readmissions.

**Figure 13: CMS Readmissions metrics, HCA hospitals vs. national\textsuperscript{118}**

<table>
<thead>
<tr>
<th>Measure</th>
<th>HCA’s outliers in readmissions</th>
<th>National % outliers in readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital return days for heart failure patients</td>
<td>21%</td>
<td>47%</td>
</tr>
<tr>
<td>Hospital return days for pneumonia patients</td>
<td>26%</td>
<td>51%</td>
</tr>
<tr>
<td>Ratio of unplanned hospital visits after hospital outpatient surgery</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Heart failure 30-Day Readmission Rate</td>
<td>3%</td>
<td>16%</td>
</tr>
<tr>
<td>Hospital return days for heart attack patients</td>
<td>22%</td>
<td>36%</td>
</tr>
</tbody>
</table>

CMS notes that “Returning to the hospital for unplanned care disrupts patients’ lives, increases their risk of harmful events like healthcare-associated infections, and costs more money. Hospitals that give high quality care can keep patients from returning to the hospital and reduce their stay length if they have to come back.”

Additionally, a 2021 meta-analysis supports the link between staffing and readmissions. The authors found “strong evidence for a significant association between nurse staffing levels and NSPOs [nursing sensitive patient outcomes],” and ranked readmissions as one of the NSPO’s with high strength of evidence. A frontline caregiver at an HCA hospital in California told researchers that patients have begged hospital staff not to be discharged because no one is present at their home to care for them. After being discharged, for what the caregiver can only guess are nonmedical reasons, many of these patients are readmitted, according to her account, because as the patient feared their condition worsened without appropriate care as they recovered.

**Patient Surveys show Missed Nursing Care and Breakdowns in Communication at HCA Hospitals**

The CMS HCAHPS survey is a nationalized, standardized survey for measuring patients’ perceptions of their hospital experience. It is intended to allow valid comparisons to be made across hospitals locally, regionally and nationally. HCAHPS surveys are administered to a random sample of adult hospital patients in the medical, surgical, or maternity service lines between 48 hours and 6 weeks after they are discharged. The survey is not restricted to Medicare beneficiaries, and so it represents the experiences of a variety of patients.

HCAHPS surveys present a variety of questions about the patient’s hospital stay, allowing them to answer if they experienced something Never, Sometimes, Usually, or Always, as in the sample question:

While HCA would again be expected to meet or exceed the national average for patient satisfaction, HCA hospitals as a whole had a higher rate of negative answers from their patients than the national average on all 25 HCAHPS measures for which CMS provides national averages. HCA’s performance on several of these questions (as compared to national averages) is shown below.

<table>
<thead>
<tr>
<th>Percent of respondents who reported ...</th>
<th>National Answer</th>
<th>HCA Answer</th>
<th>HCA rate % above national rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>When receiving new medication staff Sometimes or Never discussed possible side effects</td>
<td>29%</td>
<td>36%</td>
<td>23%</td>
</tr>
<tr>
<td>They Sometimes or Never received help after using the call button as soon as they wanted</td>
<td>9%</td>
<td>13%</td>
<td>50%</td>
</tr>
</tbody>
</table>
2.1 HCA Hospitals Show Deficits on Quality Metrics

It is also telling that some of the questions where HCA lags the national average by the highest percent are related to the time and attention that staff are able to spend with patients, such as getting help to use the restroom and learning about treatments and care plans. This suggests that missed nursing care is happening at these hospitals.

Missed nursing care, identified as "care left undone, unfinished care, and implicitly rationed care," refers to "any aspect of required patient care that is omitted (either in part or in whole) or delayed." The amount of missed nursing care in a hospital is found to be associated with lower staffing levels and staff skill mix, more staff working overtime, and perceived staffing inadequacy. The amount of missed nursing care tasks have in turn been linked to adverse patient outcomes such as post-operative patient mortality, pressure injuries, and patient falls.

For instance, in 2021 annual results, an average of 13% of respondents from HCA hospitals answered that they sometimes or never received help after pressing the call button and 14% sometimes or never received help in using the bathroom when they wanted. This compares to 9% and 11% nationwide, meaning the negative response rate was 30% to 50% higher among HCA’s patients. There is no reason why a system of acute care hospitals reaping billions in profits should allow more patients to suffer from a lack of timely help to go to the bathroom, a situation that causes discomfort, loss of a sense of autonomy and dignity, and can lead to serious medical complications.

<table>
<thead>
<tr>
<th>Percent of respondents who reported ...</th>
<th>National Answer %</th>
<th>HCA Answer %</th>
<th>HCA rate % above national rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>They Sometimes or Never received bathroom help as soon as they wanted</td>
<td>11%</td>
<td>14%</td>
<td>31%</td>
</tr>
<tr>
<td>They did not receive written information about possible symptoms to look out for after discharge</td>
<td>12%</td>
<td>15%</td>
<td>27%</td>
</tr>
<tr>
<td>When receiving new medication the staff Sometimes or Never communicated what the medication was for</td>
<td>9%</td>
<td>12%</td>
<td>32%</td>
</tr>
<tr>
<td>They did not discuss whether they would need help after discharge</td>
<td>16</td>
<td>19</td>
<td>18%</td>
</tr>
<tr>
<td>They would probably not or definitely not recommend the hospital</td>
<td>5</td>
<td>8</td>
<td>52%</td>
</tr>
<tr>
<td>They Disagree or Strongly Disagree that they understood their responsibilities in managing their health</td>
<td>5</td>
<td>7</td>
<td>50%</td>
</tr>
<tr>
<td>Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)</td>
<td>8</td>
<td>10</td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: CMS Annual HCAHPS data 10/2021. National averages provided by CMS. HCA averages are unweighted.
2.2 A PROBLEM WITH PRESSURE ULCERS MAY BE HIDDEN UNDER THE SURFACE

Pressure ulcers, also known as pressure injuries or bed sores, are “damage to an area of the skin caused by constant pressure on the area for a long time.” For hospital inpatients, who are already being treated for serious health conditions, pressure ulcers make recovery more painful, and more dangerous due to the risk of a pressure ulcer becoming infected.

Why adequate staffing in hospitals is necessary to prevent pressure ulcers

Pressure injury specialists assert that “pressure ulcers are not inevitable.” Academic literature has found associations between hospital-acquired pressure injuries and staffing adequacy. One study found that “an extra hour of nursing service provided by RN [registered nurses] reduced the risk for HAPU [hospital-acquired pressure ulcer] development by 80%.” Another paper discovered that “Patients admitted to an ICU with more RN hours per patient day had significantly lower incidence of CLBSI, VAP, 30-day mortality, and decubiti [pressure injuries].” A 2018 meta-analysis noted that a higher level of nurse staffing on a Critical Care Unit (CCU) was also associated with lower incidence of pressure injuries.

Nursing educators point out that preventing pressure ulcers can be nursing intensive. Some of the recommended care tasks for pressure ulcer prevention on a high-risk patient include repositioning the patient every 1-2 hours, using a minimum of 2 people to pull the patient up in bed to prevent friction, performing a skin assessment and inspection each shift, checking incontinence pads every 2-3 hours and changing as needed, recording dietary intake, and offering liquids whenever staff are in the room.

There is a financial incentive to avoid documenting serious pressure ulcers

CMS has set financial incentives to manage pressure ulcer care. For fee-for-service Medicare patients, CMS will not pay hospitals for the secondary diagnosis of a Stage 3 or Stage 4 pressure ulcer developed during a patient’s hospital stay. Pressure ulcers are categorized into stages by severity, with higher numbered stages indicating more severe injuries. Stage 3 pressure injuries are wounds with full-thickness loss of skin and Stage 4 pressure injuries are wounds with “full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.”
CMS has several programs to encourage hospitals to prevent pressure ulcers, including withholding payments for hospital-acquired pressure ulcers and financially penalizing hospitals with higher occurrences of advanced-stage pressure ulcers. This approach by CMS is intended to encourage better care and prevention for pressure ulcers. However, researchers have observed that there has been a larger drop in hospital-acquired pressure ulcers reported in the administrative claims data used to implement these programs, than there has been in data that samples and reviews patient charts. This implies that many pressure ulcers go unrecorded in the administrative data.

More recently, CMS has announced it will suspend the hospital-acquired condition program due to the COVID-19 pandemic, which means the regulatory pressure to keep pressure ulcer rates as low as possible may have temporarily lifted.

In response to payment changes, HCA encouraged hospitals to eliminate hospital-acquired pressure ulcers, but did not increase staffing

After CMS adopted pressure ulcer initiatives with financial penalties, HCA began a system-wide pressure ulcer prevention program. According to an article in the Journal of Patient Safety authored by HCA’s Chief Nurse Executive, Jane Englebright, HCA’s Reducing Hospital Acquired-PrUs Program used a “combination of a repository of evidence-based tools and best practices, readily available data on PrU rates, and local flexibility with processes” to attain “the successful operationalization of improvement in a wide variety of facilities.”

