2018 Staffing Plan Overview

Department: IV Therapy
Date Updated: 5/8/2018 (6-Month Review Verified and no updates 11/27/18)
Author: Jessica Sericolo, Manager Patient Care Services

Nursing Department Overview

IV Therapy is a specialty department that provides 24/7 consultant services to all areas of the hospital to include inpatient and outpatient procedural settings. The IV therapy team preforms a variety of skills related to vascular access from placing peripheral IV sites to Midlines, PICC Lines, and Central Lines as well as Port access. In addition to line placement and maintenance they also perform line de-clotting, trouble shooting and dressing changes.

Key Quality Indicators

- IV Therapy is an all RN staff
- Small department OT used to cover LOA/Sick calls/Vacations
- No agency or travelers used
- Intravenous Nurse Society/Association for Vascular Access are the professional organizations used for access guidelines
- Seven nurses with VABC certification

Staffing Grid for Patient Census | Target Hours per Patient Day

Insert developed staffing grid for varying levels of patient census or attach to this document

Day Shift

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Charge</th>
<th>RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700-1900</td>
<td>3 days a week</td>
<td>2</td>
</tr>
</tbody>
</table>

Evening Shift

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1100-2300</td>
<td>3 days a week</td>
<td>2-3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Night Shift

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900-0700</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

IV Therapy rounds on and attends to all central and PICC line dressings they place throughout the hospital. In addition, IV Therapy will provide consultant services for any line they are asked to evaluation. IVT workload flexes up and down with the census.
Which Situations Require Staffing Variation?
IV Therapy experiences increasing call volumes when the hospital is in surge capacity. The procedural volumes often increase with hospital census. When the hospital is experiencing high census, IV Therapy looks to add additional staff during peak hours, particularly 1100-2300.

Chain of Command/ Staffing Decision Tree

Process for Staffing Variation
The IVT Charge nurses and manager monitor staffing daily and will flex up as able to accommodate for high procedural volume days.

Meals and Breaks
IV Therapy uses the cancel meal deduct feature of Kronos and is paid for their meal breaks. IVT cannot be guaranteed an uninterrupted rest break due to unpredictable hospital emergencies. IVT nurses are still encouraged to take meal and rest breaks. These breaks are not scheduled and coordinated within the team.

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)
- Survey reviewed at staff meetings
- Focus on improved communication with leadership and nursing units
- IVT cell phone initiated which allows for improved communication
- Additional education on Vocera capabilities to improve communication

Committee Recommendations:

Approved By
Jakki Stodola, Co-Chair
Director Family Birth Center

John Gustafson, RN Co-Chair
Medical Surgical, 7th floor

Syd Bersante, Market President/Pierce County President SJMC
2018 Staffing Plan Overview

Department: St Joseph Medical Center – Regional GI Lab
Date Updated: 12/10/2018 (6-Month Review Updated 12/4/18)
Author: Darcey Michaels, Clinical Manager – Digestive Services

**Nursing Department Overview**

St Joseph Hospital GI Lab is a 4-procedure room endoscopy suite that provides Gastroenterology (GI) procedures for both outpatients and inpatients in the Tacoma/Pierce County area.

- Average Daily census: Monday – Friday: 15; Saturday, Sunday: 3
- Average number of admits/discharges: Same as daily census. There is no overnight boarding in this department.
- Procedures are scheduled for 30-120 minutes depending on the type of procedure.
- This department has a mix of both inpatient and outpatient procedures.
- Both moderate sedation and general anesthesia are provided.
- Average length of stay: 2-4 hours
- Hours of operation: Monday-Friday, 0600-1800. Staff are on call weekday evenings from 1800-0700 and weekends from 0700-0700.

**Key Quality Indicators**

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

- *Patient falls prevalence – 0 YTD
- *Patient falls with injury – 0 YTD
- *Pressure ulcer rate/prevalence (N/A)
- *Target nursing hours per procedure – 5.040
- *Skill Mix – RNs, LPN and Endo Techs
- Medication errors - 1
- Staff turnover/orientation costs – RN = 2, Endo Tech = 4
- Overtime costs – past 4 pay periods = 91.25 hours – OT % of worked = 0.02%
- Agency/Traveler Usage = 0
- Patient Satisfaction Data – No data available
- Data from professional organizations (SGNA, ASGE)

**Staffing Grid for Patient Census**

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Target Nursing Hours per Procedure = 5.040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing is determined on the number of procedures rooms in operation.</td>
<td></td>
</tr>
<tr>
<td>- The GI Lab requires a charge nurse (RN), admit/recovery nurse (RN), sedation nurse (RN), and procedure assistant (RN/Endo Tech).</td>
<td></td>
</tr>
<tr>
<td>- One additional Endo Tech is scheduled to perform cleaning and high-level disinfection of endoscopes.</td>
<td></td>
</tr>
<tr>
<td>There is one manager that oversees the GI Lab and a surgery scheduler at SJMC who is responsible for scheduling and charge entry.</td>
<td></td>
</tr>
</tbody>
</table>
Day Shift – 10-hour shifts

<table>
<thead>
<tr>
<th>Number of procedure rooms</th>
<th>RNs</th>
<th>Endo Techs</th>
<th>Charge RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>+3</td>
<td>+1</td>
<td></td>
</tr>
</tbody>
</table>

Evening Shift – N/A

Night Shift – N/A

**Above Staffing Plan Contingent Upon the Following Supports/Considerations**

Support received from other units/departments or provides to other units and departments that impact staffing.

- The OR provides anesthesia tech support for General Anesthesia turn-around. The GI Lab pays for the anesthesia tech hours.
- Radiology tech support is provided for ERCPs and other procedures requiring fluoroscopy.
- Walters Same Day Surgery PACU provides Phase I recovery for General Anesthesia patients.

**Which Situations Require Staffing Variation?**

- This is a regional department that provides procedure staff for SJMC, SFH, SCH and SAH.

**Chain of Command/Staffing Decision Tree**

**Process for Staffing Variation**

Charge nurse will:
- Review procedure schedule daily to determine staffing needs for the next day
- Flex shift times up or down depending on procedure schedule

Manager will:
- Provide additional assistance by obtaining additional resources when staffing shortage exists

**Meals and Breaks**
Procedure schedules are designed to allow for meal breaks between the AM and PM procedure sessions. (AM session = 0700-1130, PM session – 1230-1700)

Charge nurse is available to provide breaks for staff who are unable to break themselves.

If charge nurse is not available to break staff for their meal or break, they are to record this on the edit log.

---

**Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)**

- **Survey results reviewed with staff?** Yes, verbally in a staff meeting

- **Staff Participation:** 3 respondents total

- **What was the theme of the results**
  - Most of answers to the questions were a 3 (“Usually”)
  - There is no “Resource” staff in this department
  - When staffing is sub-core, there is no extra help for higher acuity patients which effects throughput

- **Department work planned to address themes**
  - When the charge nurse is pulled away into a procedure room, the scheduler covers the phones at the charge desk
  - Reschedule cases to a different regional location or to a different date
  - Continue to work towards hiring to core staffing

---

**Committee Recommendations:**

**Approved By**

- **Jakki Stodola, Co-Chair**
  - Director Family Birth Center

- **John Gustafson, RN Co-Chair**
  - Medical Surgical, 7th floor

- **Syd Bersante, Market President/Pierce County**
  - President SJMC
2018 Staffing Plan Overview

Department: Med-Surg Oncology
Date Updated: December 2018 (6-Month Review Updated 11/28/18)
Author: Wendy Stickland

Nursing Department Overview

The Med-Surg Oncology & BMT Unit consists of 24 private acute care rooms and 4 protective environment rooms for hematopoietic stem-cell transplant. The unit serves as the designated inpatient oncology unit for the Tacoma-King Markets.

Types of specialized patient care & treatments provided include:

- New oncology/hematology diagnosis and work-up
- Chemotherapy and biotherapy administration
- End-of-life care and complex pain management
- Stem cell apheresis, erythrocytapheresis
- Stem cell transplantation
- Acute cancer-related and treatment-related symptom management
- Med-Tele overflow

Average Daily Census: 26.5
Average length of stay: 6.82

Key Quality Indicators

Accredited through the American College of Surgeon’s Commission on Cancer.
  - 2018 received 3-year accreditation
  - Certified Nurses in Service Line 45%

- CLABSI (1)
- CAUTI 0.0
- HAPU 0.315
- Falls with injury: 0.00
- HOUS: 13.36 FY-19
- RN, CNA/CA care team
- Staff turnover/orientation costs: 9.13% / 18 mo. – 2 yrs. specialty training
- End of shift overtime: High acuity patients / paper chemotherapy orders
- Professional organizations:
  - 2 RNs attended ONS Congress, Philadelphia, PA
  - 5th Annual Certification Celebration Dinner
  - CEs at staff meetings and annual Oncology Skills Day
  - Active PSONS Chapter with monthly educational opportunities

Staffing Grid for Patient Census  Target Hours per Patient Day: 13.36
### Above Staffing Plan Contingent Upon the Following Supports/ Considerations

**Organizational support/resource for:**
- Chemotherapy administration
- Hazardous drug handling, administration, disposal and spills
- CVADs, PORTs

**Which Situations Require Staffing Variation?**
- Stem Cell Thawing & Transplant; Clinical Trial patients
- High-Risk Chemo/Bio Treatments (IL-2, Chemo Desensitization and IP Chemo)
- Acute Post-Transplant Patient, Oncologic Emergencies: DIC, TLS
- Increased number of isolation patients or 1:1s, MH or detained patients
- Complex Pain Management or Sedation Requiring Frequent Titration
- Increased Numbers of High-Risk Treatments: Chemo, Insulin or Cardiac gtts.
- Increased ADT
- Radiation transport needs

---

### Chain of Command/ Staffing Decision Tree
Process for Staffing Variation

Charge Nurse determines need to increase or decrease staff when hand-off report is received, and then, reassesses continually throughout the shift.

