Status **Active** PolicyStat ID **10623373**

Origination	10/2008	Owner	Joshua Weston
Last Approved	10/2021	Policy Area	Clinical Decision Unit
Effective	10/2021	Applicability	WA - Kadlec Regional Medical Center
Last Revised	10/2021		
Next Review	10/2024		

Staffing Requirements for CDU, 23.01.00

Document Type: Policy, Procedure

SUPERSEDES: 4/09, 10/08 (New to CDU 10/08, replaced SSU 22.01.00)

POLICY STATEMENT:

Ensure that adequate staffing standards are maintained for the management of patient care.

RESPONSIBLE PARTIES:

Clinical Decision Unit Charge Nurse
Clinical Decision Unit Manager

POLICY:

The following guidelines will be followed to ensure that adequate, qualified staffing is maintained in the Clinical Decision Unit

1. Staffing patterns are based on patient needs and analysis of patient acuity and nursing skill level.
2. The staffing matrix (see attachment) and Charge Nurse assessment of patient acuity and nursing skill level will determine staffing for each shift.
3. The Clinical Decision Unit's normal RN to patient ratio is 1:5 or 1:4
4. Staffing may be under the matrix when most patients have a lower acuity or needs and staff has sufficient skill and experience.
5. Staffing may be above the matrix when there are increased patient needs, increased patient acuity, or insufficient level of skill or experience of nursing staff, such as the following:
    - Use of patient restraints

- High volumes of patients in isolation, restraints, or high fall risk.
- Patients requiring increased emotional support (i.e. end of life care, psych-social issues)
- Titrated drips requiring special or frequent monitoring. (Does not include heparin.)
- Patients requiring 1:1 supervision
- Patients experiencing detox
- Patients with frequent assessment needs (i.e. post cath, CBI, etc.)
- Medically unstable patients
- Staff untrained for patient care required or inexperienced

6. The Charge Nurse will assign staff to patients' care in accordance with the degree of supervision needed by each individual patient and nurse and the availability of the Charge Nurse and other support staff.
7. If the standard is compromised due to patient acuity, patient volume, lack of nursing or ancillary personnel, and/or lack of in-house resources, the Charge Nurse will implement the following actions in the recommended sequence:
    - Contact the PCC
    - Contact Unit Manger
    - Contact Director of Nursing Services
    - Use the Daily Staffing Sheet to document all steps taken to resolve the problem and the reason for staffing deficit.
8. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.
9. Registered nurses in each of the patient areas will prescribe, delegate, coordinate and supervise the care provided by the CNAs and Unit Secretary/Technician.

Attachments

CDU Matrix.pdf

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	10/2021

Executive Assistant	Heather Shipman: Executive Assistant	10/2021
Dir Nursing Svcs	Kathy Christensen: Dir Nursing Svcs	10/2021
Unit Manager	Joshua Weston: Mgr Unit	10/2021

Clinical Decision unit

Staffing Matrix Guideline

CDU DAYS					CDU NOC			
# Pts	Lead RN	RN	CNA	HUC	Lead RN	RN	CNA	HUC
1	1	1	-	-	1	1	-	-
2	1	1	-	-	1	1	-	-
3	1	1	-	-	1	1	-	-
4	1	1	-	-	1	1	-	-
5	1	1	-	-	1	1	-	-
6	1	1	-	-	1	1	-	-
7	1	1		-	1	1	-	-
8	1	1-2	1	-	1	1	1	-
9	1	2	1	-	1	1-2	1	-
10	1	2	1	1	1	2	1	-
11	1	2	1	1	1	2	1	-
12	1	2	1	1	1	2	1	-
13	1	3	1	1	1	3	1	-
14	1	3	2	1	1	3	1	-
15	1	3	2	1	1	3	2	-
16	1	3-4	2	1	1	3	2	-
17	1	4	2	1	1	3-4	2	-
18	1	4	2	1	1	4	2	-
19	1	4	2	1	1	4	2	-
20	1	4-5	2	1	1	4	2	-
21	1	5	2	1	1	4	2	-
22	1	5	2	1	1	4-5	2	-
23	1	5-6	2	1	1	5	2	-

- Lead nurse on day (weekends/weekdays) may take 1-2 patients based on the leads assessment to assist with patient flow and nurse assignments. Night shift may take up to 3 at the beginning of shift if needed.
- Number of anticipated recoveries may be counted in the census from 0600-1000 Monday-Friday, up to 23.
- Lead nurse may consider using a staffing ratio of 5 to 1 in order to facilitate flow on the unit. This is dependent on acuity and the lead RN's assessment.
- Scheduled IV therapies will be staffed outside of this matrix.

Updated 10/25/2021

Status **Active** PolicyStat ID **8053825**

Origination	07/1997	Owner	Erika Barton
Last Approved	08/2020	Policy Area	Emergency Dept.
Effective	08/2020	Applicability	WA - Kadlec Regional Medical Center
Last Revised	08/2020		
Next Review	08/2023		

Staffing Requirements, 24.00.08

SUPERSEDES: 06/13, 6/11, 10/10, 05/08, 02/08,05/07, 5/05, 11/03, 4/03, 7/23/02, 10/00, 11/98, 7/97

POLICY STATEMENT:

Ensure that adequate staffing standards are maintained for the management of patient care in the Emergency Department (ED).

RESPONSIBLE PARTIES:

ED Unit Manager; ED Clinical Coordinator; and ED Charge Nurse

POLICY:

1. The following guidelines will be followed to ensure that adequate, qualified staffing is maintained in the ED in all patient care rooms.
2. Staffing is based on patient volumes and arrival times and how they impact standards of emergency nursing care.
3. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.

PROCEDURE:

The staffing standards are as follows 7 days a week, except as noted

	ED Nursing Staff (Includes Charge Nurse)		
	Time	**Standard**	
	0700 – 0900	7	

0900 – 1100 1000 – 1100	9 11	
1100 – 1200	13	
1200 – 1300	14	
1300 – 1400 1400 – 1500	15 16	
1500 – 1900	17	
2100 – 2200	15	
2200 – 2300	13	
2300 – 0000	11	
0000 – 0100	10	
0100 – 0200	9	
0200 – 0300	8	
0300 – 0700	7	
Emergency Department Technicians (EDT's)		
Time	**Standard**	
0700 – 1000	3	
1000 – 1100	4	
1100 – 1400	5	
1400 – 1500	6	
1500 – 1900	7	
1900 – 2200	6	
2200 – 2300	5	
2300 – 0200	4	
0200 – 0300	3	
0300 – 0700	2	

1. Patient census and acuity must be evaluated when assessing staffing standards in the department.
2. It is the responsibility of the ED Charge Nurse to evaluate the situation and secure additional staff or to reallocate staff to ensure the staffing standards.
3. Staff may be reduced due to low census in accordance to respective Collective Bargaining Agreements. Charge nurses are responsible for contacting the Patient Care Coordinator (PCC) prior to sending staff home to see if additional resources needed.
4. If the standard is compromised due to patient acuity, patient volume, lack of nursing or ancillary personnel, and/or lack of in-house resources, the Charge Nurse will implement the following actions in the recommended sequence.
    A. Follow the Short Staffing Algorithm (see attached)

B. Contact the Unit Manager or Clinical Coordinator.

C. If additional resources are needed, notify leadership prior to calling in staff to work.

D. Review Capacity Management Policy (634.00)

5. Use the ED daily communication sheet to document all steps taken to resolve the problem and the reason(s) for staffing deficit.

1. Daily patient care assignments:
    A. The Unit Manager works Monday through Friday, assisting in the department as necessary/available.
    B. The Clinical Coordinator works Monday through Friday, assisting in the department as necessary/ available.
    C. The Clinical Educator will work 40 hours per week and will assist in the department as necessary/ available.
    D. The Charge Nurse will be designated based on the job description, skills and ability, and assigned accordingly. Every effort will be made to have the most qualified nurse on each shift as the Charge nurse. When more than one qualified Charge nurse is on a shift, other Charge nurses will rotate room assignments and working in Check-in.
    E. A daily staffing roster is provided to the Charge Nurse assigning staff to all patient care zones in accordance with skills and ability and documented on the ED daily communication sheet. Staff who are on orientation will be taken into consideration when assignments are made. Assignments will be posted on a designated clipboard at the Charge nurse desk, in all patient care zones and publicly in the department per RCW 70.41.420
    F. Registered nurses in each of the patient areas will, delegate, coordinate and supervise the care provided by the Emergency Department Technicians.