Interestingly, HCA’s program focused on eliminating hospital-acquired pressure ulcers and let hospitals have “local flexibility” in how they made it happen. During the program, hospital-acquired pressure ulcers were monitored by facility-based, regional, and national executives over a period of two years, and those facilities that did not show a decrease in hospital-acquired pressure ulcers were encouraged to keep trying.

HCA compiled a list of recommended best practices during this program that was shared with facilities. Some of the recommended best practices included patient care improvements, while others focused on controlling how pressure ulcers are documented, including the verification of skin assessments by a second clinician, and a clinical review processes to improve accuracy. Facilities were encouraged to use whichever practices would lower their rates of hospital-acquired pressure ulcers.

HCA reports its hospitals’ rate of hospital-acquired pressure ulcers of all stages fell by 47.1% during the study period, and the rate of more-heavily penalized stage III and IV hospital-acquired pressure ulcers decreased 66.3% between 2011 and 2013. HCA’s decrease in reported pressure ulcers was greater than what researchers observed in a broader study of the trends. One study of all eligible claims in three states found there was a 40% drop in the occurrence of hospital-acquired pressure ulcers of all stages and very little decrease in the rate of stage III and IV pressure ulcers between 2009 and 2014. HCA hospitals had a larger decrease in a shorter period of time than the much
larger group of hospitals reviewed in this study.\textsuperscript{153} However, there was no corresponding increase of staff at HCA hospitals that one might think necessary to achieve this drop. In fact, HCA's FTE per adjusted occupied beds decreased between 2011 and 2013.\textsuperscript{154}

**While HCA reports improved hospital-acquired pressure ulcer rates, inspection reports and lawsuits indicate continued problems**

* Lawsuits filed against HCA-owned hospitals show disturbing allegations of untruthful documentation of pressure ulcers.*

In 2019, Vicki Oleson filed a civil lawsuit against HCA Florida Fawcett Hospital in Charlotte County, Florida after the death of her husband John Oleson. Mrs. Oleson alleged that Fawcett Memorial was negligent in caring for her husband,\textsuperscript{155} who developed a new pressure ulcer after being admitted through the emergency room on April 2, undergoing heart surgery, and then recovering in the hospital without receiving pressure ulcer prevention measures. The lawsuit alleges that staff recorded the pressure ulcer as being “present on admission” on April 22, even though it had first been documented as “redness” on April 6. It also alleges that Mr. Oleson’s discharge summary on April 24 did not mention the pressure ulcer in its skin assessment, but when he arrived at a different hospital, doctors found the pressure ulcer to be unstageable and ordered a number of wound care measures for him. Sadly, despite these measures, Mr. Oleson developed sepsis and passed away on May 2.\textsuperscript{156} This case was dismissed with prejudice in September 2020.

Another grieving partner of a deceased patient settled a case with HCA Florida Fawcett Hospital under similar circumstances. The patient’s husband alleged that his wife developed new pressure ulcers while receiving treatment for a stroke at Fawcett Memorial and a nursing facility. The pressure ulcers allegedly progressed to Stage 4 and the patient had to have her leg amputated above the knee. Unfortunately, this patient also passed away, and her husband alleged that the pressure ulcers and the amputation contributed to her untimely death.\textsuperscript{157} The allegations against Fawcett Memorial included that the facility failed to provide and document pressure ulcer prevention care, failed to provide adequate nutrition, and allowed the patient to develop gangrene.\textsuperscript{158} The complaint claimed that the Florida Department of Children and Families investigated the case and “concluded that there were verified findings of medical neglect and inadequate supervision by Fawcett Memorial Hospital and its employees.”\textsuperscript{159}

In South Carolina, Grand Strand Regional Medical Center was sued by the family of a former patient who acquired a sacral pressure injury during her stay at the hospital. She stayed at Grand Strand for a few weeks, then was transferred to Regency Hospital of Florence. Interestingly, “There is no mention of wounds or pressure ulcers in Grand Strand’s records during the relevant period...” At Regency, the patient’s wound was described as “a large, unstageable sacral pressure ulcer.” The suit alleges that the hospital was negligent by “failing to diagnose and treat the pressure ulcers [patient] sustained while under its care.”\textsuperscript{160} This case settled.
In Florida, the family of a deceased patient who received care at both HCA Florida Palms West Hospital and HCA Florida JFK Hospital sued both hospitals for failing to prevent and treat the pressure sores acquired by the patient at Palms West Hospital. The patient developed Stage 2 pressure injuries while admitted to Palms West Hospital; then, was discharged home. A month later, the patient was admitted to JFK Hospital "with what was documented to be a Stage 3 sacral pressure sore, which was later documented by JFK MEDICAL CENTER as Stage 2." The suits suggests that since photos of the pressure sores "were taken throughout [the patient's] admission but were conveniently not taken on the day of discharge" the hospital was trying to hide the worsening of the patient’s pressure sore. Upon discharge, the patient was transferred to a non-HCA hospital where their pressure sore was measured as "a large unstageable pressure sore," much more severe than what was documented at JFK Medical Center. By the time the patient was discharged from the third hospital, the pressure sore was documented as a Stage 4 injury, one that exposed bone. The patient died after "nearly five months of pain and suffering from the horrendous bedsore." The case settled.

**Failures to document pressure ulcers at an HCA hospital have shown up in inspection reports**

When assessment, prevention and treatment tasks are all missed, it is possible for pressure ulcers to be absent from a patient’s record. An example of this was found in Tennessee, when a patient who was treated at Tristar Hendersonville Medical Center at the beginning of October 2018 was admitted at a second hospital at the end of the month. The second hospital documented six pressure injury wounds on the patient’s body that needed documentation and treatment, but CMS inspectors found that the patient’s medical records from Tristar Hendersonville did not include documentation of them.

Researchers have also noted that there are "counteracting effects" preventing the documentation of pressure ulcers. If a facility implements nursing-intensive pressure ulcer prevention practices such as frequent skin assessments, it is likely that staff will identify pressure ulcers in their assessments. Ironically, poor care for pressure ulcers may hide the true rate they occur. Missed nursing care is associated with inadequate staffing, and studies show that documentation and care planning tasks are among those most frequently missed by nurses pressed for time.

**HCA hospitals have repeatedly failed to meet standards of care for pressure ulcers**

CMS inspection reports have revealed disturbing failures in pressure ulcer prevention and treatment at HCA-owned facilities across the country. The patients who were impacted by these failures endured suffering and complications that may have been prevented with better treatment.
Failures to implement pressure ulcer prevention measures at HCA hospitals:

In Texas, CMS inspectors found that a patient at HCA Houston Healthcare Kingwood developed a Stage 3 pressure injury during his 26-day stay. During that time, the patient did not receive skin assessments on 12 days and was repositioned only 21 times. At another Texas HCA hospital, CMS found skin assessments and repositioning were not consistently performed for high-risk patients. In an interview, one patient “stated he was only repositioned when he asked the staff to do it,” even though he needed staff assistance for all activities. At least one patient had a Stage 2 pressure injury.

HCA-owned hospitals in Florida, Louisiana, and Colorado were also cited in CMS inspections between 2018 and 2021 for violations related to pressure ulcer prevention. CMS inspectors in each state found patients who developed pressure injuries after pressure ulcer prevention practices were not implemented properly. Given the time-intensive nature of prevention tasks such as skin assessments, photography and frequent repositioning, this may be a sign that nursing staff are not given enough time to complete them.

Failures to treat existing pressure ulcers at HCA hospitals:

Surveyors also found that HCA hospitals in Florida and Alaska failed in providing care for pressure ulcers that patients had already developed. HCA Florida Lake Monroe Hospital in Sanford, Florida was cited when a patient had a documented Stage 2 pressure injury, but “there was no evidence in the record that any of these steps [to address the sore] were taken.” Similarly, Alaska Regional Hospital was cited when a patient’s documented pressure injury was not addressed in their nursing care plan. This monitoring failure put patients at risk of not having wounds identified and treated.

To truly improve pressure ulcer care, HCA needs to listen to its frontline workers

Based on the disturbing incidents described in hospital inspection reports and lawsuits (See see page 38 for more examples), SEIU believes there is room for improvement in the way HCA treats pressure ulcers. These hospital-acquired injuries are not something that can be swept under the rug and ignored, and they cannot be prevented unless staff have enough time to complete the assessments, repositioning, and one-on-one attention that they require. HCA workers need more of a voice in how patient care is delivered in order to prevent any more patients from suffering unnecessarily.
2.3 ADDITIONAL EXAMPLES OF HCA’S PATIENT CARE FAILURES

HCA’s staffing practices have direct consequences for patients. Hospital inspection reports and patient lawsuits reveal a pattern of concerning patient safety and care failures at HCA facilities. These failures include insufficient staffing and unqualified staff performing complex patient care. They also indicate patterns of patient care failures such as hospital-acquired pressure injuries (bed sores), missed nursing assessments, delays in treatment, patient falls, and the endangerment of patients. HCA hospitals have also been cited for deficiencies in staff training and staffing assignments, as well as failures to report adverse patient events and conduct quality improvement activities. These stories suggest that HCA’s business strategy of providing inadequate staffing leads to injurious and sometimes deadly consequences for the company’s patients.