- Staffs to the skill and ability of the nurse and acuity of patients
- Rounds to assess patient acuity
- Attends 0930 & 1630 Bed Huddle
- Collaborates with Clinical Manager to determine need for additional staff.
  If it is determined that extra staff or skill is needed the Charge Nurse calls-in.

Meals and Breaks

Break RN role / day shift 0830-1700

- Charge Nurse rounds to support rest and meal breaks
- Manager follows-up with staff who frequently miss breaks
- Education and brainstorming sessions at staff meetings on the value of breaking and break requirement

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Reviewed at March Staff Meetings
  o Sent out to staff that missed meeting in newsletter format
- Results
  o Low participation, but overall positive trends
  o Concerns: Change in Centralized Equipment availability, dietary, supply changes

Committee Recommendations:

Approved By

Jakki Stodola, Co-Chair
Director Family Birth Center

Date

John Gustafson, RN Co-Chair
Medical Surgical, 7th floor

Date

Syd Bersante, Market President/Pierce County
President SJMC

Date
2018 Staffing Plan Overview

Department: SJMC Outpatient Oncology Infusion Clinic
Date Updated: December 3, 2018 (6-Month Review Updated 12/5/18)
Author: Deberie Connor, Clinical Manager

Nursing Department Overview

Description of the types of patients served in this nursing unit,
- Average Daily census: 18 – 25 patients
- Average number of admits/discharges/transfers: 18 - 25
- Average length of stay: 30 minutes to 7 hours

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*

- *Patient falls prevalence: None
- *Patient falls with injury: None
- *Pressure ulcer rate/prevalence: None
- *Nursing care hours per patient day: 1.28
- *Skill Mix: RNs, CA2 and PAR
- Medication errors: 1 in the last 6 months
- Staff turnover/orientation costs: 1 in the last 6 months
- Overtime costs / end of shift overtime: <2%
- Agency/ Traveler Usage: 1 (Shared with other clinics)
- Patient Satisfaction Data: Press Ganey
- Data from professional organizations
- NDNQI Data ( Relevant reporting units):

Staffing Grid for Patient Census  Target Hours per Procedure: 1.28

Insert developed staffing grid for varying levels of patient census or attach to this document
Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CA2</th>
<th>PAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 – 26</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17 – 20</td>
<td>1</td>
<td></td>
<td>2 then review for possible reduction</td>
<td>1</td>
</tr>
<tr>
<td>15 – 16</td>
<td>1</td>
<td></td>
<td>2 then review for possible reduction</td>
<td>1</td>
</tr>
<tr>
<td>&lt;14</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Weekend Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>RNs</th>
<th>PAR/CA2</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>2</td>
<td>1 on Saturday only</td>
</tr>
</tbody>
</table>

**Above Staffing Plan Contingent Upon the Following Supports/Considerations**

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- Pharmacist and Pharmacy Technician
- Laboratory Services
- Diagnostic Imaging
- Environmental Services
- Blood Work North West for Plasma Pheresis
- Nurse Navigators and Nurse Coordinator
- Financial Account Representative (Conifer)

**Which Situations Require Staffing Variation?**

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Patient appointment cancellation, no show or reschedule
- New patients with High Alert medication requiring frequent monitoring
- Sick calls, vacation

**Chain of Command/Staffing Decision Tree**

**Process for Staffing Variation**

- Charge Nurse reviews the schedule the day before to determine appropriate staffing levels
- Charge nurse evaluates the volume and staffing throughout the day and will flex up or down the staffing depending on volume and acuity.
- The Manager is notified when staffing shortages exist and every attempt is made to ensure staffing does not affect the care of the patients.
- Schedule is adjusted if the department is not able to accommodate the volume due to low staffing
Meals and Breaks

- Staffs are provided breaks and lunches as required and are encouraged to do so after safely handling off their patients to another nurse.
- Charge nurse assigns meal time for nurses. Break and meal time schedule is written on the assignment sheet. Charge nurse covers for break.
- No patient appointments made between 1200 and 1 pm unless approved by the charge nurse.
- If patient assignment does not allow for breaks and/or lunches, the manager will provide back-up and the employee will have their pay adjusted to cover for the missed time.

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Survey results reviewed with staff? What format was used? (staff meetings, shift huddles, e-mail) Culture of Safety was reviewed to staff individually

- **Staff Participation:** 100% of RN’s, 100% CNA’s, 100% PAR

- **What was the theme of the results?** The result was combined with Inpatient Oncology. Team works together to take care of all patients in the clinic.

- **Department work planned to address themes.** Continue with open communication that affects the clinic, leadership updates, etc.

Committee Recommendations:

Approved By

Jakki Stodola, Co-Chair  
Director Family Birth Center

John Gustafson, RN Co-Chair  
Medical Surgical, 7th floor

Syd Bersante, Market President/Pierce County  
President SJMC

Date
2018 Staffing Plan Overview

Department: Walters SADU/PACU/ECU
Date Updated: August 13, 2018
Author: Karen Cook, Clinical Manager

Nursing Department Overview

WDS perianesthesia provides pre and post-operative care to surgical patients, and post-operative care to GI patients requiring general anesthesia.
- Average daily census is 22-28 cases per day with 2-10 additional GI cases to PACU
- Average number of admits/discharges/transfers, average 5 overnight observation patients, 18-24 outpatients, and 5 will be admitted to the hospital as inpatients
- Average length of stay is less than 24 hours

Key Quality Indicators

Use this section for a delineation of what constitutes "safe" nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:
- *Patient falls prevalence – 4 falls, no injury
- *Patient falls with injury - zero
- *Pressure ulcer rate/prevalence - zero
- *Skill Mix – RN, CA, DSA
- Medication errors – 11, no harm to patients
- Staff turnover/orientation costs – 5 = 8.8%
- Overtime costs / end of shift overtime <2%
- Agency/ Traveler Usage- 520 hours, to cover several LOA

Staffing Grid for Patient Census  Target Hours per Patient Visit: 4.0

<table>
<thead>
<tr>
<th>SADU</th>
<th>Admit/Discharge RN</th>
<th>Charge/Resource RN</th>
<th>Admit/Discharge CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-15</td>
<td>3/3</td>
<td>2</td>
<td>1/2</td>
</tr>
<tr>
<td>16-20</td>
<td>4/4</td>
<td>2</td>
<td>1/2</td>
</tr>
<tr>
<td>21-25</td>
<td>5/5</td>
<td>2</td>
<td>1/2</td>
</tr>
<tr>
<td>26+</td>
<td>6/6</td>
<td>2</td>
<td>1/2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PACU</th>
<th>RN</th>
<th>Charge RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-8</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9-12</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>13-16</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17-20</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>21-24</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>25-28+</td>
<td>7-8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ECU 0700-1900</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
<td>----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Census</td>
<td>RN</td>
<td>Charge RN</td>
<td>CA</td>
</tr>
<tr>
<td>0-4</td>
<td>1</td>
<td>Shared w/SADU until 2130</td>
<td>1</td>
</tr>
<tr>
<td>5-8</td>
<td>2</td>
<td>Shared w/SADU until 2130</td>
<td>2</td>
</tr>
<tr>
<td>9-10 (Maximum)</td>
<td>3</td>
<td>Shared w/SADU until 2130</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(staffing to provide RN)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ECU 1900-0700</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Census</td>
<td>RN</td>
<td>Charge RN</td>
<td>CA</td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>2</td>
<td>Shared w/SADU until 2130</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>4-8</td>
<td>2</td>
<td>Shared w/SADU until 2130</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>9-10 (Maximum)</td>
<td>3</td>
<td>Shared w/SADU until 2130</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(staffing to provide RN)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Support Staff

<table>
<thead>
<tr>
<th>Census</th>
<th>Front desk 0500-1830</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>1</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
</tr>
<tr>
<td>21-25</td>
<td>1</td>
</tr>
<tr>
<td>26+</td>
<td>1</td>
</tr>
</tbody>
</table>

### Above Staffing Plan Contingent Upon the Following Supports/ Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- Only FHS unit that accepts overnight pediatric patients
- Most patients must be coded as outpatients
- We now can charge for inpatients
- We now have telemetry capabilities

### Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Heavy surgery schedule/ high numbers of fresh post op patients
- Increased number of isolation patients
- Inpatient bed holds
- One to one care for pediatric and critical care patients
Chain of Command/ Staffing Decision Tree

Process for Staffing Variation

- Shift start times dependent upon surgery schedule; may flex start times to accommodate patients
- Unplanned add-ons to surgery schedule
- Charge nurse determines need for additional staff and arranges for staff
- Support staff from staffing office when there are sick calls

Meals and Breaks

- Charge nurse involvement in break relief
- Complete charge nurse restructure completed with focus on improved charge nurse coverage to facilitate break relief
- Daily break schedule maintained by charge nurses
- Staff are to notify the charge nurse if they are unable to get a break and document in Kronos exception log.

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Decreased participation with improved responses. Shared at staff meeting.
- Process Improvement work completed on issues identified? Staff felt current improvement processes were working.
- What was the results/plan of action? Improved results.

