Cascade Medical Nurse Staffing Committee  
Hospital Staffing Matrix Recommendations  
in accordance with RCW 70.41.420  

September 22, 2017

Background:  
The Cascade Medical Nurse Staffing Committee met on August 9, 2017, September 14, 2017 and September 20, 2017 with a goal of developing recommendations for improved staffing of the hospital’s acute care, swing bed and emergency department functional areas.

Attendees:  
Nancy Newall, Night Shift Emergency Department Nurse  
Rhea Croll, Day Shift Emergency Department Nurse  
Chris Miller, Day Shift Emergency Department Nurse  
Julie Chandler, Night Shift Emergency Department Nurse  
Katrina Rostedt, Night Shift Clinical Resource Nurse  
Deb Schlotfeldt, Day shift Clinical Resource Nurse, formerly Night shift Clinical Resource Nurse  
Alex Riggs, RN, CIS, formerly Day Shift Clinical Resource Nurse  
Yvonne Peters, Day Shift Acute Care/Swing Bed Nurse  
Ed Smith, Night Shift Acute Care/Swing Bed Nurse  
Ray Ryan, Patient Care Tech Day shift  
Dennis Merritt, Patient Care Tech Night Shift  
Charlynn Zaragosa, ED Admitting Clerk  
Pam Prpich, ED Admitting Clerk  
Kath Virgil-Belding, Director of Nursing  
Amy Webb, Chief Operating Officer

The team discussed what was currently working well with the existing staffing matrix and where the current staffing matrix fell short of supporting a safe environment for patient care.

Elements of the current matrix that are working well:  
1. It is very positive when a CRN is able to assist with patient care. The patient and family experience is improved, care is of higher quality and safety is enhanced.  
2. ED Admitting staff have stayed late past their shift on busy nights. This has made a huge difference in the ability of the nurse to focus on patient care rather than answering phones, registering and responding to the doorbell.  
3. Having a patient care tech that can assist with inventory, stocking of supplies, answering phones in addition to delivering patient care is very positive.

Concerns with the current staffing matrix:  
1. Barriers to Admitting patients: The current matrix staffs one RN in acute care. The nationally recognized safe nurse to patient ratio for acute care is 1 RN to 4 Patients and for Swing Bed the ratio is 1 RN to 5 patients. The hospital has 9 set up beds. When the census reaches five, additional nursing support is necessary to admit more patients. The facility has not been able to staff additional nurses when needed as the need is often not known until the moment an admit is requested and the patient is waiting in the ED for disposition. The facility has turned down eight requests for admission in the past 6 weeks due to inadequate staffing levels. Physicians report frustration regarding the hospital’s inability to admit their patients. Patients in our community must go elsewhere to receive healthcare services that are within the scope of Cascade Medical to deliver.
2. Unsafe nurse staffing ratios in the Emergency Department when census and acuity go up: The Emergency Nurse Association (ENA) has published a white paper on nurse staffing recommending two nurses as the minimum number of Registered Nurses need to safely staff an Emergency Department. Analysis of 2016 Emergency
Department patient flow shows clear patterns of high census on most Friday nights, Saturdays, Holidays, Festival weekends, periodically during June and July, the entire month of August and the 2 weeks surrounding Christmas and New Year. The current staffing matrix does not address predictable weekly fluctuation and seasonal fluctuation in patient census.

3. **Unacceptable reliance on Agency Staff:** Cascade Medical has spent in excess of $97,000 during the first seven months of 2017 on nurse agency staff. Agency staff do not know hospital protocols, must quickly learn the electronic medical record and as a result often low quality documentation of services. Patients are at higher risk for safety events due to lack of understanding CM hospital work flow and systems. In addition, the presence of agency nursing has been repeatedly referred to as lowering staff moral. Nursing looks at the agency staff member who is likely making a much higher wage and they are doing less work requiring employed staff to increase their workload to pick up the missing pieces. This situation creates a negative reputation for Cascade Medical making it difficult to recruit for and retain nurses in regular full time or part time positions. Addressing the staffing matrix would enhance Cascade Medical’s ability to recruit nurses to a strong team where they know there will be adequate resources to care for patients.

4. **Daily focus on staffing needs:** Under the current staffing matrix, the Director of Nursing and often the COO must troubleshoot staffing needs on a daily basis. Approx 30-40% of the Director of Nursing’s time is spent attempting to schedule adequate nurse staff to care for patients. This is not the best use of the Nursing Director’s time which should be focused on supporting staff with improved systems, training, improved work flow, ensuring regulatory compliance, patient safety and appropriate charge capture.