Inspections of HCA hospitals are conducted by federal and state inspectors on behalf of the Centers for Medicare and Medicaid Services (CMS). They hold hospitals accountable to the Medicare Conditions of Participation (CoP) as laid out in 42 CFR Part 482. The CoP are a set of health and safety standards which health care providers must meet in order to participate in the Medicare and Medicaid programs. Federal and state surveyors record their substantiated findings in the inspection reports which CMS makes available to the public on a quarterly basis.

Some patient care failures resulted in HCA hospitals being placed under Immediate Jeopardy status by inspectors. Immediate Jeopardy means that a hospital’s “noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death.” Immediate Jeopardy citations can lead to the termination of a hospital’s payment agreement with Medicare and Medicaid. We indicate instances of Immediate Jeopardy notices being provided to HCA hospitals below.

Academic consensus points to an important relationship between hospital staffing levels and a variety of patient care outcomes. One 2016 review concluded that “the evidence supports a causal link between nurse staffing levels and patient outcomes in general hospital wards.” Patient falls and hospital-acquired pressure injuries have both been linked to staffing in cross-sectional primary studies as well as in meta-analyses and longitudinal studies. Similarly, higher levels of hospital staffing are linked to lower rates of hospital-acquired infections, lower patient mortality, and shorter hospital stays. Certain hospital-acquired conditions like wound infections, pressure injuries, and pneumonia have been associated with patient exposure to understaffing. Studies find that hospital staffing is also related to hospital workforce outcomes such as staff burnout, nurses’ intention to leave their job, and staff absenteeism. Research into the importance of hospital staffing to patient care and worker wellbeing helps to contextualize the staffing failures found at HCA hospitals.
The following stories from HCA hospitals were collected from hospital inspection reports and lawsuits. They are organized by the type(s) of care failures that they describe.

Understaffing

In Florida, HCA Florida Blake Hospital was cited for staffing failures. CMS “determined the facility failed to have sufficient patient care staff to ensure patient care needs were met.” One unit had thirty-seven patients but only seven nurses and two patient care technicians. The unit charge nurse admitted that there were not enough staff to accomplish care tasks like feeding and repositioning patients. One patient told surveyors that “his bed has been changed twice, because [he] had a bowel movement in the bed, [he] just couldn’t hold it any longer... staff refused to get him up stating [they] ‘didn’t have time.’”

In Texas, inspectors cited Las Palmas Del Sol Healthcare for deficiencies in patients’ rights to care in a safe setting, nursing services, staffing and delivery of care, and RN supervision of nursing care. Surveyors found “the hospital did not supply an adequate number of licensed registered nurses and other personnel ... and presents a risk to all patients admitted to the hospital.” One of these risks was an increased frequency of patient falls. On a day when their unit was short one RN and one nurse assistant, a patient fell and suffered injuries.

In California, Good Samaritan Hospital was cited for numerous staffing-related failures. In two intensive care units, nurse-to-patient ratios exceeded 1:2 for a total of seven different occurrences, in violation of the California Nurse Staffing Ratio Regulation. These occurrences of understaffing were associated with missed patient assessments, including a failure to monitor and assess a patient who was administered the opioid Fentanyl. One nurse “stated she was assigned to three patients and she did not have time to perform assessment for three patients.” Another nurse told inspectors she felt she did not have enough time to assess patients. There were also two consecutive night shifts in which the hospital’s Emergency Department did not have a charge nurse present to lead and coordinate patient care.

Good Samaritan Hospital’s staffing problems went beyond nursing staff. The suction cannisters in the hospital’s neonatal intensive care unit were expired but had not yet been replaced because “no unit technician was working.” The hospital also failed to provide a sitter for a patient going through alcohol withdrawal even though a physician had ordered it for the patient’s safety.

In Florida, HCA Florida Ocala Hospital was sued by a former patient for negligence. She was admitted to the hospital for observation while in the ER. The patient says she was
placed in restraints without a required doctor’s order; instead, “restraints were placed for staff convenience and/or because the emergency department was understaffed.”

During her stay, the patient suffered an unwitnessed fall, the details of which are unknown due to missing documentation in the patient’s medical records. A CT scan revealed a new large subdural hematoma of the brain and emergency brain surgery was performed on the patient. As a result, the patient had to undergo subsequent brain surgeries and has developed life-altering neurological and physical limitations. The case is ongoing.

Telemetry Understaffing

Hospital telemetry units provide crucial care to patients who are in need of around-the-clock, remote electronic monitoring of cardiac conditions and oxygen levels. As the use of telemetric monitoring has expanded, so has the importance of the workers who interpret the monitor screens and communicate their results with clinicians. CMS inspection reports and patient lawsuits reveal repeated, telemetry-related staffing failures in HCA hospitals.

The performance of telemetry technicians is linked to the number of patients they are monitoring. In one study, when the number of patients being monitored by one technician increased from 40 to 48 patients, technicians in the study began to respond dangerously slowly to simulated adverse patient events. Researchers found that for telemetry technicians, “Task performance decreased as patient load increased.” The following stories illustrate that understaffing of telemetry technicians can have severe consequences for patient safety.

In Florida, surveyors placed HCA Florida Citrus Hospital in Immediate Jeopardy after poor staffing of the telemetry unit precipitated a patient’s death. There were too many patients on telemetry monitors and not enough telemetry technicians to monitor them all, which led to a communication delay between the technician and nursing staff about a patient’s life-threatening heart rhyme change. In the hospital’s plan of correction, it identified “Staffing” as a contributor to the patient death. The hospital wrote, “Once the patient census rose above 90, the facility contingency plan should have been initiated,” to avoid similar failures, “the facility staffing plan of 1 Monitor Tech to 45 patients will be followed at all times.”

In Florida, surveyors discovered a breakdown in supervision of patients at HCA Florida South Tampa Hospital. For one patient on telemetric monitoring, “there was no evidence that the telemetry technician notified the nurse of a life-threatening change in the patient’s heart rhythm. The patient’s cardiac distress went unnoticed until a nurse checked up on the patient and called a Code Blue, signaling the need for emergency cardiac life support. The patient died shortly after the Code Blue was called. In a separate incident, a telemetry technician again failed to notify clinical staff of a life-threatening heart rhythm change in a patient who was subsequently transferred to a higher level of care.”

In Florida, HCA Florida Blake Hospital was sued by the family of a former patient who died due to alleged telemetry failures. After being admitted to the hospital, the patient
was placed on the hospital’s telemetry floor. However, the suit claims the patient was never attached to the telemetry equipment. Allegedly, the patient was, “progressively over-medicated with Morphine, Percocet, and Dilaudid while waiting to be cleared for surgery.” A nursing assistant doing the rounds found the patient unresponsive; a Code Blue was not called until thirty minutes after the patient was found. According to the suit, “The Blake Hospital floor nurse was no-where to be found.” The patient was pronounced dead 11 minutes after the Code Blue was called. The case settled.

In Florida, CMS found HCA Florida Oak Hill Hospital deficient regarding staffing and delivery of care. The hospital failed to have nursing staff appropriately provide care for patients on cardiac telemetry monitoring. Against physician orders, a patient was not placed on telemetry monitoring when they needed it. More troubling is the comment by the Director of Nursing Administration that “audits to ensure that the facility was in compliance [with telemetry policy] had not been done.”

In California, Los Robles Regional Medical Center was sued by SEIU Local 121RN over the alleged assignment of telemetry patients to nurses in an unsafe manner. According to the lawsuit, “the hospital routinely places patients with remote telemetry in the care of nurses who do not hold the appropriate competencies to safely care for patients with in the facility.” Assigning patients on telemetric monitoring to nurses who lack telemetry-specific training could lead to care failures.

**Bed Sores/Pressure Ulcers/Pressure Injuries**

According to the National Pressure Injury Advisory Panel (NPIAP), pressure injuries (also known as pressure ulcers and bed sores) are “localized damage to the skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device.” For patients, pressure injuries bring pain, risk of infection, and increased utilization of health care services.

In the academic literature, pressure injuries are linked to inadequate hospital staffing. Higher levels of nurse staffing on Critical Care Units are associated with lower incidence of pressure injuries. Other scholars found that lower pressure injury rates were predicted by a combination of more experienced staff and fewer contract nurses. Better staffing can reduce pressure injuries.

One study found strong associations between hospital unit-acquired pressure ulcer incidence and RN-perceived staffing adequacy. RN-perceived staffing adequacy captures whether unit-level nurses believe that there are enough staff to provide quality care to patients. The authors found that “Perceived staffing adequacy was a significant predictor [of unit-acquired pressure ulcers] in all three models in which it was included.” Hospital staff have the most insight into whether a hospital has adequate staffing levels to provide quality care to patients.