Attachments

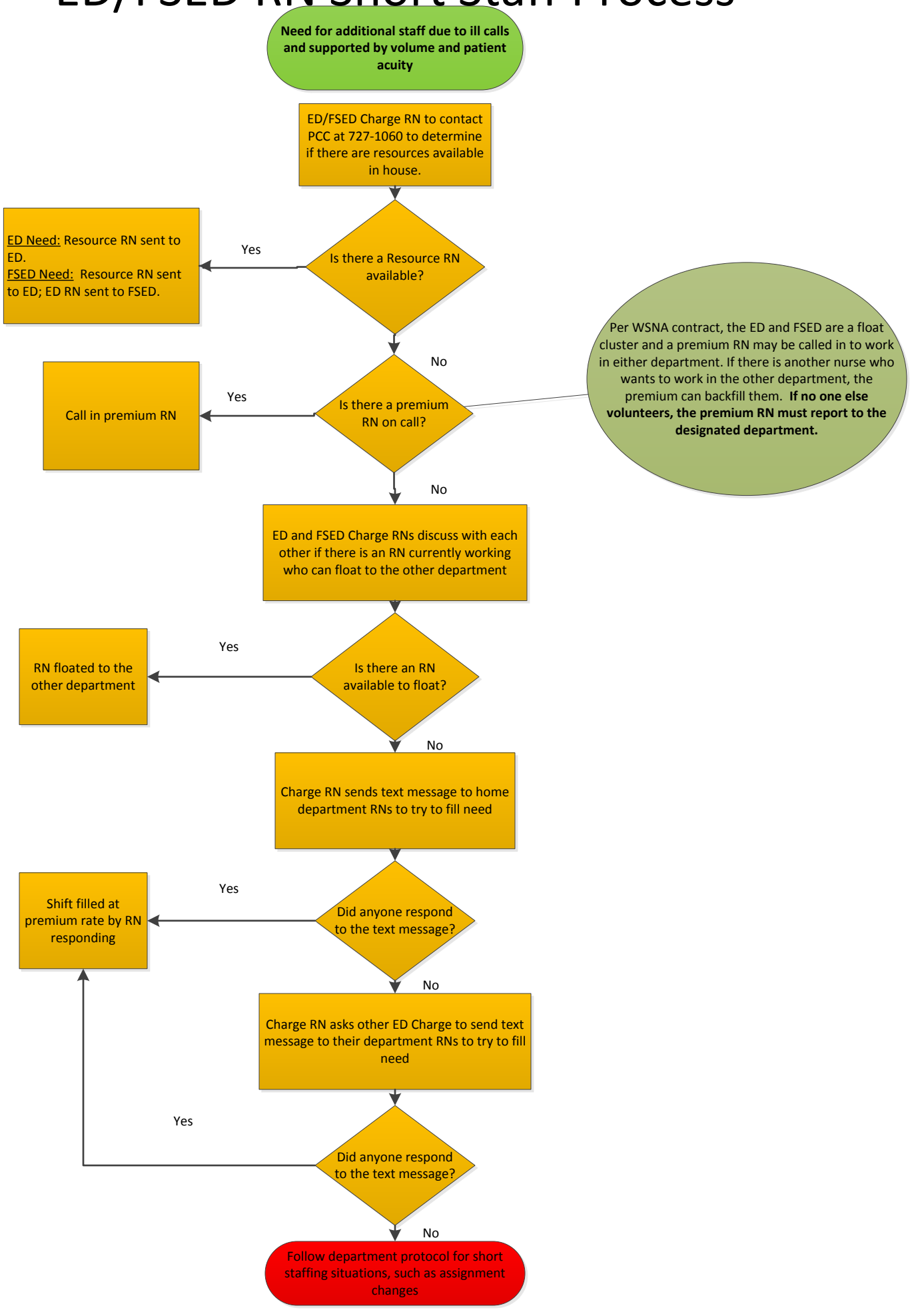
RN Short Staffing.pdf

Approval Signatures

Step Description	Approver	Date

VP, Nursing & CNO	Kirk Harper: CNO	08/2020
Executive Assistant	Heather Shipman: Executive Assistant	07/2020
ED Manager	L Currey: Mgr Unit [ND]	07/2020

ED/FSED RN Short Staff Process



Status **Active** PolicyStat ID **3673601**

Origination	12/1997
Last Approved	11/2019
Effective	11/2019
Last Revised	11/2019
Next Review	11/2022
Owner	Trinity Mugo
Policy Area	Birth Center
Applicability	WA - Kadlec Regional Medical Center

Guidelines for Staffing, 26.02.01

Document Type: Guideline

1. PATIENT ACUITY: Patient acuity will be assessed every shift to assure adequate staffing.
2. PATIENT ASSIGNMENT: Patients with higher acuity will be assigned to the more experienced nurse on duty.

BIRTH CENTER:

Recommended nurse-patient ratios based on "Guidelines for Perinatal Care", 8TH Edition, 2017, Guidelines for Professional Registered Nurse Staffing for Perinatal Units, 2010

LABOR & DELIVERY CARE:

1:1	Initial Triage: (this ratio may change to 1 nurse to 2-3 observations as maternal/fetal status is determined to be stable until patient disposition).
1:3	Antepartum testing: Nonstress testing and observations
1:3	Antepartum patients in stable condition
1:1	Antepartum patients who are unstable
1:1	Continuous bedside attendance for woman receiving IV magnesium sulfate for the first hour of administration. No more than one additional couplet or woman for a nurse caring for a woman receiving IV magnesium sulfate in a maintenance dose.
1:2	Cervical ripening with pharmacologic agents
1:1	Laboring patient with medical or obstetrical complications during labor
1:1	Laboring patient receiving oxytocin
1:1	Laboring with minimal to no pain relief or medical interventions
1:1	Laboring being monitored via intermittent auscultation

1:1	Regional anesthesia: continuous bedside nursing attendance during initiation until condition is stable
1:2	Premature labor patients being stabilized on tocolytics
1:1	Patients in second stage, fetal distress, post-partum hemorrhage
2:1	Birth; one nurse responsible for the mother and one nurse whose sole responsibility is the baby.
1:1	Initial post-partum recovery (for at least 2 hours)
1:1	Ill patients with complications
1:1	Initial C-section recovery (for at least 2 hours)
1:1	Circulating for cesarean delivery

MOTHER-BABY CARE:

1:2	Immediate postoperative day who are recovering from cesarean birth as part of the nurse-to-patient ration of one nurse to three mother-baby couplets.
1:3-4	Recently born infants and those requiring close observation
1:3	Stable Mother-Baby couplets
1:5-6	Post-partum patients without complications (no more than two to three women on the immediate postpartum day who are recovering from cesarean birth as part of the nurse-to-patient ration of one nurse to five to six women without complications).
1:3	Postpartum Patients with complications, but in stable condition
1:5-6	Newborns needing only routine care

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	11/2019
Executive Assistant	Heather Shipman: Executive Assistant	10/2019
Birth Center Manager	Trinity Mugo: Mgr Unit	10/2019
Registered Nurse Birth Center	Teriesa Pleyo: Clinical Educator RN	10/2019

Status **Active** PolicyStat ID **11242687**

Origination	07/1996
Last Approved	05/2022
Effective	05/2022
Last Revised	05/2022
Next Review	05/2025

Owner	Jill Mathews
Policy Area	Intensive Care
Applicability	WA - Kadlec Regional Medical Center

Acuity/Staffing for Intensive Care, 29.33.00

Document Type: Standard

GENERAL INFORMATION:

Patients receiving nursing care in the Intensive Care Unit (ICU) have a wide variety of acuity, and guidelines are helpful in determining appropriate patient assignment and care.

1. Lead Nurse will be responsible for appropriate assignment based on available staff and patient acuity.
2. Experienced ICU RN's (KMC employees, travelers, agency) will care for the most critically ill patients.
3. RN's floated from Stepdown Unit will care for med-surg patients or stable critical care patients.
4. Experienced ICU RN's with open-heart training, or who are in training, only may care for open-heart patients in the immediate recovery period.

INDICATOR	CRITERIA
A. Guidelines for High Acuity Staffing, 1:1 nurse ratio	1. IABP (if stable may go to 2:1 at lead discretion) 2. Open Heart Surgery until early extubation or stabilized. 3. Continuous cardiopulmonary monitoring, assessment, and interventions every 5 minutes required. 4. Hypothermia (if stable may go to 2:1 at Lead discretion) 5. CRRT
B.Guidelines for Moderate Acuity Staffing, 1:2 nurse ratio	1. Frequent cardiopulmonary monitoring, assessment, and interventions required (every 1-2 hours).
C.Guidelines for Low Acuity Staffing, 1:3 to 1:4 nurse ratio	1. Patients with orders for medical, surgical, Cardiac or inpatient rehab.

Approval Signatures

Step Description	Approver	Date

VP, Nursing & CNO	Kirk Harper: COO	05/2022
Executive Assistant	Heather Shipman: Executive Assistant	05/2022
Mgr	Jennifer Hibbert: Mgr Unit	05/2022
Clinical Educator - RN	Jill Mathews: Clinical Educator RN	05/2022

Status **Active** PolicyStat ID **8030365**

Origination	02/1989	Owner	Brandie Gibson
Last Approved	06/2020	Policy Area	NICU
Effective	06/2020	Applicability	WA - Kadlec Regional Medical Center
Last Revised	06/2020		
Next Review	06/2023		

NICU Guidelines for Staffing, 43.05.01

Document Type: Guideline

PURPOSE:

Ensure that adequate staffing standards are maintained for the management of patient care.

RESPONSIBLE PARTIES:

NICU Unit Charge Nurse
NICU Unit Coordinator
NICU Unit Manager

POLICY:

1. The following guidelines will be followed to ensure that adequate, qualified staffing is maintained in the NICU Unit.
2. Staffing patterns are based on patient volumes, patient needs and analysis of patient acuity trends.
3. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.

PROCEDURE:

1. It is the responsibility of the NICU Charge Nurse to evaluate the situation and secure additional staff or to reallocate staff to ensure the staffing standards are met.
2. Staff may be reduced due to low census according to established criteria set forth in the WSNA and SEIU contracts. For non-licensed staff, consideration for low census will be made

dependent upon patient volumes and needs of the department. Charge Nurses are responsible for contacting the Patient Care Coordinator (PCC) prior to sending staff home to see if additional resources are needed within the Maternal Child Departments and/or within the facility.

3. If the standard is compromised due to patient acuity, patient volume, lack of nursing or ancillary personnel, and/or lack of in-house resources, the Charge Nurse will implement the following actions in the recommended sequence:
    a. Contact the PCC to assist with problem solving and resource allocation.
    b. Request staff from the previous shift to stay over.
    c. Request staff from the next shift to come in early.
    d. Call additional staff to come in to work (i.e.: per diem, regular staff, agency nurses (if available), or consider creative changes to the schedule).
    e. Monday-Friday, contact the Clinical Coordinator and/or Unit Manager.
    f. Weekends, contact the Clinical Coordinator or Unit Manager on call for Maternal Child.
4. Use the Daily Staffing Sheet to document all steps taken to resolve the problem and the reason for staffing deficit.
5. The Charge Nurse will assign staff to patients' care in accordance with the degree of supervision needed by each individual and the availability of that Charge Nurse.
6. Registered nurses in each of the patient areas will delegate, coordinate and supervise the care provided by the Unit Secretary/Technicians.
7. Daily Patient Care Assignments:
    a. The Unit Manager works Monday through Friday, assisting in the department as necessary/available.
    b. The Clinical Coordinator works Monday through Friday, assisting in the department as necessary/available.
    c. The Clinical Educator will work 40 hours per week and will assist in the department as necessary/available.
    d. The Charge Nurse will be designated based on the job description, skills and ability, and assigned accordingly. Every effort will be made to have the most qualified nurse on each shift as the Charge Nurse.
    e. A daily staffing roster is provided to the Charge Nurse listing all scheduled staff available for patient care assignments. Assignments will be made taking staff skills and ability into consideration. Assignments will be posted publicly in the department per RCW 70.41.420

INDICATOR	CRITERIA
A. PATIENT ACUITY	Patient acuity will be assessed every shift to assure adequate staff.