Committee Recommendations:

Approved By
Karen Cook, MSN, RN, Co-Chair
Clinical Manager Peri-Op Services

John Godtke, RN Co-Chair
Med/Surg 7th Floor

Syd Bensante, Market President/Pierce County
President SJMC

Date 8/13/18
Date 9/13/18
Date 10/11/18
Nursing Department Overview

Description of the types of patients served in this nursing unit:
- Cardiac cath patients with or without coronary intervention, peripheral vascular cases with or without intervention, EP procedures- including pacemakers, ablations, watchmans, leadless pacemakers; TEE/CV, loop recorders
- Varies 15-25
- Varies drastically day to day. Approximately ½ of our patients will discharge from our unit. Others are inpatients, or transfers from other hospitals that will return to the original hospital or require a bed in SJMC
- 4 hours (for patients who discharge from our department)

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:
- *Patient falls prevalence- 1
- *Patient falls with injury- near fall (pt ambulated to toilet with proper foot wear and staff standing by, his knee gave out and he caught himself on the bathroom rail but scraped his knee)
- *Pressure ulcer rate/prevalence- N/A
- *Skill Mix- 20 RNs, 10 CVT/RT, 1 HUC, 1 CNA
- Medication errors- 1
- Staff turnover/orientation costs
  - Turnover included interim manager, 6 RNs, and 2 CVT/RT and 3 Travel RNs
  - There remains an open manager position
  - 6 RNs have been hired, 3 CVTs hired and 1 CVT traveler remains
- Overtime costs / end of shift overtime- Cath lab FYTD average 4.38%, PPP 3.75%; EP FYTD average 6.96%, **PPP 8.41%**
- Agency/ Traveler Usage
  - 3 traveler RN and 1 CVT

Staffing Grid for Patient Census  Target Hours per Patient Day: _EP:5.8, Cath Lab7.4
Insert developed staffing grid for varying levels of patient census or attach to this document

Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induction/Recovery</td>
<td>2 @ 0600</td>
<td>1 HUC @ 0800</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 @ 0700</td>
<td>1 CNA @ 0900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 @ 0800</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 @ 0900</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure nurses</td>
<td>1 @ 0600</td>
<td>3 @ 0600</td>
<td>3 @ 0600 (1 lead tech)</td>
</tr>
<tr>
<td></td>
<td>4 @ 0700</td>
<td>4 @ 0700</td>
<td></td>
</tr>
<tr>
<td>EP</td>
<td>Charge</td>
<td>RNs</td>
<td>RCIS/RT</td>
</tr>
<tr>
<td>1 @ 0600</td>
<td>3 @ 0600</td>
<td>2 @ 0600</td>
<td></td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/ Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- We send CV techs to support cases in OR which include TAVR, endovascular AAA repair and 24/365 on call for peripheral OR cases
- We transport all of our patients throughout the hospital, except inpatient TEE/CVs which are brought to our recovery area for the procedure
- We received ample support from ED for codes or pharmacy needs, as well as great support from ICU when Impella or balloon pump patients arise

Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Heavy surgery schedule; high number of emergent add-on cases; having all 5 procedure rooms running at once stretches all areas of our department; when throughput becomes an issue from Full capacity, it impacts greatly our procedures and recovery staff
- 3 staff are on call for after hours and weekends, occasionally the weekend procedure become too great and additional staff are called in to assist

Chain of Command/ Staffing Decision Tree
Process for Staffing Variation

- We are unable to utilize staff from other areas except ACC but this is rarely accessible. We do get assistance from staffing with CNAs when they are able to.

Meals and Breaks

- Breaks are taken in between procedures as best as possible. If staffing is short, the charge nurse does her best to go around and relieve nurses for breaks. The lead tech also does the same for the techs.
- Staff are putting in Kronos if they did not receive their breaks and writing on the edit log

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Unclear how or if the survey results were discussed with staff.
- 1 RN participated in the survey.

Committee Recommendations:
Track mandatory overtime for unit and escalate to director to show improvement and progress as changes are implemented.

Approved By

Jakki Stodola, MBA, BSN, RNC, Co-Chair
Director, Family Birth Center

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

Syd Bersante, Market President/Pierce County President SJMC
2018 Staffing Plan Overview

Department: Family Birth Center 12th and 14th floors   Cost Center 3500
Date Updated: December 2018
Author: Tabatha Farrington, Clinical Manager

Nursing Department Overview

St Joseph Medical Center (SJMC) Family Birth Center is a Level 3A Birthing Center. The department is licensed to provide care for pregnant women of all gestational ages and deliver women (provide inpatient care) who have reached a gestational age of 25 weeks or greater. All pregnant women who are greater than 16 weeks presenting to this facility with a pregnancy complaint are evaluated in the Family Birth Center.

The department is open 24/7 and is licensed as an OB ED so that women may be triaged for all obstetrical complaints. There is a board certified OB/GYN physician on duty at all times to provide immediate care for our patient population. The FBC is capable of stabilizing and caring for all types of pregnancy conditions. Patients requiring specialty care or a higher level of service will be transferred to a facility providing that specialty in accordance with transfer policies and procedures. The Family Birth Center complies with all state, federal and regulatory agencies.

The Family Birth Center is located on two floors of the tower. The 14th and 12th floors are divided as follows:

14th Floor has 11 Birthing rooms and 1 triage room that includes 3 triage bays. All bed spaces have central monitoring capabilities. There is one quad that is used for our high-risk patients, procedures and overflow rooms as needed. This quad has 7 patient rooms. There are two operating rooms located on the 14th floor. C/sections are routinely performed in these ORs.

12th Floor has 23 private postpartum rooms. The 12th floor rooms are also used to assist with hospital overflow on a case by case basis. Clean surgical patients who do not need complex care or telemetry may be cared for on the 12th floor as well as some antepartum overflow 22 weeks or less gestation.

The Family Birth Center delivered 4138 babies in FY18 (MBC delivered 261 in FY18).

- Average number of births per day: 11.4
- Average length of stay: 1.93 days (24 hours post-delivery for Vaginal Deliveries and 48 hours post-delivery for C/Section patients).
Key Quality Indicators

The Family Birth Center collects and monitors data for the purpose of assessing department function, safe patient care, and quality clinical outcomes. These include:

- Primary C/section Rate 19.8% (was 24.87%)
- Lacerations - 3rd and 4th degree w/o instrument 0.9%
- VBAC success rate 59.8% (was 21.74%)
- Episiotomies 1.9% (was 2.28%)
- PC-01 Newborns electively delivered at less than 39 weeks gestation 1.5%
- PC-02 NTSV C/section Rate 25.4%
- PC-03 Antenatal Steroids 100% (was 98.55%)
- PC-05 Exclusive Breast milk feeding rate 82.6% (79.67%)
- Overtime: YTD 1.31%
- Agency/Traveler Usage was 0
- Staff turnover FY17 14.56% (25 vol/2 invol) FY18 18.55% (32 vol/2 invol)
- Residency provided for 21 RNs FY18
- Orientation provided for 8 experienced RNs FY18
- Safe Deliveries Roadmap WSHA (standardizing induction, labor management guidelines)
- AWHONN Data (Association of Women’s Health, Obstetric and Neonatal)
- Vermont Oxford Network NiCQ (National collaborative on quality)
- BFHI accredited

Family Birth Center achievements:
- Baby Friendly Hospital Designation achieved.
- 1 Employee of the Month
- Nomination for unit RNs at the March of Dimes (Jenica Sandall Quality RN)
- Successfully implemented QBL for postpartum hemorrhage
- Post Birth Warning signs education to patients
- ACLS for OB population (regional)
- Created and deployed extensive education for the 4 most common areas impacting maternal morbidity and mortality (hemorrhage, hypertension, sepsis, and cardiac).
- Pilot program for WSHA regarding MEWT implementation.
- Reduced antibiotic exposure to newborns by 50% due to the EOS calculator nurse driven change.

Staffing Grid for Patient Census  Target Hours per Patient Day 16.09

St Joseph Family Birth Center is staffed by:
- RNs specializing in Obstetrical Care and Newborn Care
- Surgical Technologist
- Nurse Techs
- Care Assistants
- Perinatal Social Workers
- Lactation Consultants and Educators
- Receptionist/Schedulers
- Clinical support coordinator

Additional Care Providers on site:
- Board Certified OB/GYN Physicians
Additional Care Providers on site (continued):
- Family Practice Physicians
- Family Practice MD Residents- 1st, 2nd, 3rd year
- Certified Nurse Midwives

RN Shifts Include:
0700-1930
0900-1730 (Break RN)
1100-2330 Monday through Friday
1900-0730
2100-0530 (Break RN)
2300-0730 (1RN)

Care Assistant Shifts Include:
0600-1430
0700-1930
1900-0730

Social Workers:
0800-1630

Lactation Consultant:
0800-1630

Surgical Technologists:
0700-1930
1900-0730

The basic staffing plan for the Family Birth Center is as follows:

Staffing for the 14th floor includes:
- **Day Shift (12 hours)**
  - 1 Charge Nurse
  - 12 RNs
  - 1 Break RN (8 hours)
  - 1 Receptionist/Scheduler 07-1530
  - 1 Surgical Tech
  - 2 Care Assistants

- **Evening shift**
  - 1 Receptionist/Scheduler 15-2330
  - 1 RN 11-1930 (only 0.6 FTE)
  - 2 RNs 1100-2330 Monday through Friday

- **Night Shift (12 hours)**
  - 1 Charge Nurse
  - 12 RNs
  - 1 Break RN (8 hours)
  - 1 Receptionist/Scheduler 23-0730
  - 1 Surgical Tech
  - 2 Care Assistants.
Staffing for the 12th floor includes:

**Day Shift**
- 1 Charge Nurse
- 6 RNs
- 1 Break RN
- 3 Care Assistants

**Night Shift**
- 1 Charge Nurse
- 6 RNs
- 2 Care Assistants

Daily staffing is accomplished utilizing the nationally recognized AWHONN staffing guidelines.