HCA hospitals have a demonstrated pattern of pressure injury assessment, prevention, and care failures. Stories from lawsuits and hospital inspection reports convey the consequences of HCA’s staffing model.
In Florida, a former patient of HCA Florida JFK Hospital sued the hospital for care failures which led to her acquiring a Stage 3 pressure ulcer. The suit claims that an order for the patient to be repositioned every two hours was only given after a pressure ulcer had already been documented. Hospital staff “failed to document the wound sizes and stages” for the pressure ulcer that the patient had developed. According to the complaint, the patient was later readmitted with an “extensive, large sacral decubitus, stage 4.” The complaint alleges that the patient was transferred to HCA Florida Palms West Hospital for surgery to address the pressure ulcer wounds, however, after surgery, “proper care was not performed by Palms West nurses and the surgically-closed sacral pressure sore re-opened.” The complaint further alleges that eventually, the wound “encompassed her entire buttocks and sacrum, and was larger than the hospital measurement ruler,” and that while receiving treatment for her sacral pressure wound, the patient acquired new pressure ulcers on her leg and heel. By the time she was discharged to a nursing home, the complaint alleges that the patient had developed multiple Stage IV, hospital-acquired pressure ulcers. The case settled.

In Florida, HCA Florida North Florida Hospital was cited by CMS for failing to prevent the acquisition of facility-acquired pressure ulcers and “to prevent the worsening of facility acquired pressure ulcers” for two patients. Both patients developed Stage 3 pressure injuries while in the hospital. The patients were not being repositioned as often as required to prevent pressure injuries.

In South Carolina, the family of a former patient sued Colleton Medical Center after the patient’s death. The patient was admitted to the hospital with pressure ulcers acquired at a nursing home. The hospital allegedly “failed to properly treat or document the stage of [patient’s] pressure ulcers for five (5) days after her admission.” The pressure ulcers were later measured as being “bilateral Stage IV pressure ulcers with necrotic tissue.” The patient was discharged to hospice where she died, allegedly, due to her pressure ulcers. The case settled.

In Florida, another lawsuit from the family of a former patient of HCA Florida JFK Hospital alleges that the patient “developed an infected sacral pressure sore with exposed tendon, muscle and bone due to a lack of proper care and treatment” at the facility. This case settled.

In Texas, inspectors cited HCA Houston Healthcare West for failing to assess and elevate three patients who were admitted though the emergency department. All three patients were assessed as having no skin issues at the time of admission, but developed pressure injuries within days of admission. One of the patients acquired a Stage 3 pressure injury.

In Florida, HCA Florida Northwest Hospital was sued by the family of a former patient who acquired “bilateral heel pressure sores, as well as a Stage IV sacral pressure sore”
while he went back and forth between the hospital and a skilled nursing facility. The case settled.

In Florida, a former HCA Florida Northwest Hospital patient sued the facility after acquiring a deep tissue injury to his left heel and Stage 3 pressure ulcer while recovering from surgery. The left heel wound never healed and eventually developed into gangrene, requiring a debridement surgery in which the dead flesh around the wound was surgically removed. Still, the wound did not heal, leading to the patient undergoing a leg amputation. The patient developed “a significant, permanent disability” as a result of the pressure injuries acquired during his stay at the HCA hospital. The case settled.

In Florida, HCA Florida JFK Hospital was sued by the family of a patient who had “developed an infected Stage IV [4] pressure sore to his hip with exposed bone due to a lack of proper care and treatment at the hospital.” The case settled.

In Texas, HCA Houston Healthcare Clear Lake was sued by a former patient who acquired “a Stage IV sacral ulcer” due to the hospital’s alleged failure to prevent the development of the ulcer and consistently assess and document the ulcer wound. Documentation of the patient’s pressure injury was inconsistent, but “there is little documentation in the medical records of any increased turning and repositioning” to prevent the patient from acquiring such an injury.

In Florida, the wife of a former HCA Florida Westside Hospital patient sued the hospital after the patient acquired “an unstageable sacral pressure sore and ultimately died” due to alleged care failures. The suit claims that physician orders for wound care and patient repositioning to prevent pressure sores were not carried out as ordered, leading to the patient’s acquisition of the deadly pressure injury.

In South Carolina, a Grand Strand Regional Medical Center patient sued the hospital after he “developed a sacral decubitus ulcer and a pressure ulcer over the occipital area of his scalp.” The patient was discharged with an ostomy bag and his “day to day life and function has been entirely uprooted as he is forced to balance pressure sore prevention with his ostomy bag in place.” This case is in resolution.

In Florida, a patient of HCA Florida Bayonet Point Hospital sued the hospital after acquiring “pressure sores on his bilateral buttocks and posterior legs which were now open and which formed the shape of a bedpan.” The patient was at risk for developing pressure injuries due to his altered mental status and lack of mobility. The case settled.

In South Carolina, Trident Medical Center was sued by a former patient who was discharged “with a large unstageable B buttock ulcer” after more than a month in the hospital. Documentation of the pressure ulcer was inconsistent: the patient was admitted to Trident on July 19, however, the pressure ulcer was first documented on August 4 as “POA (Present on Admission).” When the patient was discharged, there was no

“Pressure sores on his bilateral buttocks and posterior legs ... formed the shape of a bedpan.”
documentation of the ulcer. The same day that the patient was discharged, another hospital documented the patient’s ulcer as “a Stage 4 decubitus ulcer.” The case settled.

In South Carolina, a patient sued Grand Strand Regional Medical Center after he “developed preventable pressure ulcers due to the [hospital’s] failure to properly treat him.” The patient acquired these ulcers because the hospital allegedly failed to implement adequate skin care management measures.

In Florida, HCA Florida Ocala Hospital was cited by CMS for failing to provide wound care instructions to two patients discharged with hospital-acquired pressure injuries. Both patients had developed Stage 2 pressure injuries but were discharged from the hospital without being educated on pressure injuries or provided instructions for how to care for their pressure wounds. Discharge planning going undone is a commonly-reported form of missed nursing care.

Delays in Patient Treatment

In Florida, HCA Florida Largo Hospital was cited by CMS for supervision of nursing care failures. A patient presented with high blood pressure and an elevated heart rate. A physician was not notified of the patient’s elevated vital signs and therefore no interventions to reduce the patient’s high blood pressure or fast heart rate were implemented. When a nurse went to get a second set of vital signs, they "found the patient without a pulse."

In California, Regional Medical Center of San Jose was cited for delayed ED triage assessments. Hospital policy states patients presenting to the ED will be triaged, “within 10 minutes of arrival.” In January 2021, two patients in the hospital’s ED each had to wait 14 minutes before they were triaged. On May 29, 2021, a patient was not assessed until 23 minutes after arriving. These failures "had the potential to cause untimely recognition of emergency medical conditions."

In Virginia, CMS cited Chippenham Johnston-Willis Medical Center after two patients did not get needed hemodialysis services. One patient had an order for hemodialysis on June 22, 2021, but did not receive dialysis until June 25. They experienced worsening symptoms and required oxygen. Two months later, a patient was ordered to receive hemodialysis on August 28, but did not receive it until August 30. Nurses’ attempted to coordinate hemodialysis services, but the dialysis providers were not available.

In Colorado, North Suburban Medical Center was cited for dialysis provision failures. One patient missed several routine hemodialysis treatments while at the hospital, and developed a condition of fluid buildup in their chest, weakness, and shortness of breath. Hospital staff “failed to identify and alert medical providers in regards to [patient]’s chronic medical condition and hemodialysis needs.”
Missed Assessments & Other Failures

The scholarly research on missed nursing care (MNC) emphasizes that certain types of care are more likely to go undone than other forms of care. Specifically, care activities which more likely to be missed are those whose "effect on patient health is indirect and less immediate; [which] require relatively more time to complete and/or require an unpredictable amount of time to complete; and [which] are less likely to be audited." Care activities like assessing patients, evaluating and changing care plans, and documenting assessments and plans are most likely to be left undone. Academic reviews find that MNC is strongly associated with hospital staffing levels, suggesting that the following assessment failures at HCA hospitals may be due to the company’s staffing policies.

In Texas, the parents of an infant patient at HCA Houston Healthcare Clear Lake sued the hospital after the infant died of septic shock. The suit claims that the hospital failed "to properly monitor and evaluate the patient" and “to follow established protocols to prevent the spread of infection.”

In Florida, HCA Florida Memorial Hospital was cited by CMS for deficiencies in nursing care plans. Surveyors found that “the facility failed to ensure consistent implementation of the nursing care plan intervention related to pressure wound dressing changes” for two patients. There were gaps in one patient’s medical record regarding the emergence and development of their pressure injuries. The patient died after a month in the hospital during which time their wounds were not treated properly.