A. PATIENT ASSIGNMENT	Patient assignments will be determined by the Charge Nurse based on patient acuity and skills and ability of the nurse.
A. STAFFING RATIO GUIDELINES	See below for acuity based staffing ratios

A. GUIDELINES FOR HIGH ACUITY CARE STATUS, 1:1 NURSE RATIO:	1. Critically unstable infants requiring multi-system support. 2. Infants with complicated ventilation status, multiple IV drips, invasive monitoring. 3. Low birth weight infants with frequent apnea and bradycardia (≥ 1 per hour) on caffeine. 4. Infants <1000g for 48-hours.
B. GUIDELINES FOR MODERATE ACUITY CARE STATUS, 1:2 NURSE RATIO:	1. Critically ill but stable infants including <1000 gm >48-hours 2. Frequent cardiopulmonary monitoring and assessment (i.e., q 1-2 hours). 3. Infants requiring ventilator support, oxyhood, on high flow nasal cannula or nasal CPAP with or without invasive monitoring. 4. Stable IV drips, hypoglycemia requiring frequent blood glucose monitoring. 5. Occasional episodes of apnea and bradycardia requiring mild to moderate stimulation on caffeine. 6. Infants with feeding intolerance on TPN and Lipids.
C. GUIDELINES FOR LOW ACUITY CARE STATUS, 1:3 NURSE RATIO:	1. Stable infants requiring cardiopulmonary monitoring and assessments q 3-4 hours. 2. Infants with occasional episodes of apnea and bradycardia requiring mild stimulation not on caffeine or having no episodes at all. 3. Stable infants who are being nipple and/or gavage fed. 4. Stable infants with mild congenital malformations.

	5. Stable infants on nasal cannula on less than or equal to 30% $Fi0_2$.

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	06/2020
Executive Assistant	Heather Shipman: Executive Assistant	06/2020
Manager, Unit	Melanie O'Brien: Mgr Unit	05/2020
Clinical Educator - RN	Sarah Ball: Coord Nursing Floors	05/2020

Status Active PolicyStat ID 11931433

Origination	10/1995	Owner	Lucas Urlacher
Last Approved	07/2022	Policy Area	Cath Lab
Effective	07/2022	Applicability	WA - Kadlec Regional Medical Center
Last Revised	07/2022		
Next Review	07/2025		

Cardiovascular Services: Master Staffing Plan , 48.02

Document Type: Policy, Procedure

SUPERSEDES: 07/05, 03/99, 09/98, 04/96, 10/95

POLICY:

The Department of Cardiovasclar Services is an "open-ended" patient care facility that routinely provides services to patients twenty-four (24) hours a day, seven (7) days a week. Pre-scheduled procedures requiring nursing intervention are scheduled 0700-1730 Monday through Friday. Staff provide twenty-four hour on-call coverage for emergent after hour procedures.

PROCEDURE:

Staffing Mix

The staff in the Department Cardiovascular Services is comprised of professional Registered Nurses, Cardiovascular Technologists, Radiology Technologists, and Certified Nursing Assistants. Classified staff are screened and certified through the Kadlec Medical Center (KMC) Department of Nursing Personnel. Staff are referred to the Manager, Leads and Clinical Nurse Educator of Cardiac Services for interview, pre-hire skill evaluation, hiring decision and training. Prior experience in cath labs or critical care areas is a preferred qualification.

Basic Staffing Pattern

The staff schedules in the Department of Cardiovascular Services are a bi-weekly rotating schedule. Every attempt is made to obtain optimal staffing levels by utilizing Per Diems, extra shifts, and premium shifts.

Intra Op Staffing Matrix

Lab Rns	8 RNs	7 RNs	6 RNs	5 RNs
Lead	1	1 (Float)	1 (PR/Float)	1 (PR/Float)
Lab 1	1	1	1	1
Lab 2	1	1	1	1
Lab 3	1	1	1	1
Lab 4	1	1	1	1
Lab 5	1	1	1	
PR / Float	1	1		
Float	1			

PR / Float - Manages procedure room cases while helping to manage breaks, lunches, and case loads in other rooms as able

Float - Assists with breaks, lunches, and may be part of room rotations

Lead - Lead RN will orchestrate daily operations and case flow in coordination with Tech lead. This will include adjusting schedules, fielding phone calls, providing breaks and lunches, attending bed huddle (RN only), and coordinating with other departments. In situations of low staffing or critical patients the Lead may also be assigned to a room.

Technologist Staffing Expectations: 2 Technologists will be present for all major procedures and will be assigned the role of scrub and monitor. If 2 technologists are unavailable an RN who is trained and deemed competent by the manager or educator may substitute either role based on skills. If 2 caregivers with adequate skills are unavailable the case must wait. In the event 3 technologists are available per room the 3rd technologists will be assigned the circulator role. This role provides support with setup, supplies, as well as breaks. For complex procedures 3 technologists is ideal.

ON-CALL PATTERN			
0700-0700	SATURDAY AND SUNDAY	1 Cardiac RN / 1 IR RN	2 Cardiac Techs / 2 IR Techs
0700-0700	ALL HOLIDAYS	1 Cardiac RN / 1 IR RN	2 Cardiac Techs / 2 IR Techs
1900-0700	WEEKNIGHTS	1 Cardiac RN / 1 IR RN / 1 Backup RN	2 Cardiac Techs / 2 IR Techs / 2 EP Techs

Pre/Post Op Staffing

Staffing for Pre/Post op includes our 12 bay unit that manages the majority of preop, holding, recovery, and discharging for the cath lab department. This doesn't include Phase 1 recovery or regular holding of critical patients. Pre/Post follows AORN recommendations for RN to patient ratios (generally 1:1 for

active preop and 1:3 for phase 2 and holding). Staffing level considerations are based on the number of labs open on a given day. More specifically how many patients will be actively preopped in a given hour and how many will need post op care in a given hour. This paired with AORN standards helps guide staffing adjustments over base staffing. Minimum staffing numbers are as follows:

	Monday	Tuesday	Wednesday	Thursday	Friday
Lead	1	1	1	1	1
RN	4	5	6	6	4
CNA	1	1	1	1	1

As additional rooms open in the lab, or multiple add ons take place, Nurses will be added to the matrix. For example, some Mondays are scheduled as "TAVR Mondays", we add an additional preop RN to our base minimum staffing on these days. Additional nurses may come from resource team, Cath lab Intra op, or unit RNs who aren't scheduled.

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: Chief Operating Officer	07/2022
Executive Assistant	Heather Shipman: Executive Assistant	06/2022
Dir Nursing Svcs	Nancy Dahlberg: Dir Nursing Svcs	06/2022
Manager	Lucas Urlacher: Mgr Cardiovascular Services	06/2022

Status **Active** PolicyStat ID **10500521**

Origination	06/2013
Last Approved	10/2021
Effective	10/2021
Last Revised	10/2021
Next Review	10/2024
Owner	Andrea Dixon
Policy Area	Free Standing ED
Applicability	WA - Kadlec Regional Medical Center

Staffing Requirements, 54.04.00

Document Type: Policy, Procedure

SUPERSEDES: 06/13

POLICY STATEMENT:

Ensure that adequate staffing standards are maintained for the management of patient care.

RESPONSIBLE PARTIES:

Freestanding Emergency Department Unit Manager

Freestanding Emergency Department Charge Nurse

POLICY:

1. The following guidelines will be followed to ensure that adequate, qualified staffing is maintained in the Freestanding Emergency Department (FSED) in all patient care rooms.
2. Staffing is based on patient volumes and arrival times and how they impact standards of emergency nursing care.
3. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.

PROCEDURE:

The staffing standards are as follows:

FSED Nursing Staff (Includes Charge Nurse)

Time	Standard
0200 – 0800	3
0800 – 1100	4
1100 – 1200	5
1200 – 1300	6
1300 – 1400	7
1400 – 2000	8
2000 – 2300	7
2300 – 0000	6
0000 – 0100	5
0100 – 0200	4
ED TECHNICIAN	**Standard**
0900-1300	1
1300-2100	2
2100-0100	1
CT//US/XR Technologists	
Time	Standard
0600 – 1100	2
1100 – 2300	3
2300 – 0600	2
EVS/Housekeeper	
Time	Standard
0600 – 1400	1
2200 – 0600	1
Medical Laboratory Supervisor	
Time	
0800 – 1600	1
Medical Laboratory Technologist	
Time	Standard
0600 – 1100	1
1100 – 2300	2
2300 – 0600	1
Patient Access Representative	
Time	Standard
0600 – 1000	1

1000 – 2200	2
2200 - 0600	1
Security Officer	
Time	Standard
0600 – 1800	1
1800 – 0600	1

1. Patient census and acuity must be evaluated when assessing staffing standards in the department.
2. It is the responsibility of the FSED Charge Nurse to evaluate the situation and secure additional staff or to reallocate staff to ensure the staffing standards.
3. Staff may be reduced due to low census according to WSNA Collective Bargaining Agreement or by the Charge nurse for other staff members.
4. If the standard is compromised due to patient acuity, patient volume, lack of nursing or ancillary personnel, and/or lack of in-house resources, the Charge Nurse will implement the following actions in the recommended sequence.
    A. Follow RN Short Staffing Process to fill RN staffing needs
    B. Request staff from the previous shift to stay over.
    C. Request staff from next shift to come in early.
    D. Call additional staff to come in to work, (i.e., per diem, regular staff, agency nurses, if available, or consider creative changes to schedule).
    E. Monday-Friday, contact the Unit Manager.
5. Use the FSED daily communication sheet to document all steps taken to resolve the problem and the reason(s) for staffing deficit.
6. Daily patient care assignments:
    A. The Unit Manager works Monday through Friday, assisting in the department as necessary/available.
    B. The Clinical Educator will work 40 hours per week and will assist in the department as necessary/available.
    C. The Charge Nurse will be designated based on the job description, skills and ability, and assigned accordingly. Every effort will be made to have the most qualified nurse on each shift as the Charge nurse. When more than one qualified Charge nurse is on a shift, Charge nurses will rotate the Charge nurse assignment as assigned.
    D. The FSED Charge nurse will oversee the flow of patients and consider the staff to patient ratio taking into consideration staff who are on orientation.