5. **The CRN position has not worked as intended:** The CRN, Clinical Resource Nurse, position was envisioned as an eclectic RN role that would be responsible for helping in Acute Care when needed, helping in the ED when needed, participating in assigned administrative projects related to nursing quality and delivery of care, act as charge nurse, assist with staffing, arrange patient transport, appointments and back up the Hospital Case Manager. After approximately 18 months of implementation, the feedback from the nursing team is that the CRN is seldom in a position to assist when needed with patient care. This especially true for ED nurses who need support. When the census reaches 5 or above in Acute Care, the CRN must take a patient in Acute care. This results in their inability to also provide nursing support in the ED. There are also times when the CRN is supporting the ED and unable to assist with Admissions/Discharges in Acute care which can be problematic when there is one RN on duty and multiple Admissions or Discharges in a day. Requiring a staff member to move between two very distinct care environments (acute care and ED) and be equally competent in both areas has not proven successful.

6. **Telephone management, doorbells, registration, family support:** In the current matrix, the ED admitting/registration clerk is scheduled to end their shift at 7:00pm. The ED is often busy until about 11:00pm. After 7:00pm there is only one ED nurse on duty and a CRN that is floating. After 7:00pm the ED Nurse must simultaneously assess the patient, call the physician on duty, register the patient, order labs or x-rays based on medical staff approved protocols, answer incoming phone calls and respond to the door bell. Analysis of ED patient flow indicates that there are more than 2 patients in the ED at the same time most Friday evenings, Saturdays, Holidays, Sundays of festival weekends, most days during the month of August and during Christmas break (Dec 24-Jan 1). Volumes vary after 7pm Monday through Thursday.

**Data sources for analysis of census and acuity:**

The committee utilized 2016 ED patient census data broken down in ½ hour increments throughout the day. The spreadsheet allowed the team to view concurrent number of patients in the ED by day of the week and hour of day. Trends in high volumes were readily apparent on Fridays, Saturdays, Holidays, Festivals, the month of August and Christmas break. Staff did note that this data did not provide information on acuity which is a significant factor in patient safety. The team also had access to Census data for Acute Care and swing bed from 2016 and 2017.

**Staffing elements considered by the committee:**

The committee engaged in robust discussions regarding a staffing mix that would address each of the concerns referenced above. On September 14th, the committee proposed 3 possible plans and discussed the pros and cons of each. The Chief Operating Officer analyzed the budget impact of the three proposals and then generated an additional seven scenarios for a total of 11 different potential staffing plans. On September 20th the team reconvened and discussed the pros and cons of the 11 proposals and their ability to address the current concerns. Katrina offered a 12th
model that was also reviewed. A modification of Katrina’s model was chosen as the preferred model to recommend to Administration. This will be discussed in detail later in this document. The staffing proposals ranged in budget impact (additional expense as compared to current matrix) from $89,000 to $340,000. The Chief Operating Officer discussed the need for the proposal to be budget neutral. The committee would have to consider the revenue needed to offset the additional expense and ensure that the source of additional revenue was realistic and attainable. The obvious source of revenue to offset additional staffing expenses is through addressing the barriers to inpatient admissions. The final proposal will achieve budget neutrality with an addition of 64 budgeted swing bed patient days. This is equivalent to 4 additional patients admitted throughout the year.

Of note, proposals containing a Hospital Unit Secretary (HUC) were discussed. After reflection the committee felt that the unit was not physically large enough to support a HUC role. Concerns were expressed about where this person would physically be stationed to do their job and that in a small unit people need to be able to do multiple tasks. It didn’t make sense to the committee to add a role that did not include direct patient care. It was determined that with adequate RN staffing, a patient care tech could perform many of the functions of a HUC while still contributing to patient care.

The committee also discussed the use of an emergency department technician to enhance care in the ED. While this seemed appealing from a financial standpoint, the team determined that given the unpredictability of patient census and acuity in the ED, and considering the ENA recommendations for a minimum of 2 RNs in the ED, a second RN instead of an ED technician would be a better choice for patient safety.

The committee discussed changing the lengths of shifts for the patient care technician role (name to be changed back to Certified Nursing Assistant, CNA, out of respect for the scope of practice for persons who have earned this credential). Changing the length of shifts was a potential financial enhancement to the proposal. However, there are duties performed by the CNA in addition to patient care that would then need to be shifted back to licensed staff such as stocking, infection control, phones etc. Reducing the length of the CNA shift did not contribute to solving the concerns related to the current matrix.