In Florida, the family of a patient at HCA Florida Osceola Hospital sued the hospital after the patient died “as a result of the severe anoxic brain injury” she received in the aftermath of ovarian cyst surgery. The patient had been on general anesthesia for the surgery and then was moved to the Post-Anesthesia Care Unit (PACU). There, the PACU nurse only documented the patient’s vital signs when she was first brought onto the unit. The patient’s vital sign monitoring alarms were also turned off. The patient fell into cardiac arrest while on the PACU, and was quickly revived. However, she died 11 days later due to a brain injury she suffered while not breathing.

In Florida, surveyors visiting HCA Florida Kendall Hospital found the hospital deficient regarding supervision of nursing care. A patient who had been admitted to the hospital for 12 days was discharged earlier but later “returned for necrotic toes on right foot.” The patient had foot gangrene despite being in the hospital for the previous 12 days, during which time “there was no evidence of nursing reassessment documentation for changes in the vascular condition to the [patient’s] right foot.” Hospital policy states patients should be assessed reassessed every shift or whenever there is a change in condition. Nursing assessments of the patient’s foot went undone, precipitating the development of gangrene in the patient’s foot.

In Kansas, CMS cited Menorah Medical Center for nursing assessment failures. For 8 patients sampled, inspectors found no evidence of reassessment for patients who had been administered pain medications like oxycodone hydrochloride, hydrocodone, and fentanyl as required by hospital policy. Inspectors wrote, “The failure to reassess has
The failure to reassess has the potential to place all patients in the facility receiving pain medication at risk for undetected adverse reactions or uncontrolled pain.

In Virginia, inspectors found that Reston Hospital Center failed to document the administration of medication for a patient who was being given morphine. Incomplete documentation included the amount of morphine that the patient had been administered.

In Florida, HCA Florida Trinity Hospital was cited by inspectors for a pattern of missed nursing assessments in the hospital’s ED. There was a lack of documentation proving that patients were being reassessed by a nurse every hour as required by hospital policy.

Patient Falls

In-hospital patient falls are a significant problem for the entire hospital sector. Every year, roughly 700,000 to 1 million patient falls occur in U.S. hospitals. Between 30% and 50% of in-hospital falls result in patient injuries. Patient falls are associated with increased health care use, including increased length of stay in the hospital. In 2008, CMS determined that it would not reimburse hospitals for injuries related to patient falls since “these types of injuries and trauma should not occur in the hospital.” Research suggests that 1/3 of patient falls are preventable.

Academic research indicates associations between hospital staffing and patient falls. One study found patient falls to be associated with both nurse staffing hours and skill mix. Another research paper found, “Units with no injury falls were associated with a higher percentage of unlicensed direct care staff hours.”

One study concludes that missed nursing care “mediates” the relationship between patient falls and staffing. Inadequate staffing puts pressure on staff to perform more care activities in less time, meaning that they might miss or deprioritize certain care tasks such as “ambulation, patient assessments each shift, focused reassessment, call light response, and toilet assistance” which prevent patient falls. The following stories of falls in HCA hospitals reflect the consequences of the company’s staffing decisions.

In Florida, the family of a former HCA Florida Northwest Hospital patient sued the facility after the patient suffered a fall. The fall occurred after the patient had been left sitting in a chair alone for 40 minutes. No hospital staff witnessed the fall, they responded after hearing the sound of someone falling. The patient suffered a hip fracture which required surgery, after which he acquired a Stage 2 pressure injury on his heel. The heel pressure wound worsened and the patient required amputation. A patient fall escalated into limb amputation for a patient whose “condition has deteriorated immeasurably.”

In Florida, HCA Florida Northwest Hospital was cited for a nursing care plan failure. A patient on the telemetry unit was “at risk for fall” and therefore placed under fall.
precautions. The RN assigned to the patient wrote that they “would benefit from a sitter.” The next day, staff heard a loud noise and found the patient on the floor with a “bump over his left eye and laceration on left eyebrow.” The patient was transferred to the ICU after his fall because he had an intracranial hemorrhage. Nine days after admission, “the patient was discharged to hospice.” At the time of the fall, there were 8 sitters available in the hospital. The hospital’s decision to not provide an at-risk patient with a sitter contributed to the patient’s injury and subsequent deterioration.

In South Carolina, Grand Strand Regional Medical Center was sued by the family of a patient who “suffered from a fall which resulted in a pelvic fracture” allegedly because the hospital failed to implement sufficient fall prevention measures.

In Florida, CMS cited HCA Florida Blake Hospital for an RN supervision of care failure. Nursing notes revealed that a patient “had an unwitnessed fall earlier in the morning.” According to the notes, the nurse left the patient unattended to get equipment and found the patient on the floor upon returning. The fall resulted in “a questionable mild dislocation of the right shoulder” for the patient.

In South Carolina, Trident Medical Center was sued by a patient’s family after they “suffered a fall which resulted in a fractured femur that required surgical repair.” The family claims Trident failed to assign sufficient staff to ensure that all necessary care was performed for the patient. The case settled.

In Florida, HCA Florida Brandon Hospital was cited by CMS for patient fall failures. A patient, despite being “legally blind, and hard of hearing,” was assessed to be “not at high risk for falls.” The patient was left unattended while the nurse left to give medication to another patient. The nurse then heard a “loud thud from the patient’s room.” Inspectors found that no fall interventions had been implemented post-fall. Two days later, the patient fell again, hitting his head. The patient had “sustained injury which required surgical repair.” The hospital failed to prevent the patient’s first fall, then failed to implement interventions that could have prevented the patient’s second, more severe fall.

In Florida, the family of a former patient at Grand Strand Regional Medical Center sued the hospital after the patient suffered two falls even though she had been assessed as a fall risk. The patient’s first fall was witnessed and assisted by a CNA. However, the patient suffered a second, unwitnessed fall which resulted in a skull fracture. This fracture produced a hemorrhage which led to the patient’s death. The case is ongoing.

In Florida, CMS cited HCA Florida Ocala Hospital for a nursing care plan deficiency after failing to ensure that a post-fall reassessment was conducted after a patient fall. The patient was found by staff “on the floor next to the bed sitting on a bed pad” and did not know why she was on the floor. Despite this unwitnessed fall, no patient reassessment was documented. Assessments and documentation activities are commonly reported as missed nursing care when nurse workloads are high.

In Florida, a former HCA Florida Gulf Coast Hospital patient sued the facility for negligence after a fall. The patient was recovering from back surgery and “called for
assistance numerous times without any response." Subsequently, she tried to reposition her body by herself. The bed rail on the hospital bed collapsed and she partially fell from the bed, feeling a "popping" sensation in her back. The patient suffered painful nerve damage to areas associated with bowel and bladder function. A failure to respond quickly to calls for assistance led to a patient suffering a permanent physical injury.\textsuperscript{276}

In Texas, HCA Houston Healthcare Southeast was cited for patient care assignment deficiencies after an unattended patient, identified as a fall risk, injured her head while falling out of a bed. According to staff interviews, ICU staff transporting the patient had to rush back to the ICU, so they left the patient unattended. The patient remained unattended and unassessed by the new unit staff and was without a bed alarm or call light. Hours later, nurses found the patient on the floor with a bleeding head injury that required stitches.\textsuperscript{277}

In South Carolina, a former patient of Trident Medical Center sued the hospital after she suffered a fall that resulted in chronic back pain. The patient was in the Trident ED for seizures. After she regained consciousness in the ER, “the medical staff at Trident allowed a newly admitted patient, with stroke and seizure symptoms, who had just recently regained consciousness, to walk unattended down the hall to a bathroom available to the general public.”\textsuperscript{278} While in the bathroom, the patient suffered an unwitnessed fall which left her with spinal fractures and chronic pain.\textsuperscript{279}

In Colorado, CMS found that the Medical Center of Aurora failed to provide follow-up care and monitoring for two patients who experienced fall events. One patient suffered an abrasion on his back when he fell out of bed, but did not get a nursing assessment or follow-up care for it. Another patient fell and bruised her buttocks, but her fall was not recorded until a family member told a nurse about it two days later. The second patient’s nurse was aware of the fall, but said the charge nurse told her not to initiate the fall protocol, record an injury assessment, or document a skin assessment because the fall happened on a fall protection floor mat. Two out of four floor nurses said they did not report falls on protective floor mats and/or if the patients were not injured.\textsuperscript{280} Nursing care left undone often entails activities that “are less likely to be audited.”\textsuperscript{281}

In Florida, HCA Florida Ocala Hospital was sued for negligence by a former patient who suffered a debilitating fall at the hospital. The patient was on blood thinner medications and fell in the shower because a bar in the shower stall broke. Even though hospital staff were notified of the fall, they “failed to document the fall in [patient’s] chart, thereby depriving notice to all medical personnel reviewing [patient’s] chart of that important, red flag event.” The suit alleges that because of the fall and blood thinner regimen, the
patient developed a spinal hematoma. The undocumented and untreated hematoma left the patient “completely paralyzed from her abdomen to her feet.”