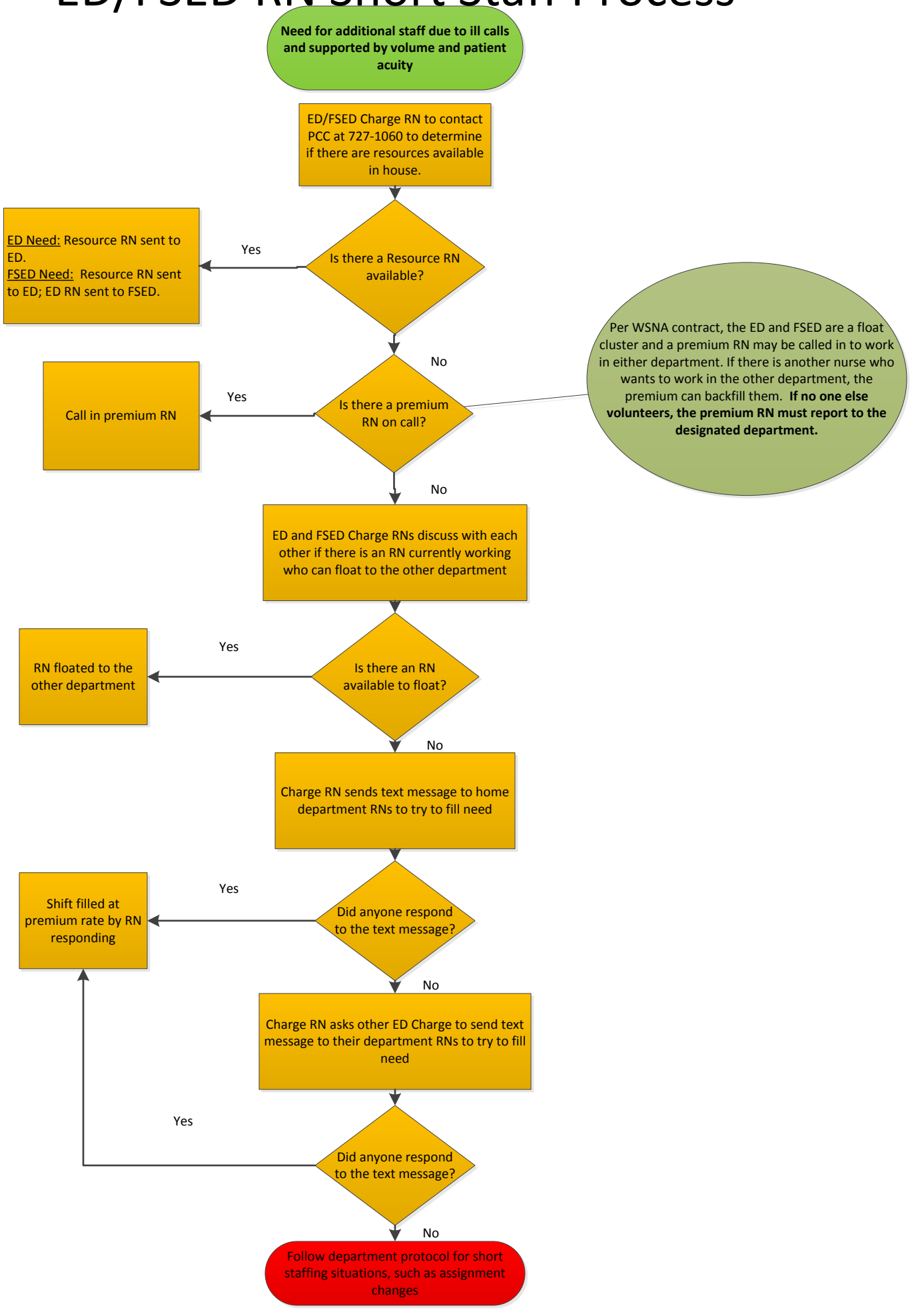
Attachments

RN Short Staffing Process

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	10/2021
Executive Assistant	Heather Shipman: Executive Assistant	10/2021
Registered Nurse	Andrea Dixon: Mgr Unit	09/2021

ED/FSED RN Short Staff Process



Status **Active** PolicyStat ID **11420856**

Origination	01/2009	Owner	Zachary Miller
Last Approved	05/2022	Policy Area	Acute Care
Effective	05/2022	Applicability	WA - Kadlec Regional Medical Center
Last Revised	05/2022		
Next Review	05/2025		

Acute Care and Surgical Units: Staffing Guidelines, 62.01.00

Document Type: Standard

SUPERSEDES: 5/13,1/09, 2/06, 10/04, 6/17/02

Indicator	Criteria
A. Patient Acuity	Patient acuity will be assessed every shift to assure adequate staffing.
B. Patient Assignment	Patients with higher acuity will be assigned to the more experienced nurse on duty or a lesser RN to patient ratio. Any change in patient to staff ratio needs to be reported to transfer center.
C. Staffing Guidelines	Registered nurses will assess, delegate, coordinate and supervise the care provided by the CNAs, Nurse Techs, Nurse Externs and Unit Secretaries.
Staffing patterns are based on patient needs and analysis of patient acuity and nursing skill level. The staffing matrix is used as a guide for each shift and is based on budgeted nursing hours per patient day and minimum staffing standards. The Acute Care Units (Surgical, 3OP, 4RP, 6RP, 7RP and 8RP) normal RN to patient ratio is 1:5 on days and nights. Staffing may be flexed up or down to meet the needs of the patients, unit, hospital and staff experience/ resource availability per the Lead RN. RN	

staffing and patient ratios may be adjusted for the following:

- Patients in restraints, (more than one patient per RN assignment)
- Increased volume of patients in isolation, confused patients or bariatric patients
- Patients requiring a large amount of emotional support (ie. dying patients, major psychological or social issues)
- 1:1 patients such as suicide risks or those with safety risks
- medicated drips requiring increased observation or frequency of assessments (See Guideline for Administration of Medicated IV Drips and Stat IVP Medications, 650.12.01)
- DKA patients on Insulin drips or Endotool with frequent blood sugars
- Complex chemotherapy protocols (multiple timed, IV meds)
- New chemotherapy patient requiring significant patient education
- Acute leukemia inductions
- Large percentage of float staff, new agency staff, or inexperienced nurses
- ETOH detox
- Medically unstable patient requiring assessments more frequently then every 1-2 hours
- Patients with orders for frequent assessment needs or equipment (post cath, CBI, etc.)

Units experiencing the need to adjust staff/ patient ratios should implement the following actions: 1) Check assignments and look for opportunities to shuffle staff within the unit to correct pinch points 2) If unable to adjust any further and changes need to be made please alert the PCC and transfer center to update volume capability 3) Follow chain of command for any concerns that are unable to be corrected

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: COO	05/2022
Executive Assistant	Heather Shipman: Executive Assistant	05/2022
Administrative Director, Nursing Services	Kathy Christensen: Dir Nursing Svcs	05/2022
Unit Mgr	Zachary Miller: Mgr Unit	05/2022

Status Active PolicyStat ID 11240614

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Next Review	03/2025

Owner	Emily Choi
Policy Area	Stepdown Unit
Applicability	WA - Kadlec Regional Medical Center

Stepdown Unit Standards of Care 62.03.00

STEPDOWN UNIT STANDARDS OF CARE

Purpose: To define nursing expectations for patients in the Stepdown Unit. Patients may require more frequent monitoring based on conditions, and interventions.

SCOPE: This standard of care encompasses all Registered Nurses working within the Stepdown Unit who have met the minimum competencies to work without the oversight of a preceptor

Part 1: Assessments and Documentation

KEY WORDS	DETAIL and FREQUENCY
Admission Assessment	Admission assessment to be started at the patient's point of entry, *(i.e., Emergency Department, Same Day Surgery, or the Inpatient Departments)* A. Admission assessment completed and documented within **four hours** of admission 1. Head to toe physical assessment , including baseline neurological exam and psychological status (including the CSSRS suicide risk assessment) 2. Screening for immunizations, delirium (CAM), suicide, sleep apnea, and sepsis 3. Allergies documented 4. Review and validation of prior arrival medications 5. Height and Weight obtained and documented 6. Fall risk 7. Skin Assessment/Braden scale, photo documentation of skin issues completed 8. Patient/Family Education Plan 9. Initiation of Care Plan 10. Patient belongings B. The initial physical assessment MUST be completed by an RN. The initial physical assessment may need to be performed in a more timely fashion based on the patient's clinical diagnosis and psychological/emotional state. (This includes vital signs, pain score, height & weight, and fall risk) C. Place appropriate bands on the patient (i.e. ID, DNR, Allergy, etc.) D. Admit history should be completed by the end of the shift unless the patient is received within three hours of change of shift.
Ongoing Assessment	A. Comprehensive assessment to be completed within two hours of the beginning of each shift B. Problem focused re-assessments conducted every four hours or more frequently as patient condition warrants 1. The scope and intensity of any further assessments are determined by the patient's diagnosis, treatment and patient response to interventions 2. Any change in patient condition requires an immediate assessment 3. Other change of status assessments to be completed by an RN should occur following:

	• Interdepartmental transfers • Post-procedures • Post-operative **NOTE:** Assessment findings that are Within Defined Limits as defined by policy #619.00.00 will be entered in the EMR by documenting WDL. • Assessment findings that fall outside of defined Normal Limits will be entered in the EMR by documenting WDL Except. When this selection is chosen, all exceptions to normal limits will be documented. Exceptions may be documented via the choices in the EMR or by annotation.
Vital Signs	A. Perform and document vital signs every four hours and PRN patient condition. This includes: HR, BP (MAP), RR, and POX. (ETCO2 measurements as appropriate). B. Vasoactive Drip Infusions: with active titration of infusions, HR and BP are documented every 15 minutes. If no titrations have occurred over the last hour, decrease documented BP and HR to every 30 minutes. C. Document temperature every 4 hours. If temperature greater than 101 ^{0}F (^{0}C) increase temperature monitoring every 2 hours. D. Continuous pulse ox on all patients on high flow, BIPAP, PCA. E. Use MEWS assessment tool to determine if a patient with a score ≥4 requires additional monitoring or interventions F. PHYSICIAN NOTIFICATION: SBP > 160 mmHg or < 95 mmHg DBP > 110 mmHg MAP < 70 mmHg HR > 120 bpm or < 55 bpm RR > 25 breaths/min or < 8 breaths/min SaO2 < 92% or if Oxygen has been increased twice in 4 hours Temperature > 101.5°F *Refer to Modified Early Warning System (MEWS) to Assess for Clinical Deterioration, # 600.15.00* Mews Assessment Tool:
Pain Assessments & Scoring	A. Conducted every 4 hours at minimum. B. Assess all patients for pain using a verbal or non-verbal cues within one1 hour of admission. C. If patient is experiencing pain and being treated by a scheduled pain intervention *(i.e. Fentanyl drip),* document reassessments a minimum of every four hours. D. **PRN Pain Medication Reassessment**: ALL patients will be reassessed following pain management interventions (pharmacological or non-pharmacological) in accordance with policy 655.10.20. *Refer to Pain Assessment and Management Standards, #655.10.20*
Epidural Management	A. During continuous epidural infusion and after discontinuing the infusion, the nurse will assess: 1. BP, HR, RR (rate/depth), RASS every 15 minutes x 2 2. Then RR (rate/depth), RASS and pain score every hour for 6 hours 3. Then every 4 hours, BP, HR, RR, Temp, RASS and pain score

SCORE	3	2	1	0	1	2	3
Temperature		≤ 34.9° C or 94.8° F		35.0° - 38.4° C to 95° - 101° F		≥ 38.5° C or 101.5° F	
Heart Rate		≤ 40	41 - 50	51 - 100	101 - 110	111 - 129	≥ 130
Systolic Blood Pressure	≤ 70	71 - 80	81 - 100	101 - 199		≥ 200	
Respirations		≤ 8		9 - 14	15 - 20	21 - 29	≥ 30
Level of Consciousness				Alert	Responds to voice New confusion Restlessness	Responds to Pain	Unresponsive

	Refer to Medications: Epidural Infusion of Analgesia by Epidural Catheter, Dressing Change, Discontinuing the Temporary Epidural Catheter, #607.35.00
CAM (Delirium)	A. Performed every shift and with any change of behavior or cognition. B. Notify provider for positive CAM scores. C. Document delirium interventions every shift.
Intake & Output	A. All patients are on strict I&O monitoring. B. Document all intake and output in real time. C. NOTIFY PHYSICIAN if urine output > 300 mL/hr or < 25 mL/hr for 2 consecutive hours D. Urine output documented every four hours if urinary catheter present, every hour if on Lasix drip 1. Follow CAUTI Prevention guidelines for all urinary catheters in place: • Daily review of necessity, securement device, and foley care documented • Utilize alternative urinary measurement devices if possible E. Without urinary catheter in place, document each occurrence F. Patient without urine output for 6 hours (NOT dialysis patient), obtain bladder scan assessment and follow intermittent catheter guidelines G. Prior to the end of shift, or more frequently as patient condition, empty drains *(chest tubes, NG, JPs, etc.)* document and clear totals for all pumps. For chest tubes, mark volume on drainage collection device H. Cumulative I&O will be done every shift *(totals at 1800 and 0600)*, with 24 hour totals daily. I. Bowel movement (or lack thereof) documented daily. 1. Lack of bowel movement is to be charted as "0" in the I&O flowsheet. This is a must for all cardiothoracic patients, but recommended for all Stepdown patients. 2. Use Bristol stool assessment to document stool consistency 3. For Type 7 watery stool, notify provider and implement enteric precautions per protocol. *Refer to Management of Indwelling Urinary Catheters, #699.93.00* *Refer to Clostridium Difficile Associated Diarrhea, # 1139*
Height & Weight	A. Height is measured once admission 1. Heights documented in CM *(centimeters)* B. Weigh every patient on admit and every day. 1. Performed every AM around 0500 by night shift 2. Weights will be documented in KG (*kilograms).* 3. Document the type of scale used to obtain the weight. 4. Standing scale is to be used unless patient is unable to stand.
ECG Monitoring & Rhythm Interpretation	A. All stepdown patients will be provided continuous ECG monitoring. Telemetry orders can be renewed by the RN without contacting the physician. B. Obtain, measure and interpret ECG on admission, every shift and PRN significant changes in rhythm. C. Measure and record PR, QRS, and QT intervals, and rhythm interpretation in EMR or tele strip mounted in EMR. D. Monitor every patient in two leads *(Lead 3 and V1, or as recommended for patient specific monitoring)* E. AVOA *(Arrhythmia View on Alarm)* will be engaged for every patient, except those patients on palliative care.
Hemodynamic Monitoring:	A. Monitor hemodynamic waveforms continuously 1. DO NOT disconnect from visual waveform monitoring if catheter remains in

• Arterial Line • Arterial Sheath	place B. Arterial Line management: 1. Record Systolic, diastolic and mean pressures for arterial catheter 2. Check and document: circulation, movement, and sensation distal to arterial line: radial, femoral, or brachial every four hours 3. Notify physician for signs of decreased perfusion. 4. If femoral arterial line discontinued, follow *Arterial and Venous Sheath Removal: Use of Various Compression Methods, #697.00.00.* C. Level transducers every four hours and with changes in patient position D. Zero transducers and evaluate a square wave test every four hours E. Every shift obtain and measure arterial waveforms, clearly identify the location of line. **(should be mounted with tele strip)**
Neurologic Assessment	A. Documented every 4 hours and with any change in behavior or cognition. B. Neuro assessments should be specific to the patient's condition, but consider including *at least* LOC, orientation, speech, pupil response, facial symmetry, and motor and sensation assessment of the extremities C. Assessment every hour for patient with active neuro problems (immediate post stroke, post op neuro) D. Ischemic Stroke post- tPA infusion: 1. First 12 hours post TPA infusion must be spent in ICU prior to transfer to Stepdown. Neuro checks will then be done every 4 hours on Stepdown unit, unless otherwise ordered. 2. Upon transfer from ICU to Stepdown unit, a bedside NIHSS assessment will be completed with the transfer and receiving RN. 3. Swallow Evaluation – keep NPO until the patient has successfully passed the Bedside Swallow evaluation *Refer to Dysphagia Protocol, #612.00.00 & Nursing Bedside Swallow Screening 612.00.01*
LDA Assessment	Assess and evaluate all lines, drainage tubes and airways (LDA) every four hours A. Assess IV access every shift and PRN B. Medication drips with high potential for extravasation infusing through a peripheral IV require checks every two hours, *(Refer to Medication Administration Policy #650.12.01)* C. Gastric Tubes (OG/NG) require visual verification of initial placement and marking during the insertion process. Maintain and check patency and placement every 4 hours and prn, *(Refer to Adult Orogastric, Nasogastric and Small Bore Feeding Tube, Insertion, Care and Removal, Policy #699.13.00)* D. Chest tubes require air leak assessment Daily review of necessity to be completed for all lines, drains, and devices.
Fall Risk	A. Performed every shift *(must be completed by the end of the shift*) B. After a fall or with a change or decline in condition *Refer to Falls Prevention: Risk Assessment and Guidelines, 650.19.00*
Braden Score	A. Perform assessments based upon Braden Score: • Low to Moderate Risk (Braden score 13-18) should have a skin inspection daily or if there is a significant change. • High Risk (Braden score ≤ 12) should have skin inspected every shift paying particular attention to each bony prominence. B. Initiate skin preventative measures PRN *(i.e. prevalon boots, duoderm under medical devices, skin barriers, etc.)* C. Wound care to see patient for complex wounds D. Photo documentation of existing non-surgical wounds will be done on admit within 4 hours of admission. *(refer to Photo Documentation of Wounds and Skin Conditions #600.08 and Photo Policy #1012)*

	Refer to Pressure Ulcer Prevention and Wound Care, 655.10.21
Progressive Mobility	A. Perform and document level of mobility patient achieved every shift. B. Utilize progressive mobility algorithm. C. Utilize appropriate door magnet/signage to indicate patient's mobility level.
Nutrition Needs	A. Nutrition Risk Screen on admission B. Reassessments every 4 days and with any significant changes C. Ideally, some form of nutrition initiated within 48 hours of admission. *Refer to Adult Nutrition Screening, Assessment, Reassessment, and Documentation #665.00.00*
Columnar Insulin Protocol	Update upon new policy approval
Suicide Ideation/Risk	A. All stepdown patient will be screened on admission for suicide risk utilizing the Suicide Risk flowsheet in the EMR. Based upon results of the initial screening for anxiety and depression, a further suicide risk assessment will be performed. B. If the patient is deemed to be at risk, inform the provider of assessment findings, place a suicide precaution order, complete environmental risk assessment form, and initiate appropriate interventions. *Refer to Suicide Prevention and Management, #641.00.00 for further management details.*
Lab Values & Images	A. Reviewed daily and PRN B. Report critical values and significant findings to provider *Refer to Critical Results Notification to Providers, #699.03.00)*
Restraints	Medical Restraints: A. Documented checks conducted every two hours B. Every shift document continued need for restraints: Type of applied restraint, trialed alternatives, and education provided. C. DAILY physician order Violent Behavior Restraints: A. Documented checks conducted every 15 minutes B. EVERY 4 hour physician order required *Refer to Restraint Use, #630.00.00*
Plan of Care	A. Individualize care plan for every patient on admission and as needed for changes in patient condition B. Care plan updated every shift
Education Needs and Learning Barriers	A. Educational needs and learning barriers are assessed and documented during the admission process B. By the end of each shift, document education provided to patient/family members C. Teach-back method to be used for patient education. http://www.teachbacktraining.org D. Provide access to an interpreter when necessary for patient/family conversations.
Documentation General Standards	A. Documentation will be made in Electronic Medical Record in a timely, concurrent manner. It is the expectation that charting is to be done real time or as close to real time as possible a. Complete admission assessment is to be documented within 4 hours of admission b. A full assessment will be documented once per shift c. Focused system assessment will be documented a minimum of every 4 hours following the full assessment B. Military time will be used to document each entry in the Electronic Medical Record. C. Abnormal and significant changes or events will be documented as they occur.