<table>
<thead>
<tr>
<th>Nurse-to-Woman or Nurse-to-Baby Ratio</th>
<th>Care Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antepartum</strong></td>
<td></td>
</tr>
<tr>
<td>1 to 2–3</td>
<td>women during nonstress testing</td>
</tr>
<tr>
<td>1 to 1</td>
<td>woman presenting for initial obstetric triage</td>
</tr>
<tr>
<td>1 to 2-3</td>
<td>women in obstetric triage after initial assessment and in stable condition</td>
</tr>
<tr>
<td>1 to 3</td>
<td>women with antepartum complications in stable condition</td>
</tr>
<tr>
<td>1 to 1</td>
<td>woman with antepartum complications who is unstable</td>
</tr>
<tr>
<td>1 to 1</td>
<td>continuous bedside attendance for woman receiving IV magnesium sulfate for the first hour of administration for preterm labor prophylaxis and no more than 1 additional couplet or woman for a nurse caring for a woman receiving IV magnesium sulfate in a maintenance dose</td>
</tr>
<tr>
<td>1 to 2</td>
<td>women receiving pharmacologic agents for cervical ripening</td>
</tr>
<tr>
<td><strong>Intrapartum</strong></td>
<td></td>
</tr>
<tr>
<td>1 to 1</td>
<td>woman with medical (such as diabetes, pulmonary or cardiac disease, or morbid obesity) or obstetric (such as preeclampsia, multiple gestation, fetal demise, indeterminate or abnormal FHR pattern, women having a total of labor attempting vaginal birth after cesarean birth) complications during labor</td>
</tr>
<tr>
<td>1 to 1</td>
<td>woman receiving oxytocin during labor</td>
</tr>
<tr>
<td>1 to 1</td>
<td>woman laboring with minimal to no pain relief or medical interventions</td>
</tr>
<tr>
<td>1 to 1</td>
<td>woman whose fetus is being monitored via intermittent auscultation</td>
</tr>
<tr>
<td>1 to 1</td>
<td>continuous bedside nursing attendance to woman receiving IV magnesium sulfate for the first hour of administration; 1 nurse to 1 woman ratio during labor and until at least 2 hours postpartum and no more than 1 additional couplet or woman in the patient assignment for a nurse caring for a woman receiving IV magnesium sulfate during postpartum</td>
</tr>
<tr>
<td>1 to 1</td>
<td>continuous bedside nursing attendance during initiation of regional anesthesia until condition is stable (at least for the first 30 minutes after initial dose)</td>
</tr>
<tr>
<td>1 to 1</td>
<td>continuous bedside nursing attendance to woman during the active pushing phase of second-stage labor</td>
</tr>
<tr>
<td>1 to 2</td>
<td>women in labor without complications</td>
</tr>
<tr>
<td>2 to 1</td>
<td>birth; 1 nurse responsible for the mother and 1 nurse whose sole responsibility is the baby</td>
</tr>
</tbody>
</table>
### Nurse-to-Woman or Nurse-to-Baby Ratio

<table>
<thead>
<tr>
<th>Nurse-to-Woman or Nurse-to-Baby Ratio</th>
<th>Care Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Postpartum and Newborn Care</strong></td>
<td></td>
</tr>
<tr>
<td>1 to 1</td>
<td>continuous bedside nursing attendance to woman in the immediate postoperative recovery period (for at least 2 hours)</td>
</tr>
<tr>
<td>1 to 3</td>
<td>mother-baby couples after the 2-hour recovery period (with consideration for assignments with mixed acuity rather than all recent post-cesarean cases)</td>
</tr>
<tr>
<td>1 to 2</td>
<td>women on the immediate postoperative day who are recovering from cesarean birth as part of the nurse to patient ratio of 1 nurse to 3 mother-baby couples</td>
</tr>
<tr>
<td>1 to 5–6</td>
<td>women postpartum without complications (no more than 2–3 women on the immediate postoperative day who are recovering from cesarean birth as part of the nurse to patient ratio of 1 nurse to 5–6 women without complications)</td>
</tr>
<tr>
<td>1 to 3</td>
<td>women postpartum with complications who are stable</td>
</tr>
<tr>
<td>1 to 5–6</td>
<td>healthy newborns in the nursery requiring only routine care whose mothers cannot or do not desire to keep their baby in the postpartum room</td>
</tr>
<tr>
<td>1</td>
<td>at least 1 nurse physically present at all times in each occupied basic care nursery when babies are physically present in the nursery</td>
</tr>
<tr>
<td>1 to 1</td>
<td>newborns undergoing circumcision or other surgical procedures during the immediate preoperative, intraoperative and immediate postoperative periods</td>
</tr>
<tr>
<td>1 to 3–4</td>
<td>newborns requiring continuing care</td>
</tr>
<tr>
<td>1 to 2–3</td>
<td>newborns requiring intermediate care</td>
</tr>
<tr>
<td>1 to 1–2</td>
<td>newborns requiring intensive care</td>
</tr>
<tr>
<td>1 to 1</td>
<td>newborn requiring multisystem support</td>
</tr>
<tr>
<td>1 to 1 or greater</td>
<td>unstable newborn requiring complex critical care</td>
</tr>
<tr>
<td>1</td>
<td>at least 1 nurse available at all times with skills to care for newborns who may develop complications and/or need resuscitation</td>
</tr>
</tbody>
</table>

### Minimum Staffing

<table>
<thead>
<tr>
<th>Minimum Staffing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>A minimum of 2 nurses as minimum staffing even when there are no perinatal patients, in order to be able to safely care for a woman who presents with an obstetric emergency that may require cesarean birth (1 nurse circulator; 1 baby nurse, one or both of whom should have obstetric triage, labor and fetal assessment skills). A scrub nurse or surgical tech should be available in-house or on call such that an emergent birth can be accomplished within 30 minutes of the decision to proceed. Another labor nurse should be called in to be available to care for any other pregnant woman who may present for care while the first 2 nurses are caring for the woman undergoing cesarean birth and during post-anesthesia recovery.</td>
</tr>
</tbody>
</table>
Above Staffing Plan Contingent Upon the Following Supports/ Considerations

- The Family Birth Center OBHG MD and RN respond to obstetrical emergencies and needs throughout the hospital
- The Midwifery Birth Center census affects FBC staffing
- The FBC has no alternate space to place patients
- The FBC transports their patients from the ED and main admitting as well as other areas in the hospital (diagnostic imaging, etc.).
- The FBC has closed staffing so resources to cover short notice are only utilized from NICU and the Midwifery Birth Center

Which Situations Require Staffing Variation?

- The unpredictability of the census
- Patient acuity and status changes
- Short notice occurrences (tardy, bereavement, illness, FCA, etc.)
- Sharing resources with NICU and MBC due to their needs

Process for Staffing Variation

- The Charge Nurses review staffing needs every 4 hours and make adjustments accordingly
- RNs from NICU and MBC support staffing needs and vice versa.
- Response is dictated by variables: acuity, nurse/patient ratio, skills/abilities
- Adjustments may occur anytime during the shift
- Manager on call: Each of the 3 clinical managers rotate call during the week. They are available for questions, concerns and guidance 24hours/7days while on call. At minimum huddle occurs between manager and charge at 05 and 17 each day.

Chain of Command/Staffing Decision Tree

Charge RN→Clinical Manager→Director

Meals and Breaks

- We use a Break Sheet for breaks to ensure accountability. The sheet has specified time slot groupings.
- We have a Break Nurse shift from 0900 to 1730 and 2100 to 0530. The day shift is staffed 7 days per week on 14th floor and 4 days per week on 12. The 14th floor Break nurse facilitates breaks for the MBC RN when necessary. The night shift is staffed 7 days a week on 14th floor and has opportunities available for the open shifts. The Charge nurse facilitates breaks on 12 when there is no Break nurse.
- The Charge nurse collaborates with the break nurse to help facilitate breaks and ensure they are being taken.
- Nurses who are on low census and are on call are to be called in to facilitate breaks if the census proves to be a barrier.
- Frequent communication with staff/charge nurses to address concerns and problem solve ways to ensure breaks. When new staff are hired, breaks are discussed and a plan for incorporating them into the workflow takes place. This is also reemphasized with staff on an ongoing basis.
Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

2018 Staff Survey results were reviewed with employees at our Staff Meeting

Staff Participation: 117 This is an ALL TIME HIGH!!
- 97 RNs (51 Day/1 Eve/45 Night)
- 16 CNAs (8 Day/8 Night)
- 4 ORTs (2 Day/2 Night)

Percent positive (Always/Almost always) IMPROVED for ALL questions!!!

Our identified Strengths:
- I am able to take my breaks and lunch at a reasonable and appropriate time (63%)
- I am able to complete my shift on time (35%)
- I feel supported by the resource staff (32%)

Opportunities to improve from LAST year (2017 survey):
- Help is readily available when a second person is needed for patient care.
  - 3.42% indicated Almost Never (was 27%) IMPROVED!
- Staffing assignments are able to accommodate changes in patient conditions.
  - 6.84% indicated Almost Never (was 19%) IMPROVED!
- I am able to take my breaks and lunch at a reasonable and appropriate time
  - 4.27% indicated Almost Never (was 19%) IMPROVED!

Opportunities to improve THIS year (2018 survey):
(These are the Lowest scoring questions)
- Staffing assignments are able to accommodate admission and transfers.
  - 6.84% indicated Almost Never
- My unit has the necessary supplies and equipment to allow for safe efficient patient care.
  - 7.69% indicated Almost Never
- I have adequate time to spend orienting/precepting new staff
  - 5.13% indicated Almost Never
Process Improvement work completed:

- Provided 2300-0730 RN shift to back our 1100-2330 RN shift (alternating weeks of M-TH and T-F) to increase coverage at a time when “overlap” staff are leaving. This enhanced break coverage for nights as well
- 11-1930 shift every 3rd weekend to provide added coverage
- Changed our residency focus to 1/3 dayshift and 2/3 nights for those hired into a nightshift FTE.
- Decreased the patient load for the preceptor/resident to facilitate learning
- Continued focus on making sure equipment needs are met
- Break nurses continue to check and adjust the process for providing breaks most effectively
- Continued with 4 hour “break” opportunity for ORTs as needed depending on OR schedule

Committee Recommendations:

- Vocera units for all staff to include Mother Baby Unit to expedite communication for non-emergent assistance.