**Patient Endangerment**

The following stories of patient endangerment at HCA hospitals speak for themselves. However, it’s useful to reflect on the preventability of such stories. A scholarly review found that one-tenth of all inpatient hospital stays include an event in which care resulted in an undesirable clinical outcome, approximately "half of which are preventable." Patient safety failures are not an inevitable or unpreventable occurrence.

In Florida, the family of a former patient sued HCA Florida JFK Medical Center after a catastrophic medication failure which left the patient in a coma. The patient was recovering from surgery and had been prescribed Dilaudid, an opioid painkiller eight times stronger than morphine. The patient was ordered a usually large dose of Dilaudid to be administered intravenously, in addition to Dilaudid that he was receiving via Patient-Controlled Analgesia (PCA). A nurse administered the large Dilaudid dose, “failing to give it slowly as ordered” and “left before monitoring the effects of this massive dose.” The medication pushed the patient into respiratory arrest, a sign of an opioid overdose. The patient fell into a coma and remained in it when the lawsuit was filed.

In Florida, HCA Florida JFK Hospital was cited by CMS for failures in the treatment of two adolescent psychiatric patients. The patients were involved in physical confrontations on the hospital’s behavioral health unit. Rather than intervene to minimize contact between the patients, staff administered psychotropic drugs to one of the patients and subsequently failed to assess the patients’ condition afterwards. Surveyors found no evidence the hospital implemented other measures to reduce the risk of altercations between the patients. Florida law prohibits hospitals from using “seclusion or restraint for punishment, to compensate for inadequate staffing, or for the convenience of staff.” The fact that no other interventions were used to address the patient altercation suggests that using psychotropic drugs to restrain an adolescent patient was compensation for inadequate staffing.

In Missouri, Research Medical Center was placed into Immediate Jeopardy because, “The facility failed to follow physician orders for a 1:1 sitter (continual observation for safety) for one discharged patient ... that allowed her to successfully elope (escape) from the facility.” The patient was on the psychiatric unit after experiencing an acute psychiatric break. Physician orders placed the patient on 1:1 monitoring, however, hospital staff placed her on 2:1 monitoring instead, and assigned one PCT in the hallway to monitor two different patients. At one point, the PCT had to assist the other patient, and found “it was impossible to watch Patient #3 in her room, at the same time she was assisting the second patient in her room.” After returning from assisting the second patient, the PCT found that Patient #3 had eloped from her room and fled the hospital. Surveyors criticized the hospital: “Patient #3 was assessed as an elopement risk but was not on elopement precautions which included 1:1 observation and successfully eloped from the facility 33 hours after she had undergone and [sic] emergency C-section for the delivery of her infant. **This**
Patient #3 was assessed as an elopement risk but was not on elopement precautions which included 1:1 observation and successfully eloped from the facility 33 hours after she had undergone and [sic] emergency C-section for the delivery of her infant. This placed her at a higher risk of post-surgical complications and risk for her safety.

In Florida, HCA Florida Palms West Hospital was cited by inspectors after a patient death. A hospital RN removed a central venous catheter (CVC) from a patient while the patient was sitting up in a chair, which she acknowledged as "not the appropriate way" to do so. This inappropriate removal technique led to "complications of probable air embolism" for which the patient was quickly intubated. Despite the intubation, the patient suffered brain death and medical care was withdrawn. "The patient passed away ... with the parents at the bedside" 4 days after the improper CVC removal. Even for trained hospital workers, personnel and experience understaffing can lead to the use of safety workarounds.

In Florida, HCA Florida Northwest Hospital was sued by the widow of a patient after hospital staff overdosed the patient on the opioid painkiller Dilaudid. The suit alleges that documentation and evaluation failures by hospital staff led to the patient overdosing on the drug. The overdose led to the patient suffering a hypoxic brain injury which precipitated a deadly stroke months later.

In South Carolina, Trident Medical Center was sued by the widower of a patient who died after suffering an anoxic brain injury while sedated for an MRI and CT scan. The suit alleges that there was "no evidence that [the patient] was monitored for any vital signs during the procedure" despite being sedated using painkillers such as fentanyl, oxycodeone, and Morphine.

In North Carolina, Mission Hospital was cited by CMS for failures which precipitated a patient’s in-hospital death from a suspected “hospital IV drug use overdose.” A patient with a history of drug use experienced a pattern of suspicious events: a disconnected IV line, losing consciousness in the bathroom with used syringes, and “an unknown white substance” in the patient’s room. Despite this pattern, the sitter in the patient’s room was removed. The patient was later found dead “with her IV disconnected and [saline] flushes found in her bed.” Interviews revealed that the nurse that conducted the patient’s admission assessment “had not received any education on patients with a history of substance abuse.” A physician stated that the sitter in the patient’s room should have remained in place after the pattern of suspicious events became known.

In Virginia, CMS found Reston Hospital Center deficient with regard to patient safety. Medications such as saline flush syringes, insulin and insulin syringes, asthma treatment Albuterol, Tylenol, the anti-epileptic drug Gabapentin, the anti-inflammatory Celebrex,
antibiotics, and various laxatives were left unattended and unsecured on hospital carts. In an interview, the hospital’s VP of Quality stated that the hospital did not have a policy for safe and secure medication storage.296

In Texas, HCA Houston Healthcare Southeast was cited by CMS for failing to provide care in a safe setting for a psychiatric patient. Although the patient had a physician order for suicide precautions, the patient was able to obtain multiple sharp objects while staying in the ED. 297

In Texas, CMS cited HCA Houston Healthcare Clear Lake for a failure “to promote and maintain the rights of its patients, by ensuring patients receive care and services in a safe setting free from abuse/ neglect.” In one incident, a patient fell out of a chair and lay unattended in a pool of his own blood for 17 minutes before being taken to the ER. The inspection also revealed instances of patient sexual abuse. The facility had temporarily shut down its Senior Care Unit prior to the CMS investigation.298

In South Carolina, the family of a patient at Colleton Medical Center sued the hospital after the patient died of an “anoxic brain injury” when he stopped breathing inside an MRI machine. Despite needing oxygen assistance, the patient was sent into an MRI machine “without pressurized air to assist with his breathing and with no ability to monitor his heart, breathing, or oxygen levels.” During the MRI, the patient stopped breathing, was removed from the machine, and then was resuscitated. The patient was without oxygen for at least 19 minutes. The resulting brain injury led to the patient’s death 10 days after the MRI incident.299

In Tennessee, Parkridge Medical Center was cited for patient rights failures. The inspection found that a Mental Health Technician stepped away from a patient who was ordered to be on 1:1 monitoring due to suicidal ideation. The technician moved out of arm’s length of the patient, who then harmed herself using plastic cutlery. The patient was transferred to the ER to treat her wounds.300

Improper Use of Restraints & Seclusion

Hospitals participating in Medicare must abide by a number of standards which are specific to the practices of restraint and seclusion. Physical restraint is “[a]ny manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.”301 Restraints can also be medications when they are “used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement.”302 Regulations dealing with restraint and seclusion are extremely detailed and specific because of the long and controversial history of such practices in medicine.303

Many clinicians assert that restraint and seclusion “should only be used as a last resort.”304 Despite stringent regulations and clinicians’ aversion to restraint and seclusion, we found numerous troubling care failures related to such practices at HCA hospitals. These deficiencies may stem from HCA’s demonstrated pattern of low staffing.
Scholars have found that “when unit skill mix was low, hospital staff were apparently more likely to use restraints.” Similary, another study linked higher numbers of “more qualified nurses” to lower rates of patient distress such as patient self-harm, medication refusal, and alcohol intoxication, all of which can be antecedents to restraint and seclusion. One paper uncovered an association between increased RN staffing and decreased restraint use on critical care units. Another concluded, “high RN absenteeism in combination with a high patient load was associated with significantly higher use of restraints.”

With this context in mind, the following inspections reveal concerning patterns of restraint and seclusion practices at HCA hospitals.

In Idaho, CMS placed West Valley Medical Center in Immediate Jeopardy because it failed to provide care in a safe setting for 2 patients who were secluded/restrained. Inspectors found that lack of staff training and lack of assessment led to multiple restraint violations. One patient was placed in four-point limb restraints without justification, administered a cocktail of chemical restraints, and kept secluded in an isolation room without assessment. The hospital’s failures “had the potential [to put] all patients being treated for Behavioral Health at risk for serious harm, injury, or death.”

In Texas, CMS cited HCA Houston Healthcare Tomball for dangerous restraint failures. A patient spent two days in mechanical wrist restraints. Behavioral restraints can only be ordered for four hours at a time, and the facility failed to obtain physician orders for most of these restraint uses. The patient was also administered Hydromorphone, a sedative stronger than morphine, three times over a nine-hour period. After the third dose, the patient’s oxygen levels plummeted. They had to be placed on a BiPAP and transferred to the ICU. Sedatives used as chemical restraints pose “unique risks” such as “memory issues and respiratory depression” to patients. A patient was doubly restrained, with wrist restraints and a sedative, which seems to have contributed to their respiratory decline.