	D. Medication administration will be documented appropriately on the Electronic Medical Record, as outlined in HW P&P 650.11.05.

Part 2: Management of Patients

Acuity/Staffing INDICATOR / CRITERIA **High Acuity 3:1 nurse ratio** A. Neurosurgery patients (transsphenoidal biopsies, cranioplasty or tumor resection patients) for the immediate 24hour postoperative period after arriving from PAU and post TPA patients for the first 24 hours following TPA administration. B. High flow oxygen or continuous non-invasive ventilation whereby the interruption of therapy would cause significant decompensation in the patient. C. Tracheostomy requiring frequent intervention and/or ventilator weaning D. EKOS, Uni-fuse or any patient with arterial access in place which requires frequent assessment or monitoring, including the immediate post-removal period where frequent post hemostasis site assessments must be completed. E. Trans venous pacing F. Any vasoactive infusions requiring frequent titration or patient assessment to ensure hemodynamic stability. Refer to Policy *Guideline for Administration of Medicated IV Drips and Stat IVP Meds 650.12.01* *** For High acuity patients, portable tests and procedures should be requested to come to the patient's room. If a test is deemed immediately necessary and cannot be a portable exam, the RN will validate whether the patient is deemed stable enough to leave the floor by the attending physician. These patients WILL be accompanied by an RN, on a transport monitor for the test or procedure.*** **Moderate Acuity 4:1 nurse ratio** A. Acutely ill patients who are moderately stable with an elevated risk for instability, requiring a high intensity of care and vigilance. ***For Moderate Acuity Patients requiring transport to a test or procedure, the RN will validate whether the patient is deemed stable enough to leave the floor by the attending physician and whether an RN is required to accompany the patient for the test or procedure.*** **Low Acuity 5:1 nurse ratio** A. Patients with orders for medical, surgical, inpatient rehab. B. Hemodynamically stable patients, not requiring frequent monitoring and interventions, and/or not on telemetry.	–
Safety and Room Set-up	A. Rooms will contain: 1. Alaris IV pump with at least 3 soldiers

	2. Continuous suction unit with tubing and tonsil tip (Yaunker) suction device. 3. Oxygen flow meter, and appropriate size bag-valve mask device (Ambu). 4. Side rail bumpers will be placed for patients with seizure disorders and severely agitated patients. B. Mobility impaired patients will be moved with the assistance of adequate staff members as well as using the minimal lift techniques and provided safety equipment. C. Supplies and equipment will be checked and/or restocked at each bedside by the nurse or designee after each shift and when a patient is discharged or transferred. D. EKG monitors will be in the "on" mode at the nursing station at all times. E. RN will verify that Auto View On Alarm is active on the GE monitor and that the alarm volume is set to no lower than "5". Exception: comfort care patients.
IV Access	A. All Stepdown patients are to have at least 2 IV access points until discharge or transfer orders are placed. B. IV dressings will be labeled with date/time changed. C. IV tubing will be labeled with date to change. D. IV lines with continuous medication infusions (not including maintenance fluids) will be labeled with the medication being infused. *Refer to Peripheral IV Therapy Policy # 650.12.18.01)* *Refer to Guideline for Administration of Medicated IV Drips and Stat IVP Medication Policy 650.12.01*
End of Shift Hand-Offs	A. Nurse to nurse communication should be done at patient's bedside for any changes or handoff of the care team, including AIDET and introduction of the new care team member. B. Each patient's Kardex is to be updated every shift and used during hand-off to ensure consistency of report. This Includes: 1. Name, age and date of birth, 2. physician, 3. code status, 4. allergies, 5. diagnosis and chief complaint, 6. pertinent medical history, 7. assessment abnormalities, 8. vital signs and I&Os, 9. medical treatments and interventions, 10. care received, 11. recent and anticipated changes and notes for multi-disciplinary rounds C. Hand-off is to include: 1. Visual inspection of IV sites and infusing fluids/ drips. Dual sign-off is to be done in MAR for all titrateable drips. 2. Visual inspection of wounds,& tubes, including a two person skin assessment on high risk patients.

	3. Safety checks – *Emergency equipment, suction equipment, alarms engaged, IV tubing labeled appropriately. Etc.* 4. Order Review
Receiving Patients from Cath Lab, ICU, or Post-op	A. All sites, incisions, and drains are to be visualized by both receiving nurse and nurse handing-off. B. A first set of vitals (and neuro assessment if applicable) is to be done before the nurse handing-off leaves. C. Signed and held orders must be in computer before the nurse handing off leaves. D. All vasoactive and heparin drips are to be verified by both nurses, charted using dual-sign off in MAR. E. Patients on EKOS: both nurses verify machine is on (yellow light is blinking, timer is running), verify dosing of drips, inspect site(s). *Refer to Catheter Directed Thrombolytic Therapy with or without EKOS 29.20.15*
Activities of Daily Living	A. Baths/showers/LDA care: 1. CHG Bath completed and documented daily for all patient with central line access 2. ECG electrodes will be replaced during baths/ showers. 3. Urinary catheter care and peri-care completed and documented every 12 hours and PRN. B. Oral care: 1. Oral care will be performed *at least* every 12 hours on all patients, and at least every 4 hours on patient that are npo, have an ngt/ogt/peg or are on Continuous Bipap, or Hiflow O2 2. Tracheostomy and/or tube feeding patients are provided oral care every 4 hours and PRN C. Tracheotomy sites will be cleaned and skin assessment around trach and under trach ties done every 8 hours using Trach care kits. Trach ties will be changed whenever soiled, D. Mobility impaired patients will be turned every 2 hours, in bed and repositioned every 30 minutes if up in chair, unless contraindicated.
Discharge Planning and Education	A. Discharge planning will begin on admission and revised throughout the patient's hospital stay. Appropriate referrals will be initiated to assist with post-discharge needs. B. Education needs will be addressed upon admission and a plan of care developed to meet those needs C. Patient/family/significant others will be involved in discharge planning and education as appropriate. D. Education tools (i.e. booklets, videos) will be utilized to assist in meeting education needs. E. Instruction will be given as needed regarding medications throughout the hospital stay and at discharge. F. Discharge instruction sheet will be completed at time of discharge with the patient/family/significant others as appropriate. G. Staff will provide the following for patients requiring transport to another acute care facility: 1. Correct chart preparation and necessary

	radiology films. 2. PCC or designee to obtain acceptance of the receiving facility to assure bed availability. 3. Call report to the receiving facility.
Involvement in Care and Support of Patient, Family, and Significant Others	A. Patient/family/significant others will be kept updated regarding the plan of care, daily activities planned, and any anticipated changes. Tests, procedures, and equipment will be explained. B. Plan of Care/Goals will be written on patient's whiteboard and updated daily. C. Patients/family/significant others will be encouraged to participate in care as appropriate. Questions from patient and family will be encouraged D. Confidentiality will be maintained through adherence to Hospital policy. E. Interpreters and communication devices will be provided for patients unable to speak or are non-English speaking. F. Patient's religious preferences with regards to diets and rituals will be permitted as much as possible. Patient's minister/chaplain/priest and/or hospital chaplain will be notified of hospitalization if requested or indicated. Privacy will be provided for the patient and religious leader or mentor.
Care for the Dying or Deceased Patient	A. Consider AIMS or Palliative care team involvement for any end of life care planning. B. When a patient dies: a. Support will be provided to family and significant others present by providing them with the opportunity to be with the deceased in private as long as needed. b. Post mortem care will be provided with respect for the family's wishes. Any tubes/lines/IVs or catheters may be removed so long as the patient's death is not a coroner's case. c. The Organ Procurement team should be notified of any impending or expected patient deaths. d. Organ and/or tissue donation will not be discussed with the patient's family unless the family initiates the issue or the procurement coordinator designates the patient as a potential donor, at which point the OPO will contact the decedent's family. *Refer to: Post Mortem Care, 623.00.00*
Care of Patients during dofetilide (Tikosyn) Loading ((*does not apply to patients already taking TIKOSYN*	A. 12 lead EKG must be done before initiation of first dose B. 2 hours after each dose, QTc must be measured. Per provider's order, this is either done with a 12 lead EKG, or by RN on tele monitor (measure R-R and QT to obtain QTc). For HR < or =60 bpm, record QT interval (instead of QTc interval). C. In progress note, record QTc (or QT for HR < or =60) for all ECGs. D. For v-tach, order stat mag and K levels, and hold next dose until discussed with physician. E. Hold next dose and notify physician if : 1. HR <50 bpm