Approved By

Jakki Stodola, MBA, BSN, RNC, Co-Chair
Director, Family Birth Center

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

Syd Bersante, Market President/Pierce County
President SJMC

Date
# 2018 Staffing Plan Overview

**Department:** Gig Harbor Same Day Surgery  
**Date Updated:** August 13, 2018  
**Author:** Karen Cook, Clinical Manager

## Nursing Department Overview

Description of the types of patients served in this nursing unit,
- Average Daily census: 5
- Average number of admits/discharges/transfers: 5/5
- Average length of stay: 4 hours

## Key Quality Indicators

Use this section for a delineation of what constitutes "safe" nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk:*  
- Patients transferred to ED: 1  
- Patient falls: 0  
- Pressure ulcer rate/prevalence: 0  
- Skill Mix: RN/ST/HUC  
- Medication errors: 0  
- Staff turnover/orientation costs: 3 = 17%, this is related to decrease in volume and LC  
- Overtime costs / end of shift overtime: <2%  
- Agency/ Traveler Usage: 0  
- Patient Satisfaction Data:

### Staffing Grid for Patient Census  
**Target Hours per Surgical Case Hours: 9.62**

<table>
<thead>
<tr>
<th>Day</th>
<th>Charge</th>
<th>RNs</th>
<th>ST</th>
<th>HUC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

## Above Staffing Plan Contingent Upon the Following Supports/ Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.
- Provide support for Materials Management by performing duties on-site
- Provide EVS duties for all OR turnovers and patient discharges
- Provide on-site support coordinator
- Any transfers require 911 call

Which Situations Require Staffing Variation?
Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Heavy surgery schedule/ high numbers of fresh post op patients
- Increased number of isolation patients
- Extended surgery schedule (past 4:30 pm)
- Patient transfer to hospital for post-op care
- Gaps in the schedule due to surgeon start times and commitments to clinic schedule and/or surgery at another location
- End of the day staffing requires 2 PACU nurses until OR nurse is available as the second RN.

Chain of Command/ Staffing Decision Tree

Process for Staffing Variation

- Review of schedule regarding off requests or emergent staff issues.
- Who notifies whom?
  - The manager or charge nurse make assignments the day prior. Staff start times are flexed to cover patient needs.
- When in the shift should this occur?
  - 1-2 days prior to the day of surgery
- 6-week schedule is built to cover staffing based on surgery blocks and traditionally heavier days. Flexing up also occurs the day or two prior when caseload is known.

Meals and Breaks

- We use a break board that staff puts their time on, and we have a person scheduled in each area to give. In the rare instance that they miss a break they are paid for it.
### Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Too few responses received to be relevant.

### Committee Recommendations:

---

**Approved By**
- Karen Cook, MSN, RN, Co-Chair
  Clinical Manager Per-Op Services
  
  **Date:** 8/13/18

- John Gustafson, RN Co-Chair
  Med/Surg 7th Floor
  
  **Date:** 9/13/18

- Syd Belsante, Market President/Pierce County
  President SJMC
  
  **Date:** 10/10/18
2018 Staffing Plan Overview

Department: Mental Health Unit
Date Updated: 12/06/2018
Author: Gina Croppi RN-BC

Nursing Department Overview

Description of the types of patients served in this nursing unit,
- 23 bed acute care psychiatric voluntary unit
- Average Daily census: 20.61
- Average number of admits/discharges/transfers: 108
- Average length of stay: 6.93

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:
- Patient falls prevalence: Falls are primarily without injury decreased from FY-18 to FY-19. Made a lot of progress in this area. Falls reviewed and shared in DMB. Fall Task Force initiated due to continued increase in falls. RN q shift fall assessment with improved EPIC upgrades, signage for pt. rooms, whistles for patients, red slippers, bed alarms if indicated, shared with patients at AM and PM Goals and Safety Group, and Staff Safety huddles.
- Patient falls with injury. No reportable events
- Seclusion/Restraint Minutes: Minutes Increased over FY 18 to 19. Episodes decreased, which shows us the patients requiring this level of care were in S/R for longer periods of time. 2 of 3 were involuntary admissions
- Nursing care hours per patient day: 10.82 has remained the same.
- Skill Mix: RN’S, LPN, Mental Health Therapists, Recreational Therapist, Social Workers, CNA’S, and HUC
- Medication errors. Have decreased from 16 errors in FY17-18 to 5 for FY18-19. This was a focus for strategic goal. Medication errors are looked at on an individual basis and for trends. BCMA scores above 95% past year.
- Staff turnover/orientation costs. 19.52% turnover rate this past year increased this past year. Some nurses completing their ARNP. Some turnover related to closure of the MHU and the new Wellfound Behavioral Health Hospital.
- Overtime costs / end of shift overtime. Increased this year due to FTE vacancies in hard to fill positions. 1 to 1 needs have increased.
- Agency/ Traveler Usage. None for past year.
- Patient Satisfaction Data. Patient satisfaction has remained with little to no change
Shared governance council has focused on identified opportunities.
- Data from professional organizations: 4 total nurses this past year have completed their Psych Certification with ANCC
- HBIPS. Best practice indicators to be obtained on admission as well as transition of care into the community. To be above 95% for reimbursement. Met 1 of the 2 goals.
- Currently in process of a Joint Venture with MultiCare which will create a 120-bed free standing Behavioral Health Hospital named Wellfound. Goal is to release current MHU Staff Nurses in phases to move to Wellfound. Wellfound will open with a planned date of March 5th for Wave 1 of opening. Wave 2 in April 2019. The SJMC MHU will close by mid to end of May 2019

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Target Hours per Patient Day</th>
<th>10.82</th>
</tr>
</thead>
</table>

Insert developed staffing grid for varying levels of patient census or attach to this document

Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-23</td>
<td>1</td>
<td>4</td>
<td>1 to 1</td>
<td>2.5</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>3.5</td>
<td>1 to 1</td>
<td>2.5</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>3.5</td>
<td>1 to 1</td>
<td>2/1 SB</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>3/SB</td>
<td>1 to 1</td>
<td>2/1 SB</td>
</tr>
</tbody>
</table>

Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-23</td>
<td>1</td>
<td>4</td>
<td>1 to 1</td>
<td>2.5</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>3.5</td>
<td>1 to 1</td>
<td>2.5</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>3.5</td>
<td>1 to 1</td>
<td>2/SB</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>3/SB</td>
<td>1 to 1</td>
<td>2/SB</td>
</tr>
</tbody>
</table>

Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-23</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>17-19</td>
<td>1</td>
<td>1</td>
<td>SB</td>
<td>1</td>
</tr>
<tr>
<td>14-16</td>
<td>1</td>
<td>1</td>
<td>SB</td>
<td>1/SB</td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/ Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- Psychiatric Assessment Team: Supports most all of CHI Hospitals. An average 4-5 new consults a day within SJMC.
- Charge RN may respond to areas of hospital to initiate transfers to MHU after patient is medically stable.
- Rapid Response/Code Blue utilized on this unit.
Which Situations Require Staffing Variation?
Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Increased number of detained patients on unit.
- Increase in high acuity to include acute medical needs, total care for ADL’S, patients that are very psychotic, confused, needing frequent redirection, and staff assist.
- Increase number of admissions and discharges.
- Increase number of patients on 15-minute checks to include suicide checks, fall risk, safety precautions and elopement risk.

Chain of Command/ Staffing Decision Tree

**Process for Staffing Variation**

- Charge nurse re-evaluates staffing levels including 1:1 staffing every four hours.
- Staffing for the next eight-hour shift is done by the current shift charge nurse.
- We are a closed staffing unit with exception of use of CNA float pool to assist in 1 to 1 coverage.
- Charge RN completes all unit screenings for admissions and will take a patient load if necessary.
- Clinical manager/Director is available to Charge Nurses 24/7 for consultation regarding staffing levels. Patient and staff safety is always the primary concern.

**Meals and Breaks**

To ensure staff is receiving allotted breaks: We have filled both break RN nurse positions. Nurses coordinate with Break Nurse for break coverage. If nurses are unable to take their allotted meal and rest breaks they can also consult with the Charge RN to assist.

**Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)**

Survey results were shared at staff meetings and feedback was received by staff on safety at this staff meeting. We had a very small volume of staff take this survey.

**Committee Recommendations:**

No recommendations were made by Committee.
Approved By

Jakki Stodola, MBA, BSN, RNC, Co-Chair
Director, Family Birth Center

Date

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

Date

Syd Bersante, Market President/Pierce County
President SJMC

Date
2018 Staffing Plan Overview

Department: 7th floor Med-Surg SJMC
Date Updated: February 12, 2018
Author: Lori Pelland and Cathy Smith

### Nursing Department Overview

Description of the types of patients served in this nursing unit,
- Average Daily census : 34
- Average number of admits/discharges/transfers: 10
- Average length of stay: 4.35

### Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk:*:
- *Patient falls prevalence: 47 falls in the past year (1-1-17 to 1-25-18)
- *Patient falls with injury: 2 fractures (ribs), 2 bruises, 2 abrasions the rest no injury, no reportable
- *Pressure ulcer rate/prevalence: 7 pressure /0.566 (any stage /1000 pt days) , we had 2 unstageable that were reported to the state (these were both very sick Dr. Brown Whipple patients that had long surgeries)
- *Nursing care hours per patient day: 10.33
- *Skill Mix: RN/CNA/CA added break nurses (1100-1930)
- Medication errors: 46 common themes: delay, left at bed side, not scanned
- Staff turnover/orientation costs: 20.1 (includes 4.7 vacant positions)/ $192,000
- Overtime costs / end of shift overtime: Average incremental hours is 70 with average cost $3974.00; OT% of worked hours 4.1%
- Agency/ Traveler Usage: 324 hours since December 2017
- Patient Satisfaction Data: 67.9 with a goal of 69.4 hospital wide from LOM dashboard
- Data from professional organizations: n/a
- NDNQI Data (Relevant reporting units): n/a

| Staffing Grid for Patient Census | Target Hours per Patient Day | 10.33 |
Insert developed staffing grid for varying levels of patient census or attach to this document Day
Shift Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge/Resource RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>36-32</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>31-27</td>
<td>1</td>
<td>.5</td>
<td>7</td>
</tr>
<tr>
<td>26-23</td>
<td>1</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>22-20</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-32</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>31-27</td>
<td>1</td>
<td></td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>26-23</td>
<td>1</td>
<td></td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>22-20</td>
<td>1</td>
<td></td>
<td>5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-32</td>
<td>1</td>
<td>8</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>31-27</td>
<td>1</td>
<td>7</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>26-23</td>
<td>1</td>
<td>6</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>22-20</td>
<td>1</td>
<td>5</td>
<td></td>
<td>2.5</td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or
provides to other units and departments that impact staffing.