In Texas, CMS cited HCA Houston Healthcare Northwest for failing to offer alternatives to reduce the need for restraints. A patient tried to get out of bed while restrained and got stuck with her feet and body hanging off the bed. Inspectors found that alternatives to restraint had not been considered.

In Virginia, Henrico Doctors’ Hospital was cited by inspectors for failing to obtain renewed orders for restraints after the original restraint order expired and failing to ensure a restrained patient was assessed as required. These failures are especially concerning since the patient being restrained was “a nonverbal autistic and mentally challenged young adult.”

In Florida, two HCA hospitals failed to report to CMS patient deaths in which restraints “[c]ontributed directly or indirectly to a patient’s death.” HCA Florida Osceola Hospital was cited after a patient fell out of a bed fitted with restraints, striking their head on the floor. The patient was discharged to hospice and died soon after. The hospital did not report the patient death to CMS as required. HCA Florida Poinciana Hospital was found deficient after a patient died while subject to similar bed rail restraints. The
hospital did not report the death as a restraint-related one to CMS.\textsuperscript{315}

\section*{Staff Education/Training}

The following stories highlight the consequences of hospital staff training failures. Such failures often consist of unqualified staff performing complex care tasks which, if conducted improperly, can lead to severe harm and even death for patients.

In South Carolina, Trident Medical Center was sued by the family of a patient after care failures led to the patient’s death. The lawsuit alleges that, after surgery, the patient was readmitted to the hospital and “developed a severe pressure ulcer while laying [sic] in urine for more than two hours.” The patient developed an enterocutaneous fistula (ECF) in her abdomen. The lawsuit further alleges that, at Trident, “no proper supplies were provided to the staff to properly care for the ECF and untrained medical personnel failed to properly care for the [patient], again, the family was required to assist in cleaning the wound.” The patient died.\textsuperscript{316}

In Tennessee, TriStar Centennial Medical Center was cited for violations in staffing and delivery of care, patient rights, and nursing care plans. The hospital failed to assess the risk for suicide and violent behavior for 3 patients. In one case, a patient was found unresponsive in the morning hours and quickly pronounced dead. Staff searched the patient’s room and found two Xanax tablets as well as two Subutex (a narcotic) tabs among the patient’s belongings. Inspectors found that staff personnel files contained no records of recent training or annual competency assessments for the 9 staff on the behavioral health unit. The Nursing Director admitted, “there was no documentation for the training the mental health associates received for the belongings search and rounding.”\textsuperscript{317}

In Florida, CMS found HCA Florida Westside Hospital deficient in supervision of contract staff. A patient in the ED was admitted to the telemetry unit and was not designated a Stroke Alert despite being eligible for it based on their conditions. There was no bed available in the telemetry unit, so a contracted travel nurse from telemetry was sent to the ED to care for the patient there. Although the patient was supposed to be on telemetry monitoring, they were not connected to the equipment. The travel nurse “was assigned to 5 patients... all in the emergency department hallway.” Later, after checking the patient’s vital signs, the travel nurse and a colleague called a Rapid Response and Stroke Alert. The patient had to be taken to the ICU to treat the stroke. The telemetry director “who had interviewed and agreed to have the travel nurse work on the telemetry unit, could not confirm the travel nurse had training or experience calling a Rapid Response or Stroke Alert Code.”\textsuperscript{318} Use of temporary nursing staff has been linked to higher in-hospital patient mortality.\textsuperscript{319}

In Colorado, The Medical Center of Aurora was cited for violations of the patient care assignments standard after the hospital allowed a travel nurse to perform dialysis via
CRRT (Continuous Renal Replacement Therapy) on a patient without verifying their training or competency in CRRT.\textsuperscript{220}

In South Carolina, Trident Medical Center was sued by a former patient who alleged he was subject to excessive force by hospital security while trying to leave the hospital. The patient claims that a security guard’s use of excessive force, including punches and kicks, led to him falling down and a surgical wound on his knee opening up. The bleeding wound needed to be stitched up again.\textsuperscript{221} The suit alleges the hospital failed “to supervise and train personnel on safe and proper security enforcement protocols” and “on the safe, reasonable, and proper levels of force.”\textsuperscript{222}

In Florida, a former patient of HCA Florida Woodmont Hospital sued the facility after it allegedly “carelessly and negligently supervised, trained, and/or monitored its orderlies when they attempted to restrain and subdue” her. The patient claims the orderlies used excessive force when trying to restrain her, and that she sustained injuries as a result.\textsuperscript{223}

In California, CMS cited Good Samaritan Hospital for failing to validate the competencies of one of the hospital’s ED technicians. Specifically, the tech’s competencies for acting as an ED sitter had never been validated even though they had worked at the hospital for six months. Good Samaritan also “failed to ensure a licensed nursing staff had proper training prior to providing care to a patient with an external ventricular drain (EVD).” The ED nurse assigned to the EVD patient “stated she did not have training to take care of a patient with an EVD and was uncomfortable” with her assignment.\textsuperscript{224}

In Florida, CMS cited HCA Florida Blake Hospital for failing to conduct performance reviews of contract nurses. The inspection was in 2020; the hospital had employed two agency nurses since 2017 without conducting annual performance reviews for them.\textsuperscript{225}

**Governance**

CMS inspectors have found governance, reporting, and quality assessment deficiencies at HCA facilities. Such deficiencies point to leadership and governance failings at the company’s hospitals and suggest that some patient care failures may be going unreported.

In California, Good Samaritan Hospital was cited for quality governance failures. After two units were out-of-ratio in terms of nurses-to-patients on seven different shifts, the hospital’s Chief Nursing Officer (CNO) had no documentation of attempts to fix the chronic understaffing. Even though understaffing led to missed patient assessments on those units, the CNO admitted, “\textit{there is no system in place to evaluate the nursing care provided during out-of-ratio shifts.}” Good Samaritan’s governance failures compounded the problem of understaffing by making it harder to solve. Surveyors wrote, “\textit{The cumulative effect of these systemic problems resulted in the hospital’s inability to ensure the provision of quality health care in a safe environment.}”\textsuperscript{226}

In Idaho, West Valley Medical Center was cited for governing and quality improvement deficiencies. The facility failed to ensure that patients’ rights were protected, patients received care in a safe setting, and that restraints were used appropriately. CMS
determined that hospital leadership “failed to ensure adverse patient events were reported, analyzed, and actions were taken to prevent further incidents for patients on whom restraints were used.”\textsuperscript{327}

In Louisiana, Tulane Medical Center was cited for its failure to report two patient elopement incidents within 24 hours to the Louisiana Department of Health. These failures violated hospital policies concerning prevention of abuse and neglect.\textsuperscript{328}

In Texas, CMS determined that The Corpus Christi Medical Center failed to self-report a patient’s “allegation of sexual contact with another patient during the patients [sic] admission.” The allegation was conveyed to the hospital after the patient’s discharge by the patient’s school nurse, but, the hospital could not produce evidence “that a self report was completed according to regulations.”\textsuperscript{329}
ENDNOTES


2. https://hospitalwatchdog.org/no-continuous-monitoring-for-some-cvicu-patients/


11. SEIU analysis of local union contracts.


13. Analysis of Medicare Cost Report data. FTE Rate compares the number of staff (full time equivalents) to the volume of patients. The formula is: Full Time Equivalents/ (Adjusted Inpatient Days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities. These averages are weighted averages.


In statistical terms, the standard deviation in HCA’s 2020 FTE ratios is 1.3, while the standard deviation in non-HCA hospitals is twice as large at 2.6.

AHD.com hospital profiles for Memorial Satilla Health and Memorial Health University Medical Center. SEIU analysis of Medicare cost report data.

SEIU analysis of Medicare cost report data.

"Concerns mount as doctors leave HCA; Physicians citing more work, less pay," The Asheville Citizen-Times (North Carolina), May 16, 2021

Total FTE’s are from Form CMS-2552-10, Worksheet S-3 Part I, Row 27, Column 10. Note that one FTE could be one person working full time or more than one person working part time.

SEIU analysis of Medicare cost report data.