	2. Creatinine clearance <20 mL/min 3. Baseline QTc is >440 msec with a narrow QRS (<120msec) 4. Baseline QTc is >500 msec with a wide QRS (>119 msec) 5. The QTc increases by >15% while receiving TIKOSYN 6. The QTc is >500 msec with a narrow QRS (<120 msec) while receiving TIKOSYN 7. The QTc is >550 msec with a wide QRS (>120 msec) while receiving TIKOSYN 8. Abnormal EKG F. Verify that a prescription for TIKOSYN is provided for the patient on discharge.
Care of post-op patient	A. All patients immediately on arrival to floor post-op: 1. Vitals and assessments should be done every 15min x 4, then every 30min x 2, then every hour x 2, then every 4 hours till discharge if stable. 2. Surgical sites will be assessed per shift, unless otherwise ordered, and dressings will be changed per physician orders or wound care orders. 3. Chest tube site dressings will be changed only when loose and cannot be adequately reinforced or when drainage has soaked the dressing- Dressing may be lifted to visually inspect the insertion site. B. For patients from cath lab 1. Refer to policy *Arterial and Venous Sheath Removal: Use of Various Compression Methods, #697.00.00* 2. Note puncture site for signs of bleeding and hematoma with each vital signs check. 3. Note peripheral pulses, color and temperature of extremities bilateral with each vital signs check. Notify physician of changes in peripheral pulses, bleeding, or hematoma. C. For patients post-op cranial surgery: 1. Bedside neuro assessment with handing off nurse. 2. Maintain the HOB greater than or equal to 30 degrees unless otherwise ordered 3. Patient is not to blow their nose. 4. No nasal tubes or cannula. 5. Monitor Urine output for signs of Diabetes Insipidus 6. If patient has a lumbar drain in place, maintain level per orders. The drain should be clamped for any activity unless otherwise ordered for bedrest. D. For patients post TCAR or carotid endarderectomy: 1. Add CN VII, X, XI and XII checks to neuro checks E. For Post Cadiothoracic Surgery: 1. Incisions: i. Aquacel dressings **over sternal incisions** will stay in place 5-7 days

	ii. **All other dressing** are left in place for the 48 hours and then left open to air. If during this initial first 24 hours, the dressing in soiled or leakage of exudate occurs, then reinforce the dressing. iii. For wounds covered with ace wraps (legs or radial graft sites), the ace wraps should be removed after 24 hours. iv. Inspect the incision DAILY for redness, purulent drainage, separation of wound edges, swelling or sternal instability 2. Pacer Wires: i. All cardiac surgery patients with epicardial pacing wires in place must remain connected to the pulse generator. 3. Activity i. Up ad lib, provide encouragement for patient to increase activity ii. Up to chair for each meal iii. Ambulate QID with assistance POD #1. Increase the distance and frequency of walks daily: Plan should be to ambulate 6 times on POD #2 , up to ambulate 8 times on POD #3, up to ambulate 10 times on POD #4 4. Bowel Care: If no BM by POD 2, and no BM regimen is ordered, RN is to notify CT team. i. CT team may choose to order for POD 2: Dulcolax suppository at 0600, followed by fleets enema if still no BM ii. Document "0" in the I/O flow sheet in the EMR under stool occurrences if the patient has not produced a bowel movement for your shift. 5. Respiratory: EZPAP/IS will be used at least every hour while awake. 6. Antiarrhythmics: For new-onset Atrial Fibrillation or flutter follow the physician's orders in EPIC and notify the CTS team, being sure to discuss the patient's current venous access. If amiodarone is ordered, clarify if it is to be given through central or midline vs PIV. *Refer to Management of Surgical Wounds Post Cardiac Surgery, 29.21.02*
Care of Patients on EKOS	A. Unit must be plugged in on arrival, as battery life is only 60 minutes B. Refer to *Receiving Patients from Cath Lab, or Post-op* section above for handoff requirements C. Patient must lay flat while on EKOS, but can be log rolled from side to side if extremety with EKOS is kept straight. D. Ensure therapy is running by flashing yellow light in lower left corner of unit. Troubleshoot alarms or problems. Call EKOS hotline for help, as needed (number is on battery of unit).

	E. Refer to orders for vitals, assessments, labs, and notification parameters F. Never use the EKOS ports for other medications (other than coolant, thrombolytic or anticoagulant ordered and running on arrival). Do not let pump run dry. Never draw back on ports, as this will irreversibly clog lumen and prevent therapy form being delivered. Refer to policy *EKOS Patients Nursing care and monitoring*, # 29.20.15

Approval Signatures

Step Description	Approver	Date
CNO	Kirk Harper: CNO	03/2022
Executive Assistant	Heather Shipman: Executive Assistant	03/2022
Director	Nancy Dahlberg: Dir Nursing Svcs	03/2022
	Michelle Twomey-Santiago: Mgr Unit	03/2022

Status **Active** PolicyStat ID **7684665**

Origination	07/2002	Owner	Erin Logan
Last Approved	04/2020	Policy Area	Pre-Admissions Services
Effective	04/2020	Applicability	WA - Kadlec Regional Medical Center
Last Revised	04/2020		
Next Review	04/2023		

Pre-Admission Services: Organizational Plan, 67.01.00

Document Type: Policy, Procedure

SUPERSEDES: 2/11, DS Policy # 21.51, 05/02/07 **,** 3/04, 7/02

PURPOSE:

To provide a safe, comfortable environment for the welfare of the individual requiring pre-surgical evaluation and testing. To ensure that all pre-operative testing is completed, evaluated, and communicated to the surgeon and/or anesthesiologist as appropriate. To minimize day-of-surgery cancellations and delays of surgery due to inadequate pre-operative preparation of the patient.

PHYSICAL LAYOUT:

Pre-Admission Services (PAS) is located on the main floor adjacent to the Outpatient Procedures (OPP) Reception Desk.

PERSONNEL REQUIREMENTS:

Personnel will be specifically oriented and trained, and will meet the recognized hospital standards. They will be encouraged to participate in and document relevant PAS education programs.

ADMINISTRATION:

The Pre-Admission Services Unit Manager shall be responsible for the efficient functioning of the employees, the safeguarding and maintenance of hospital equipment, and general management of the area. PAS is directed, consistent with all surgical patients, by the medical staff through the Department of Surgery and the Department of Anesthesia. Appropriate medical staff members with specific delineation of surgical or anesthesia privileges will provide medical staff care.

HOURS:

PAS is staffed 5 days a week, Monday through Friday 0700 to19:30.

STAFFING:

Schedules are prepared monthly to provide necessary coverage.

PROCEDURE:

1. Patients are directed to the Outpatient Procedures/Pre-Admission Services reception desk after completing registration for the procedure.
2. The patient admission questionnaire and documentation is completed by the PAS RN and the patient/family.
3. The Pre-Admission Services nurse reviews the patient's health history, physician's order and guidelines from the Department of Anesthesia.
4. The Pre-Admission Services nurse utilizes the Anesthesia Preoperative Protocol to order appropriate labs, ECGs and Chest X-Rays. Orders are placed in EPIC under the 'per policy - cosign required option' using the name of the surgeon as the ordering provider so that results are sent to the appropriate EPIC in -basket.
5. Patients are directed to the appropriate department for pre-operative lab and diagnostic testing.
6. Anesthesia is consulted when applicable.
7. Pre-operative teaching is provided by the registered nurse.

Laboratory test results are reviewed by the Pre-Admission nurse. Abnormal results are reviewed by an anesthesiologist and communicated to the surgeon if surgical plan of care will be affected.

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	04/2020
Administrative Assistant	Heather Shipman: Executive Assistant	04/2020
Manager, Unit	Tracy Hasty: Mgr Unit	02/2020

Status **Active** PolicyStat ID **8030360**

Origination	03/2019
Last Approved	06/2020
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Last Revised	06/2020
Next Review	06/2023

Owner	Brandie Gibson
Policy Area	Pediatrics
Applicability	WA - Kadlec Regional Medical Center

Pediatric Guidelines for Staffing, 70.05.01

Document Type: Guidelines

POLICY STATEMENT:

Ensure that adequate staffing standards are maintained for the management of patient care.

RESPONSIBLE PARTIES:

Pediatric Unit Charge Nurse
Pediatric Unit Coordinator
Pediatric Unit Manager

POLICY:

1. The following guidelines will be followed to ensure that adequate, qualified staffing is maintained in the Pediatric Unit.
2. Staffing patterns are based on patient volumes, patient needs and analysis of patient acuity trends.
3. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.

PROCEDURE:

1. It is the responsibility of the Pediatric Charge Nurse to evaluate the situation and secure additional staff or to reallocate staff to ensure the staffing standards are met.
2. Staff may be reduced due to low census according to established criteria set forth in the WSNA and SEIU contracts. For non-licensed staff, consideration for low census will be made

dependent upon patient volumes and needs of the department. Charge Nurses are responsible for contacting the Patient Care Coordinator (PCC) prior to sending staff home to see if additional resources are needed within the Maternal Child Departments and/or within the facility.

3. If the standard is compromised due to patient acuity, patient volume, lack of nursing or ancillary personnel, and/or lack of in-house resources, the Charge Nurse will implement the following actions in the recommended sequence:
    a. Contact the PCC to assist with problem solving and resource allocation.
    b. Request staff from the previous shift to stay over.
    c. Request staff from the next shift to come in early.
    d. Call additional staff to come in to work (i.e.: per diem, regular staff, agency nurses (if available), or consider creative changes to the schedule).
    e. Monday-Friday, contact the Clinical Coordinator and/or Unit Manager.
    f. Weekends, contact the Clinical Coordinator or Unit Manager on call for Maternal Child.
4. Use the Daily Staffing Sheet to document all steps taken to resolve the problem and the reason for staffing deficit.
5. The Charge Nurse will assign staff to patients' care in accordance with the degree of supervision needed by each individual and the availability of that Charge Nurse.
6. Registered nurses in each of the patient areas will delegate, coordinate and supervise the care provided by the CNAs and Unit Secretary/Technicians.
7. Daily Patient Care Assignments:
    a. The Unit Manager works Monday through Friday, assisting in the department as necessary/available.
    b. The Clinical Coordinator works Monday through Friday, assisting in the department as necessary/available.
    c. The Clinical Educator will work 40 hours per week and will assist in the department as necessary/available.
    d. The Charge Nurse will be designated based on the job description, skills and ability, and assigned accordingly. Every effort will be made to have the most qualified nurse on each shift as the Charge Nurse.
    e. A daily staffing roster is provided to the Charge Nurse listing all scheduled staff available for patient care assignments. Assignments will be made taking staff skills and ability into consideration. Assignments will be posted publicly in the department per RCW 70.41.420

INDICATOR	CRITERIA
A. PATIENT ACUITY	Patient acuity will be assessed every shift to assure adequate staff.