- IV Therapy department to place, monitor PICC lines and start peripheral IV lines
- 9th Floor nurses do Peritoneal Dialysis throughout hospital
- Critical Care supports Rapid Response/Code Blue throughout hospital/Code Resource Nurse
- Respiratory care supports CPAP, BIPAP and some respiratory assessment on changing
  conditions.
- Centralized transporters assist with transportation to and from tests, with discharges, obtain
  blood, takes labs down.
- 1:1 sitters
- Clinical Support Coordinator
- Discharge Hospitality Center
Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Heavy surgery schedule/ high numbers of fresh post op patients
- Increased number of isolation patients
- Full capacity/critical capacity
- High number of 1:1’s needing break coverage
- High number of heavy care patients (skin protocol turn every 2 hours, total feeders, incontinent, multiple bed changes, comatose patient care and staff can’t keep up)
- High number of patients on complex treatments (tube feedings, dressing changes, multiple drains, multiple central lines, chest tubes, pain management, multiple blood draws, trach care, frequent suctioning, accuchecks every 2 hours for insulin drip management, CBI, multiple patients needing blood transfusions, Epidural infusions, )
- High number of bedside procedures needing assist by quad RN or resource (bronchoscopy, TEE, chest tube placement, colonoscopy, endoscopy, lumbar puncture)
- High number of Bariatric patients
- New roll out of care such as Glucommander

---

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)
### Chain of Command/ Staffing Decision Tree

#### Process for Staffing Variation

Use this section to describe what process is used to determine if extra staff is needed.

- **Is the red/yellow/ green system used?** What is the response?
  - No, this did not work well for us. Staff will discuss with CN and/or manager

- **Who notifies whom?**
  - CN as they round, CN to manager/staffing/house supervisor

- **When in the shift should this occur?**
  - Rounding is ongoing
    - If the charge nurse determines that extra staff is needed, charge nurse will notify staffing to request additional staff. The need for staffing up is assessed 2 hours before the beginning of the next shift and every 4 hours during the shift.
  - Patient assignments are made to provide appropriate and quality care for each patient.
    - Staffing changes are based on staff input to the Charge Nurses, patient acuity, procedures,

- **When is extra staff for the entire shift scheduled, versus pulling staff from other areas to help nurses “catch up”?**
  - During go live situations such as glucommander, we always try to plan ahead and ask prior to the shift start
  - Managers make calls to staff to ask them to come in to help support staffing needs.

### Meals and Breaks

- Shared with the staff in June 2017. **Bold is current** Staffing Survey results 2016-2017
  - Overall feedback:
    - Staff reported how hard it was to have charge and resource pulled
    - Not enough staff at times
    - Acuity up
    - RN's doing HUC work  **We are now staffed daily with a CA.**
    - Phone are a challenge rings and rings can't get it
    - Not enough support
    - Excellent team work
    - Whipples are hard and time consuming; **We have worked with Dr. Brown on his long surgical cases that require more attention for the first 24-48 hours and he now sends them to PCU first**
• We have hired nurses specifically for meal and rest breaks and that is their only duty
• Charge nurse to check in with RN to see if they are getting their breaks and if not how they can help ensure a break.
• We encourage and talk about strategies to get their breaks

Plan:
1. Still need to continue to balance staffing up. Charge nurse do have the authority to do so. We are now balancing the schedule and moving staff around as needed so we are not up 5 one day and down 2 the next
2. Travelers have been hired. Plan is to ensure we have them over the high volume winter months. Travelers a have been very helpful these winter months
3. Working on filling vacant positions
4. Leadership is evaluating the patient ratio
5. Keep our new director in the loop with concerns.

Committee Recommendations:
No Recommendations

Approved By
Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS
Date

Tami Green, RN Co-Chair
Mental Health Unit
Date

Syd Bersante, Market President/Pierce County
President SJMC
Date
2018 Staffing Plan Overview

Department: 8BC Neurology, General Medical & Telemetry
Date Updated: February 12, 2018
Author: Kate Maul

Nursing Department Overview

Description of the types of patients served in this nursing unit: Seizures, Stroke, Cerebral Aneurysm, Traumatic Brain Injury, Multiple Sclerosis, Intracranial hemorrhage, Migraines, Infectious Diseases, Acute/Chronic Respiratory Disease, and Congestive Heart Failure. This unit has been caring for about 68% neurological patients and 32% general medical patients.

- Average daily census= 16
- Average number of admits= 4
- Average number of discharges= 5
- Average number of transfers= 3
- Average length of stay= 3.89

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

- **Patient falls prevalence:**
  - FY 17 total falls=52 (an increase in 22 falls from FY 16)
  - FY 18 total falls (July 1st-February 6th)=34

- **Patient falls with injury:**
  - FY 17 injuries= 4 minor
  - FY 18 injuries= Zero

- **Pressure ulcer rate/prevalence:**
  - FY 17 pressure ulcer: One pressure ulcer =stage 2
  - FY 18 pressure ulcer= Zero pressure ulcers

- **Nursing care hours per patient day= 10.75**

- **Skill Mix= RN/CNA see below for breakdown of staffing**

- **Medication errors:**
  - FY 17 total medication errors= 23
  - FY 18 total medication errors (July 1st-February 6th)= 13

- **Staff turnover:**
  - FY 17 quarter 3= 14.78%, FY 17 quarter 4= 18.06%
  - FY 18 quarter 1= 14.29%, FY 18 quarter 2= 11.54%

- **Overtime costs / end of shift overtime**
  - 8BC had an average of 26.75 hours of incremental overtime per pay period for FY 17
  - 8BC has an average of 21.25 hours of incremental overtime per pay period for FY 18
• *Agency/ Traveler Usage:
  128 hours of traveler usage for FY 18 on 8BC

*Patient Satisfaction Data:* The data for individual units is no longer being reported for managers. SJMC as a whole is being reported.

**Stroke Data/Metrics:**
- Stroke education completed: 77% (CMS national average= 95.1%). It is very important that stroke patients have 100% education completed correctly. It is a measure that helps keep SJMC accredited as a primary stroke center.
- VTE prophylaxis 98.3% (CMS national average= 97.7%).
- CMS stroke 30-Day Readmit Rate-Ischemic Strokes= 7.7%
- CMS stroke 30-Day Readmits Rate-Hemorrhagic Strokes= 6.7%
- The goal is for SJMC to become a comprehensive stroke center in FY 19 (survey= November 2018)
  ***All 8BC RN’s have 8 hours of mandatory stroke specific education annually

### Staffing Grid for Patient Census  
**Target Hours per Patient Day 10.75**

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-17</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>14-15</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12-13</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9-11</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Change for FY17 12/4/16 = one CNA from 0700-1530, one CNA from 0900-1730= loss of 2 hours of CNA coverage. At 0900 each CNA take a quad until 1730

**FY 18 change** = Two CNA’s from 0700-1530. Two hours of CNA time added back to 8BC staffing
Reason= increase in falls, inability to feed 1:1 Neuro patients and inability to complete ADL’s

### Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-17</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>14-15</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>12-13</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9-11</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Change for FY 17 12/4/16= one CNA from 1500-2330, one CNA from 0900-1730= loss of 6 hours of CNA coverage

**FY 18 change** = Two CNA’s from 1500-2330. Six hours of CNA time added back to 8BC staffing
Reason: CNA turnover, highest increase in falls on the unit from 1800-2330, inability to feed all 1:1 patients, incapability of necessary ADL’s
**Night Shift:**
The staffing has stayed the same for night shift for FY 17 and FY 18.

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-17</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>14-15</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>12-13</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>9-11</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

- Neuroscience trained RN’s to complete NIHSS evaluation for stroke patients throughout the hospital.
- IV therapy department to place, monitor PICC lines and start peripheral IV lines
- Critical Care supports rapid responses/code blue throughout the hospital
- Respiratory care supports CPAP, BIPAP and some respiratory assessment on changing conditions
- Centralized transporters assist with transport needs throughout the hospital

**Which Situations Require Staffing Variation?**

- Increased number of confused patients or patients in restraints requiring frequent checks.
- Increased number of mental health patients on unit that may or may not require restraints.
- Increased number of isolation patients
- Increased number of admissions and discharges during the shift
- Surge capacity including usage of temporary bed locations
- Increased number of 1:1’s needing break coverage.
- Increased number of heavy care patients (2 or more person to assist/ambulate, skin protocol turn every 2 hours, total feeders, incontinent, multiple bed changes, comatose patient care)
- Increased number of patients on complex treatments (tube feedings, dressing changes, multiple drains, multiple central lines, chest tubes, pain management, multiple blood draws, trach care, frequent suctioning, accuchecks every 2 hours for insulin drip management, CBI, multiple patients needing blood transfusions)
- Increased number of bedside procedures needing assist by Charge RN (bronchoscopy, TEE, chest tube placement, colonoscopy, endoscopy, lumbar puncture)
- Increased number of Code Blue/ RRT during the shift
Chain of Command/ Staffing Decision Tree

Process for Staffing Variation

- Staffing should be sufficient at all times to assure safe, effective patient care delivery. Staffing may be adjusted according to acuity, type and skill of caregivers and availability of staff.
- Charge nurse will round each unit every 2 hours to assess acuity of the quad and facilitate problem-solving and patient flow in the unit. They will also communicate the unit’s status to the rest of the unit and the House Supervisor to help assess the unit’s ability to accept new patients.
- If the charge nurse determines that extra staff is needed, Charge Nurse will notify staffing to request for additional staff. The need for staffing up is assessed before the beginning of the next shift and every 4 hours during the shift.
- 8BC manager is on-call 24/7. The charge RN can call or text manager regarding unit needs or issues.
- Staffing changes are based on staff input to the Charge Nurses/Manager, patient acuity, procedures, skill mix and census needs.