36 https://www.hfma.org/topics/hfm/2019/october/hospitals-innovate-to-control-labor-costs.html

37 Data from Capital IQ

38 Data from Capital IQ

39 HCA 2021 10K, p. F-5

40 Data from Capital IQ

41 Data from Capital IQ


45 HCA Healthcare, Inc. (HCA) CEO Sam Hazen on Q1 2022 Results - Earnings Call Transcript. P.2-3.

46 HCA Healthcare, Inc. (HCA) CFO Bill Rutherford on Q1 2022 Results - Earnings Call Transcript. P.13.

47 Results from SEIU member survey

48 HCA Healthcare, Inc. (HCA) CEO Sam Hazen on Q1 2022 Results - Earnings Call Transcript. P.3.

49 HCA Healthcare, Inc. (HCA) CFO Bill Rutherford on HCA Presents at 3rd Annual Wolfe Research Conference, November 18, 2021. p.8


51 Complaint, Dunn v. Marion Community Hospital, (Case no: 21CA001165A. Cir Ct. Fla. – Marion, filed 6/24/2021). ¶11-13. The case is ongoing as of May 2022

52 HCA Healthcare, Inc. (HCA) CFO Bill Rutherford on Q1 2022 Results - Earnings Call Transcript. P.5.


HCA Healthcare, Inc. (HCA) CEO Sam Hazen on Q1 2022 Results - Earnings Call Transcript. P.18.


https://www.denverpost.com/2022/05/04/donquenick-joppy-lawsuit-medical-center-aurora/


76 https://www.denverpost.com/2022/05/04/donquenick-joppy-lawsuit-medical-center-aurora/


78 https://www.denverpost.com/2022/05/04/donquenick-joppy-lawsuit-medical-center-aurora/


82 https://hospitalwatchdog.org/no-continuous-monitoring-for-some-cvicu-patients/


87 TERE HAMBY v. LARGO MEDICAL CENTER INC. Sixth Judicial Circuit Court of Florida for Pinellas County. Case No. 522021CA001720XXCICI (filed April 6, 2021). Complaint (filed April 6, 2021). p. 3.
As shown in Figure 1 above, HCA's system-wide FTE rate rose from 3.77 FTE's per adjusted occupied beds in 2019 to 3.85 in 2020, an increase in the rate of 2%. However, the nationwide average FTE rate increased from 5.5 FTE's per adjusted occupied beds in 2019 to 5.8 in 2020, which is a larger increase of 5%. The components of the FTE rate are total FTE's, a measure of the total number of staff at facilities, and adjusted occupied beds, which is a measure of patient occupancy. We compared the changes in these metrics both nationwide, and in a set of HCA hospitals that were owned by the system in both 2019 and 2020. All hospitals in the set submitted cost reports in both 2019 and 2020 with fiscal year end dates after March 31. Adjusted occupied beds, the measure of occupancy, decreased similar amounts of 5% nationwide and 6% at the HCA hospitals. However, the total FTE's employed at hospital facilities decreased by just 1% on average nationwide, but by 4% at HCA-owned facilities.
com/2022/01/a-whopping-majority-of-surveyed-workers-at-hca-say-staffing-shortage-is-compromising-patient-care/


104 https://nationaltelemetryassociation.org/how-to-become-a-telemetry-technician-everything-you-need-to-know/


112 SEIU analysis of CMS Care Compare data using 2021 annual files. Unweighted average star rating among all hospitals receiving a star rating in this year. Because star ratings take into account multiple evaluation periods, this analysis defines the HCA system to include all hospitals currently owned by HCA.

113 The numerator of this percentage is the total number of hospitals owned by HCA for the entire evaluation period which were found to be "Worse Than the National Rate," "More Days Than Average per 100 Discharges," or "Worse than expected" in the "Compared to National" field of CMS data. The denominator includes all hospitals owned by HCA for the entire evaluation period and that had enough cases to receive a comparison rank. Hospitals with "Not Available" or "Number of Cases Too Small" values in "Compared to National" are excluded from the denominator.

CMS categorizes each hospital’s performance on mortality, readmission, and complication measures based on whether the 95% confidence interval estimate of the hospital’s rate for a particular measure is completely below the national observed rate, contains the national observed rate, or is completely above the national observed rate for that measure. CMS chose to measure death within 30 days instead of inpatient deaths to use a more consistent measurement time window, because length of hospital stay varies across patients and hospitals.


SEIU analysis of CMS Care Compare data using 2021 annual files.

There are three types of readmissions measures: Rates of readmission - how often patients return to the hospital soon after being discharged. Measures of unplanned hospital visits after outpatient procedures - how often patients visit the hospital (in the emergency department, under observation, or in an inpatient hospital unit) after an outpatient procedure. Hospital return days - the average number of days patients who are hospitalized for certain conditions spend back in the hospital (in the emergency department, under observation, or in an inpatient hospital unit) soon after they are discharged.

https://data.cms.gov/provider-data/topics/hospitals/unplanned-hospital-visits


https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS

SEIU analysis of CMS Care Compare data using 2021 annual files.

National rates are provided by CMS. The national comparison group for hospitals includes “All short-term, acute care, non-specialty hospitals, including Veterans Health Administration (VHA) and Department of Defense (DoD) hospitals,” Publicly reported HCAHPS data is adjusted for case mix to allow for fair comparison. https://data.cms.gov/provider-data/topics/hospitals/hcahps

A completed survey is defined as one where the respondent has answered at least 50% of the questions. Unanswered questions are not included in the totals. (https://www.hcahpsonline.org/globalassets/hcahps/quality-assurance/2022_qag_v17.0.pdf p.174)

https://psnet.ahrq.gov/perspective/missed-nursing-care-key-measure-patient-safety


132 HCA system-wide HCAHPS scores are the average of “Answer Percent” at each HCA hospital owned during the evaluation period. National-level rates for the same time period are as provided by CMS and include data from HCA hospitals. HCA hospitals had a total of 39,316 HCAHPS surveys during this collection period. Data were retrieved from CMS’s 2021 data table “Patient survey (HCAHPS) - Hospital.” The time period for all HCAHPS measures reviewed is 7/1/2020 -12/31/2020.


139 AHRQ’s Evidence Based Nursing Handbook  https://www.ncbi.nlm.nih.gov/books/NBK2650/


154 Analysis of Medicare Cost Report data. FTE Rate compares the number of staff (full time equivalents) to the volume of patients. The formula is: Full Time Equivalents/ (Adjusted Inpatient Days/ Days in period). The adjustment to inpatient days accounts for outpatient utilization at the facilities. These averages are weighted averages.

156 Olesen vs. Fawcett Memorial Hospital inc. Filed August 8, 2019. Circuit Court of the 20th Judicial Circuit in and for Charlotte County, Florida. Case number 19000847CA. Complaint for Damages p.3.


Event ID IGBW11, Deficiency Tag: 0395. Deficiency Description: RN SUPERVISION OF NURSING CARE. St. David’s South Austin Medical Center. 3/3/2020.

Event ID IGBW11, Deficiency Tag: 0395. Deficiency Description: RN SUPERVISION OF NURSING CARE. St. David’s South Austin Medical Center. 3/3/2020.


https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals


198 Katherine Frame et al vs. Marion Community Hospital, Inc. d/b/a Ocala Regional Medical Center et al. Fifth Judicial Circuit Court of Florida for Marion County, Case No. 422019CA000604CAAXXX (filed March 15, 2019). Second Amended Complaint (filed June 7, 2021). pp. 3-8.
199 Katherine Frame et al vs. Marion Community Hospital, Inc. d/b/a Ocala Regional Medical Center et al. Fifth Judicial Circuit Court of Florida for Marion County. Case No. 422019CA000604CAAXXX (filed March 15, 2019). Second Amended Complaint (filed June 7, 2021). pp. 3-4.

200 Katherine Frame et al vs. Marion Community Hospital, Inc. d/b/a Ocala Regional Medical Center et al. Fifth Judicial Circuit Court of Florida for Marion County. Case No. 422019CA000604CAAXXX (filed March 15, 2019). Second Amended Complaint (filed June 7, 2021). p. 4.

201 Katherine Frame et al vs. Marion Community Hospital, Inc. d/b/a Ocala Regional Medical Center et al. Fifth Judicial Circuit Court of Florida for Marion County. Case No. 422019CA000604CAAXXX (filed March 15, 2019). Second Amended Complaint (filed June 7, 2021). pp. 7-8.

202 https://nationaltelemetryassociation.org/the-importance-of-a-telemetry-unit-in-hospitals/


207 Event ID: TX1J11. Deficiency Tag: 0395. Deficiency Description: RN SUPERVISION OF NURSING CARE. HCA Florida South Tampa Hospital. 4/1/2021.


225 Event ID 1WPE11, Deficiency Tag: 0395. Deficiency Description: RN SUPERVISION OF NURSING CARE. HCA Houston Healthcare West. 2/12/2021.


242 Event ID: M4DR11. Deficiency Tag: 1100. Deficiency Description: EMERGENCY SERVICES. Regional Medical Center of San Jose. 8/25/2021.

243 Event ID: NZOV11. Deficiency Tag: 2406. Deficiency Description: MEDICAL SCREENING EXAM. Regional Medical Center of San Jose. 7/21/2021.


Elizabeth Cuffy et al VS Grand Strand Regional Medical Center LLC. Court of Common Pleas of South Carolina, Horry County. Case No. 2020CP2606047 (filed October 20, 2020). Complaint (filed October 20, 2020). p. 3.
Endnotes