The committee discussed the ED admitting role at length. There was a strong desire to reclassify the ED admitting role from the Business Office to the Emergency Department. The Chief Operating Officer explained the negative impact on facility reimbursement that would occur with such a reclassification. ED nursing staff noted that the ED admitting clerk is often tasked with many business office projects and is unable to help support or facilitate patient care when there are multiple patients. In an ideal situation, the ED admitting clerk would be able to assist with transfers by making phone calls and copying medical records. There are times when it would be very valuable for the ED admitting clerk to also be able to turn over rooms between patients. ED nursing staff report they are seldom in a position to offer this support. The committee discussed extending the registration hours during predictably busy times in the ED to allow the RN on duty to focus on patient care while the ED admitting clerk managed phones, answered the doorbell, registered patients and supported families. The ED admitting clerks noted that they often have an increased workload the morning after a busy night in the ED as they must complete all the abbreviated registrations that were done by the nurse during the night. They also noted concerns for regulatory compliance as patient intake paperwork is often missing required signatures.

The committee discussed strategies to remove barriers to admission to Acute Care and Swing bed. Scheduling two registered nurses on day shift and two licensed staff on night shift (minimum one RN) would meet nationally recognized safe nurse to patient ratios of 1:4 and 1:5 even if all nine available beds are occupied. The swing bed census is historically much higher than the acute care census. Swing bed patients are receiving skilled nursing and skilled therapy services and often require a higher level of support for activities of daily living due to decreased mobility.

The committee also discussed weekly and seasonal patient flow and reviewed strategies to provide staff resources when needed to respond to these predictable increases in census while not wasting resources during times when patient census is predictably low.
### Core Staffing Matrix

<table>
<thead>
<tr>
<th>Acute Care</th>
<th>Emergency Department</th>
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<tbody>
<tr>
<td><strong>Day</strong></td>
<td></td>
</tr>
<tr>
<td>2 Registered Nurses</td>
<td>1 RN</td>
</tr>
<tr>
<td>1 CNA</td>
<td></td>
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<tr>
<td><strong>Night</strong></td>
<td></td>
</tr>
<tr>
<td>2 Licensed Nurses <em>(RN/LPN or 2 RNs)</em></td>
<td>1 RN</td>
</tr>
<tr>
<td>1 CNA*</td>
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</tbody>
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1 RN Swing Shift, Charge Nurse, Support Patient Care

*The Night Acute Care Team (Licensed staff and CNA) would be responsible for assigning one team member to the ED from 23:30 to 06:15. This could be the CNA or it could be a licensed staff member depending on the needs in the ED. Trending indicates that there are very few to no patients in the ED from midnight to 6 am throughout the year. However, it is unsafe for one staff member to answer the doorbell at night. A minimum of 2 staff members must always answer the door. In addition, the hours when there is one to zero patients in the ED is the optimal time to stock and ensure the department is ready for the next busy period.

### Seasonal Staffing Additions

<table>
<thead>
<tr>
<th>Acute Care</th>
<th>Emergency Department</th>
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<tbody>
<tr>
<td>None</td>
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Add 16 daily hours of RN staffing to:
- **Holiday Weekends**
  - President’s Day Weekend
  - Memorial Day Weekend
  - Labor Day Weekend
  - Thanksgiving Weekend
- **Holidays that do not fall on a weekend**
  - 4th of July
- All days from 12/24 through 1/1
- All days in the month of August
- Fri and Saturday of Festival Weekends:
  - Autumn Leaf
  - Oktoberfest
  - Christmas Lighting

Extend ED Admitting hours to 23:30 on the dates identified above.

### Budget Impact

**Estimated cost in excess of 2018 submitted nurse staffing budget: $154,538.83**

Inpatient increase: $118,932.64, ED Increase 36,146.19

Note: 16 hours of RN staffing for holidays, festivals, etc as noted above estimated at: $56,267.00. Some nursing staff commented that we may not need this additional coverage with the swing shift in place designed to support patient care. In this scenario the financial impact is: $98,271 which is absorbed entirely by Acute Care.

- Average length of stay for Swing Bed Patient in 2016 = 16 days.
- Daily Medicare Revenue for SWB patient = $2,422
- Average revenue per SWB Admit = $38,752

### # of additional SWB Admits required to cover projected IP additional expense: 4

### Future Staffing Considerations

1. Develop incentives for pool staff to pick up extra shifts and decrease agency use.
2. Consider developing infusion services so that a nurse can be hired to support that service line rather than pulling the ED nurse to provide these services.
Hospital Staffing Matrix Recommendations
The staffing Committee Recommendations have been approved and implemented:

Name: DeAnna Griggs
Title: Director of Nursing
Signature: 
Date: 12/20/2018

Name: Shana Ormea
Title: Chief Clinical Officer
Signature: 
Date: 12/20/2018

Name: Diane Blake
Title: Chief Executive Officer
Signature: 
Date: 12-20-18