If the patient is assessed to require more acute nursing care and/or treatment than can safely be provided in the unit, the RN assigned to the patient will notify the attending physician/practitioner, and obtain orders to transfer the patient to a higher level of care.

Meals and Breaks

- Two break RN FTE’s were added from 1100-1930 to help ensure that rest breaks and meal breaks are achieved.
- The addition of the break RN’s has created a positive impact on the unit.
  - Day Shift=94% of breaks achieved
  - Evening Shift= 88% of breaks achieved
  - Night Shift= 92% of breaks achieved

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Annual Nurse Staff Survey results were reviewed with staff during mandatory staff meetings. The staff were encouraged to share feedback and concerns regarding the survey results.
- **Staff Participation:** 8BC was combined with 9th floor in this survey. 8BC & 9th floor had the highest percentage of staff participation for the SJMC nurse staffing survey in FY 17

  % of RN’s
  - Days= 43%
  - Evenings= 21%
  - Nights= 36%

  %of CNA’s=
  - Days= 20%
  - Evenings= 60%
  - Nights= 20%
• **Issues that were identified:**
  
  **Workload:** Elimination of the HUC, Elimination of CNA hours, Charge RN being pulled to take patients while in surge capacity, RN/CNA’s having a harder time managing 1:1 feeds, confused patients, turning schedules etc.
  
  **Staff Meeting the educational and emotional needs of their patients and their family:** 8BC staff stated that they struggled to complete stroke education. They had to carry out nursing treatments and tasks over education. The staff stated that the limited time they had with patients made it difficult to provide emotional support.
  
  **Breaks:** staff on the unit did not feel that there was a process in place to help them take breaks on time.
  
  **Department work planned to address themes:**
  
  CNA hours were added back into the staffing matrix in FY 18. The addition of CNA hours have reduced falls and allowed ADL’s to be completed. The staff do feel they have more time to educate and support the emotional needs of their patients.
  
  A break RN was added in July of 2017 from 1100-1930. This has helped RN’s get meal and rest breaks.

---

**Committee Recommendations:**

No Recommendations

---

**Approved By**

Renee Yanchura, Co-Chair  
Director Emergency Services, EDO & PCS  

Tami Green, RN Co-Chair  
Mental Health Unit  

Syd Bersante, Market President/Pierce County  
President SJMC
2018 Staffing Plan Overview

Department: Ortho – 4S
Date Updated: February 12, 2018
Author: Annette Lunderville

Nursing Department Overview

- Types of patients served in this nursing unit – Orthopedic, Trauma Orthopedic, Medical, and Telemetry
- **Average Daily census** – 21.45 - knowing that we are in Surge Capacity (last year was 22)
- **Average number of**
  - Admits – 3.88 daily (last yr. 1.6)
  - Discharges/Transfer Out – 4.03 daily (decreased from 5.0)
  - Transfers In – 0.99 (decreased from 3.7)
- **Average length of stay** – 3.77 (decreased from 4.43)

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*

- **Patient falls prevalence** – 25 (down from 32)
- **Patient falls with injury** – 8 (with minor injuries or above) is down from 11
- **Pressure ulcer rate/prevalence** - 2 (down from 3)
- **Skill Mix** – RN’s and CNA’s
- **Medication errors** - All medication errors are looked at on an individual basis and for possible trends. Incident “D” (any incident that increases monitor or can cause harm) are all reviewed at the nursing pharmacy committee.
- **Volunteer Staff turnover** – 2017 was 30.23% which is up from 18.20% - mostly due to Surge Capacity
- **Overtime costs / end of shift overtime** – 5.1% - this is affected by being Surge Capacity, SADU, and 1:1’s as I don’t have FTE’s to cover this work.
- **Agency/ Traveler Usage** – 172 hours
- **Data from professional organizations** - BPCI - for Medicare pt.
- **NDNQI Data (Relevant reporting units)**: I review them when they come. If I have any I will review with the nurse that had taken care of the pt. I will also have information in the DMB.
Staffing Grid for Patient Census  Target Hours per Patient Day

Insert developed staffing grid for varying levels of patient census or attach to this document

<table>
<thead>
<tr>
<th>Day Shift</th>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19-21</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>16-18</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>13-15</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>11-12</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>9-10</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evening Shift</th>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19 - 21</td>
<td>1</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>16-18</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>13-15</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>11-12</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>9-10</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Night Shift</th>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20 - 21</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>18-19</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>15-17</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>11-14</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>9-10</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- IV Therapy department to place, monitor PICC lines and start peripheral IV lines
- Critical Care supports Rapid Response/Code Blue throughout hospital
- PT/OT spends time throughout the day shift with all joint patient, ortho trauma, and medical patients as ordered
- Centralized transporters assist with transport needs throughout the hospital
- Lab Technicians draw labs on our patients who need blood work done
- Monitor Tech. that monitor our tele patients.

Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Heavy surgery schedule/ high numbers of fresh post op patients
- Increased number of isolation patients
- Increased number of high risk for falls
- Increased number of turn every 2 hour patients
- High patient acuity
- Increased number of confused patients or patients on restraints requiring frequent assessments
- Increased numbers of admissions and discharges during the shift
- Surge Capacity with doubling up my pt. rooms
- SADU opens with joint patients
- Increased number of 1:1s needing break coverage
- Increased number of heavy care patients (skin care protocol, isolation, total feeders, incontinent, multiple bed changes, confused or combative mental health patients)
- Increased number of patients requiring complex treatments (tube feedings, dressing changes, telemetry drips, multiple drains, multiple lines, chest tubes, pain management, trach care with frequent suctioning, q2hour accuchecks, insulin drip management, continuous bladder irrigation, multiple patients requiring blood transfusions
- Increased number of bedside procedures needing assist by charge or primary RN (cardio versions, bronchoscopy, trans-esophageal echocardiogram, chest tube placement, GI studies, etc.
- Increased number of code blue/rapid response calls during the shift
- Increased number of bariatric patients

**Chain of Command/ Staffing Decision Tree**

<table>
<thead>
<tr>
<th><strong>Process for Staffing Variation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Staffing will be sufficient to assure safe, effective patient care delivery. Staffing may be adjusted according to acuity, type and skill of caregivers and availability of staff.</td>
</tr>
<tr>
<td>- If the manager or charge RN determines that extra staff is needed then the staffing office will be contacted for extra staff. The need for staffing up or down, is assessed before the beginning of the next shift and every four hours during the shift.</td>
</tr>
<tr>
<td>- Patient assignments are made to provide quality care to every patient. Staffing changes are based on acuity, procedures, skill mix, and census needs.</td>
</tr>
<tr>
<td>- Based on assessment if the patient needs more acute nursing care or treatment the patient will be transferred to a higher level of care by receiving a physician order.</td>
</tr>
<tr>
<td>- The charge RN round to assess the acuity of the patient census and facilitate problem-solving and patient flow on the unit. They will also communicate the unit’s status to the rest of the staff on the unit and the hospital supervisor to help assess the unit’s ability to accept new patients.</td>
</tr>
</tbody>
</table>
Meals and Breaks

We have a break relief nurse that works daily from 1100-1930 relieving some on the nurses breaks. Otherwise - we ask RNs and CNAs to relief breaks with like skill sets. They then decide who will go 1st and who will go 2nd for breaks and meals. The charge RN is to check in on the staff and help facilitate that staff go for breaks. Admittedly we struggle with staff members that want to finish tasks rather than pass the task to a charge RN or colleague, and go on a break. We also have new staff that are learning time management, making breaks, meals, and getting out on time difficult for some.

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Survey results reviewed with staff? What format was used? Yes, in a unit staff meeting
- Staff Participation: 14 RN’s, 4 CNA’s
- What was the theme of the results – had mostly to do with Surg capacity
- Department work planned to address themes – we currently only Surg 5 room which is down from 10 last year. We placed privacy curtains.

Committee Recommendations:
No Recommendations

Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

Tami Green, RN Co-Chair
Mental Health Unit

Syd Bersante, Market President/Pierce County
President SJMC
# 2018 Staffing Plan Overview

**Department:** ED Observation  
**Date Updated:** 01/02/2018  
**Author:** Ben Harris/Haley Wahl

## Nursing Department Overview

Description of the types of patients served in this nursing unit,
- Average Daily census: 12  
- Average number of admits/discharges/transfers: 8/4/1.2  
- Average length of stay: 22 hrs (outpatient)

## Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:
- *Patient falls prevalence FY 17 (0.4) 2 falls  
- *Patient falls with injury < 1%  
- *Pressure ulcer rate/prevalence: <1%  
- *Nursing care hours per patient day: 13.9  
- *Skill Mix: RNs & CAs  
- Medication errors: <1%  
- Staff turnover/orientation costs: CA2= 144hrs ($1872.00 with $13/hr pay). The number of hour is due to the cross-training on every floor they float to for 2 skills; RNs 150 hrs ($4500 based on $30).  
- Overtime costs / end of shift overtime: 4.3%  
- Agency/ Traveler Usage: Med/Surg sharing travelers currently, expected to end contracts May 2018.  
- Patient Satisfaction Data: rolled into entire organization-we do not get a report specific to ED Observation  
- Data from professional organizations: N/A  
- NDNQI Data: N/A

## Staffing Grid for Patient Census

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>12</th>
<th>Target Nursing Hours per Patient Day</th>
<th>13.9</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Census</th>
<th>RNs</th>
<th>CAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>1*</td>
<td>1*</td>
<td>“Can use primary nursing model.”</td>
</tr>
</tbody>
</table>

Updated 06.11.2013
Night Shift 1900-0700

<table>
<thead>
<tr>
<th>Census</th>
<th>RNs</th>
<th>CAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>1*</td>
<td>1*</td>
<td>*Can use primary nursing model.</td>
</tr>
<tr>
<td>5-8</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- ED Observation supports ED Transition patients (ERT) 4:1 RN ratio with a 8:1 CA ratio

Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Census: staffed to patient census.
- If the patient mix is greater number of inpatients versus outpatients.