A. PATIENT ASSIGNMENT	Patient assignments will be determined by the Charge Nurse based on patient acuity and skills and ability of the nurse.
A. STAFFING RATIO GUIDELINES	
1-8 Patients	At least 2 RNs based on patient acuity.
9-12 Patients	3-4 RNs based on patient acuity.
> 12 Patients	4-5 RNs based on patient acuity.

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	06/2020
Administrative Assistant	Heather Shipman: Executive Assistant	06/2020
Manager, Unit	Melanie O'Brien: Mgr Unit	05/2020
Clinical Educator - RN	Sarah Ball: Coord Nursing Floors	05/2020

Status **Active** PolicyStat ID **10216527**

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Owner	Jill Matthews
Policy Area	Kadlec Clinics
Applicability	WA - Kadlec Regional Medical Center

Staffing Guidelines: KCHO, 76.30.73

Kadlec Clinic Hematology and Oncology Infusion Unit: Staffing Guidelines

Patients receiving nursing care in the Kadlec Clinic Hematology and Oncology (KCHO) Infusion unit will have a wide variety of acuity, treatment regimens, and appointment types. Guidelines are helpful in determining appropriate patient assignment. The staffing matrix helps determine the staffing for the infusion unit and is based on budgeted nursing hours per patient day and minimum staffing standards.

1. The Lead Nurse will be responsible for appropriate assignments based on available staff and patient acuity. Goal is a 1:3 or 1:4 infusion chair patient ratio at one time.
2. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.
3. Staffing may be flexed up or down to meet the needs of the patients, unit, and staff experience/resource availability per the Lead RN or the Nurse Manager. RN staffing and patient ratios may be adjusted for the following:

- New chemotherapy/immunotherapy patients requiring significant patient education
- Patients requiring a large amount of emotional support
- Complex treatments requiring more support

1. Registered nurses in the infusion areas will prescribe, delegate, coordinate and supervise the care provided by the CNAs, injection Medical Assistant, Nurse Externs, and Nurse Techs.

Matrix:

1 Lead RN

3 Lab Draw/Support RNs

2 Triage RN

10 Infusion RNs; The Lead Nurse and/or Nurse Manager has discretion on flexing to triage, or labs/ support if needed based on census or identified need

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	09/2021
Executive Assistant	Heather Shipman: Executive Assistant	08/2021
Matthews, Jill: Mgr Unit	Jill Matthews: Mgr Nursing Clinic RN KC	08/2021

Status **Active** PolicyStat ID **7562022**

Origination	02/2002	Owner	Erin Logan
Last Approved	05/2020	Policy Area	PACU
Effective	05/2020	Applicability	WA - Kadlec Regional Medical Center
Last Revised	05/2020		
Next Review	05/2023		

Staffing Requirements, 80.05.01

Document Type: Guideline, Standard

POLICY STATEMENT:

Ensure that adequate staffing standards are maintained for the management of patient care. Staffing is based on patient acuity, census, patient flow processes and physical facility. The Perianesthesia registered nurse uses prudent judgment to determine nurse to patient ratios, patient mix, and staffing mix that reflect patient acuity and nursing intensity.

RESPONSIBLE PARTIES:

PAU Department Lead Nurse
PAU Department Unit Manager
Director of Perioperative Services

POLICY:

1. The following guidelines will be followed to ensure that adequate, qualified staffing is maintained in the PAU. (See Attachment A).
2. Staffing is based on patient needs, analysis of acuity tends, ASPAN standards and on community standards.
3. Staffing patterns will be analyzed and reviewed annually as part of the annual budget review process. Consideration will be given to findings from quality assessment and improvement activities.

PROCEDURE:

1. Patient census, acuity and ASPAN standards must be evaluated when assessing standard staffing in the department.
2. It is the responsibility of the PAU Lead Nurse to evaluate the situation and secure additional staff to ensure the standard is in compliance.
3. Staff may be reduced due to low census according to established criteria (See Attachment B).
4. If the standard is compromised due to patient acuity, patient volume, lack of nursing or ancillary personnel, and/or lack of in-house resources, the Lead Nurse will implement the following action in the recommended sequence.
    A. Request staff from the previous shift to stay over.
    B. Request staff from next shift to come in early.
    C. Call additional staff to come in to work (i.e., per diem, regular staff or consider creative changes to schedule).
    D. Monday – Friday contact the Clinical Educator.
5. Fill out the QRR report on the computer, to document all steps taken to resolve the problem and the reason(s) for staffing deficit.
6. Daily patient care assignments:
    A. The Lead Nurse will be designated based on the job description and assigned accordingly. Every effort will be made to have the most qualified nurse on Lead for each shift.
    B. The Lead Nurse will assign staff to patient care in accordance with the degree of supervision needed by each individual and the availability of that Lead Nurse. Staff will be assigned and rotated according to the complexity and dynamics of the conditions of patients considering the following:
        1. Staff expertise, strength and previous experience.
        2. PALS, ACLS and orientation.
    C. Consideration in assignments may also be given to the following:
        1. The number of staff on duty during the shift including ancillary personnel.
    D. Registered nurses in each of the patient areas will delegate, coordinate and supervise the care provided by the transport aids.

STAFFING:

1. Minimum of 2 RN's in the same unit/room where a patient is receiving Phases I level of care.
2. Minimum of 1 RN competent in Phase I recovery, has completed unit specific orientation, and is current in unit specific competencies.
3. Staff on-call for PAU must be able to report to PAU within 20 minutes.
4. If called in during an on call shift, PAU staff will contact the PCC prior to leaving the hospital and/or badging out. Call back badgings may not be 'stacked' in an attempt to generate multiple call backs.
5. On-call schedule will come out with the regular schedule each month.

6. All nurses on the regular PAU schedule will take on-call.
7. All nurses on the regular PAU schedule will take one back up PAU Satellite call.
8. Call days may be traded, but must be completed and approved in KRONOS.
9. On-call time is as follows:

Monday through Thursday	2030-0730
Friday Night	2000-0830
Saturday Night	1800-0830
Sunday Night	1800-0800
Holidays	1830-0800

ABSENCES:

1. If you know that you will be absent or late to work, you should inform the PCC as far in advance as possible, with two (2) hour minimum before shift call for illness.
2. Employees are expected to be on time and prepared to work every day they are scheduled.
3. Employees unable to fulfill this expectation will be subject to counseling and/or discipline.
4. Employees who do not report their absences in advance or engage in a pattern of tardiness and absenteeism will be subject to disciplinary action.
5. Employees who have not notified the Unit, Department Manager, for three (3) consecutive days during their work schedule will be subject to counseling including progressive disciplinary action.

Attachments

A: General Scheduling Guidlines

B: Staffing During Time of Low Patient Census

Approval Signatures

Step Description	Approver	Date
VP, Nursing & CNO	Kirk Harper: CNO	05/2020
Executive Assistant	Heather Shipman: Executive Assistant	04/2020
Contributor	Tracy Hasty: Mgr Unit	01/2020

Older Version Approval Signatures

VP, Nursing & CNO	Kirk Harper: VP, Nursing & CNO	12/2017
Administrative Assistant	Crystal Wise: Administrative Assistant	10/2017
Contributor	Tracy Hasty: Manager, Unit	09/2017

ATTACHMENT A

GENERAL SCHEDULING GUIDLINES:

1. In as far as it is possible, each employee will have a set schedule. Every attempt should be make to schedule personal matters on days off.
2. Each staff member is responsible for knowing his or her schedule and adhering to it.
3. Departmental needs have priority in all scheduling decisions.
4. Employees are expected to be flexible in order to meet the needs of the department.
5. Staff attempting to cover their own time off after completion of the schedule must have PAU Administrative approval.
6. Staff will not be allowed to arrange their own coverage for a shift if there is a staff shortage on that particular day until the shortage has been covered. If there are concerns they need to be addressed to the Department Unit Manager.
7. Schedule changes will not be authorized if it constitutes overtime, unless it has been scheduled and approved or to cover an ill call.
8. Time off on holidays will be on a rotational basis. If a holiday falls on your regular day off, it does not guarantee you have the holiday off.
9. The schedule will be posted five (5) weeks prior to the start of the schedule. Remaining needs will be filled giving consideration to overtime, skill needs, etc.
10. Lead nurses requesting to trade shifts need to ensure that nurses with like skills and abilities are available during that time.

VACATIONS:

1. Vacation leave is scheduled according to WSNA contract and the schedule needs of KRMC PAU Department. Every attempt will be made to grant employee requests.
2. Approved vacation requests shall not be canceled without the agreement of both parties.
3. Vacation/time off request will be honored according to the order in which they were received and/or compliance with non-exempt contracts. This does not necessarily include holidays. Time off during holidays will be considered by seniority and previous holiday use.
4. Vacation requests submitted on the same day for vacation during the same period will be granted according to seniority and/or in compliance with non-exempt.
5. Prior to final completion, staff may not arrange their own coverage, as this may impact departmental staffing needs.
6. If you request time off and do not have enough vacation and/or comp. time to cover the request, the time off Is considered leave without pay and as such requires prior administrative approval.
7. It is each employee's responsibility to know if they have PTO accumulated to cover their request.

ATTACHMENT B

STAFFING DURING TIME OF LOW PATIENT CENSUS:

Staffing patterns should be adjusted as needed based on changing acuity and nursing requirements, and as discharge criteria are met. Here are the following guidelines when the department is not as busy. The lead Nurse will use the guidelines set forth by the WSNA contract to determine who will be sent home.

1. Check to see if back up is available should a staff nurse be sent home, with the following.
   A. Lead Nurse
   B. Patient Care Coordinator (PCC)
2. Consider how many hours' relief resources will cover; two to four hours is reasonable, depending on back-up arrangements.
3. Consider that someone with experience may be available.
4. Notify the Patient Care Coordinator (PCC).
5. When someone goes home with an hour or less remaining to their shift, they will be on low census only, not stand-by.