Chain of Command/Staffing Decision Tree

Process for Staffing Variation

- We have a staffing grid we follow and the nursing has the ability to use more staff if patient care is heavy. This does not usually happen in EDO. Work closely with ED staff when needed to support patient care.

Meals and Breaks

- We bring in a nurse for 1100-2330 to help ensure that people get their meal breaks when multiple TBL’s are open.
- ED Observation was approved 1.35 FTE for “Break Nurse” coverage – currently hired 0.75 FTE.
- Frequently discuss importance of breaks during staff meetings and CN meetings.
- Signage posted in “off-stage” areas to remind people to take breaks.
- We ensure it is working by auditing KRONOS for edits for missed breaks.
- Round on staff daily
Annual Nurse Staff Survey

- Bedside hand-off
- Approval for Break Nurse positions

Committee Recommendations:

APPROVALS

Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

Date

Tami Green, RN Co-Chair
Mental Health Unit

Date

Syd Bersante, President SJMC

Date
I, the undersigned as President for St. Joseph Medical Center in Tacoma, WA, attest that the attached staffing plans and matrixes were developed in accordance with RCW 70.41.420 for the year 2019 and includes all units covered under our hospital license under RCW 70.41. These plans were developed with consideration given to the following elements (please check):

- Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;
- Level of intensity of all patients and nature of the care to be delivered on each shift;
- Skill mix;
- Level of experience and specialty certification or training of nursing personnel providing care;
- The need for specialized or intensive equipment;
- The architecture and geography of the patient care unit, including but not limited to placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;
- Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations;
- Availability of other personnel supporting nursing services on the unit; and
- Strategies to enable registered nurses to take meal and rest breaks as required by law or the terms of an applicable collective bargaining agreement, if any, between the hospital and a representative of the nursing staff.

Signature

Syd Bersante, Pierce County Market President

Printed Name

12-18-18

Date
2018 Staffing Plan Overview

Department: Emergency Department
Date Updated: 01/02/2018
Author: Ben Harris / Haley Wahl

Nursing Department Overview
Description of the types of patients served in this nursing unit,
- Average Daily census: 137
- Average number of admits/discharges/transfers: 31 admits; 106 discharges; transfers are variable (goal of 6/day).
- Average length of stay: Discharged- 202 minutes; admitted 346 minutes

Key Quality Indicators
Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:
- *Patient falls prevalence: FY17 14 falls
- *Pressure ulcer rate/prevalence: N/A
- *Nursing care hours per patient day: 2.98 HPPV (previous 3.17)
- *Skill Mix: RNs, ERTs, HUCs
- Medication errors: <1%
- Staff turnover/orientation costs: 480 hrs per Resident RN; 110 hrs/ ERT & HUC
- Overtime costs / end of shift overtime: 6 pay period trend—3.3% (previous 4%)
- Agency/ Traveler Usage: 13 week contract – ended summer of 2017
- Patient Satisfaction Data: Overall ED rating 58.6% (CHI-Franciscan HS top box average 64.7%)
- Data from professional organizations: N/A
- NDNQI Data – N/A

Staffing Grid for Patient Census 140 Target Nursing Hours per Patient Visit 2.98
Insert developed staffing grid for varying levels of patient census or attach to this document
Day Shift 0600-1800

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>ERT</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>1</td>
<td>15</td>
<td>5-6</td>
<td>1 HUC (starting at 0800)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*this includes 10-2230 RNs 1300-0130 RNs</td>
<td>Includes 0900-2130 and 1300-0130 ERT</td>
<td></td>
</tr>
</tbody>
</table>

Updated 06.11.2013
Night Shift 1800-0600

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>ERT</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>1</td>
<td>11</td>
<td>3-4 depending on census</td>
<td>1 HUC (shift ends 0430)</td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- ED supports Code Blues
- ED supports Trauma

Which Situations Require Staffing Variation?

- Use this section to describe legitimate situations where additional staff are required to
  Multiple 1:1 patients
- Holding transition patients in the department
- Weekend schedule
- Increase/Decrease in patient volumes

Chain of Command/Staffing Decision Tree

Process for Staffing Variation

- The CN makes the decision about daily staffing. We ask not to go above the “grid”
  which is set between 140-160 patients/day. If it is a very busy day (170 patients) and
  extra staff are available the CN can have them work if they discuss with management.
- The CN do cut/low census on low volume day- follow cut rotation.

Meals and Breaks

- We have RN’s that are non-assigned patient care roles (float and Charge Nurse) to
  cover peers to get their meal breaks.
- We have been approved 3.5 FTE’s for Break Relief Nurses (hired 1.75 FTE)
- Frequently discuss importance of breaks during staff meetings and CN meetings. Implement block break program (12/2017).
- Signage posted in “off-stage” areas to remind people to take breaks.
- We ensure it is working by auditing KRONOS for edits for missed breaks.
- Round on staff daily
Annual Nurse Staff Survey

- Process Improvement work completed on issues identified? RPI completed 10/17 for care of waiting room patients (Evaluation Nurse)
- What was the results/plan of action? Develop internal protocol for ED lockdown, implemented secure environment feedback (door locks, cameras, shatter resistant glass in remodel).

Committee Recommendations:

APPROVALS

Approved By

______________________________________ Date
Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

______________________________________ Date
Tami Green, RN Co-Chair
Mental Health Unit

______________________________________ Date
Syd Bersante, Market President
2017 Staffing Plan Overview

Department: SJMC Interventional Radiology

Date Updated: 12/10/18

Author: Andre House

<table>
<thead>
<tr>
<th>Nursing Department Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of the types of patients served in this nursing unit,</td>
</tr>
<tr>
<td>• Average Daily census – 22 procedures per day</td>
</tr>
<tr>
<td>• Average number of admits/discharges/transfers – ED, OP and IP- 5,280 procedures per year.</td>
</tr>
<tr>
<td>• Average length of stay – Variable dependent upon procedure type</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:</td>
</tr>
<tr>
<td>• *Patient falls prevalence – Low (1 fall without injury in recovery area since assuming oversight of the department in May, 2017.</td>
</tr>
<tr>
<td>• *Patient falls with injury – No reported falls with injury since assuming oversight of the department in May, 2017.</td>
</tr>
<tr>
<td>• *Pressure ulcer rate/prevalence N/A</td>
</tr>
<tr>
<td>• *Nursing care hours per patient day 50 hours per working day plus 2 RN call coverage beginning at 1730 and 24 hours- weekend.</td>
</tr>
<tr>
<td>• *Skill Mix: 2 RN to 1 Tech procedure ratio or 2 Tech to 1 RN ratio dependent upon procedure. 1 CNA supports IR M-Friday, 0730-1600).</td>
</tr>
<tr>
<td>• Medication errors- Low</td>
</tr>
<tr>
<td>• Staff turnover/orientation costs Just hired a 1.0 RN and another position is posted as 1 RN is leaving the end of December.</td>
</tr>
<tr>
<td>• Overtime costs / end of shift overtime 9.5%</td>
</tr>
<tr>
<td>• Agency/ Traveler Usage None</td>
</tr>
<tr>
<td>• Patient Satisfaction Data</td>
</tr>
<tr>
<td>• Data from professional organizations</td>
</tr>
<tr>
<td>• NDNQI Data (Relevant reporting units):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Target Hours per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert developed staffing grid for varying levels of patient census or attach to this document Day Shift</td>
<td></td>
</tr>
<tr>
<td>Census</td>
<td>Charge</td>
</tr>
<tr>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>22-25</td>
<td>1</td>
</tr>
</tbody>
</table>
Technologists.

Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>After hour call</td>
<td>2</td>
<td></td>
<td></td>
<td>IR Rad Techs</td>
</tr>
<tr>
<td>Begins at 1730-0700.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-Call</td>
<td>2</td>
<td></td>
<td></td>
<td>IR Rad Techs</td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- For example, IV Therapy department to place, monitor PICC lines and start peripheral IV lines
- 9th Floor nurses do Peritoneal Dialysis throughout hospital
- Critical Care supports Rapid Response/Code Blue throughout hospital

**IR provides admit recovery for all IR procedures with the exception of patients to undergo general anesthesia.**

**IR provides support for removal of specialty catheters for IP (such as triple lumens, non-tunneled (temp HD’s)).**

**IR RN’s provide conscious sedation for CT, MRI, Gamma Knife and Ultrasound.**

Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Solely related to volume and occasionally acuity of patients

Chain of Command/Staffing Decision Tree

Process for Staffing Variation
Project Overview Statement—Executive Summary

- Use this section to describe what process is used to determine if extra staff is needed. **Charge RN is responsible for staffing IR in consultation with Director.**
- Is the red/yellow/ green system used? What is the response?
- Who notifies whom? **Charge RN communicates with staff**
- When in the shift should this occur? **Communicated prior day and in real time if we need to low census or add staff. Planning of PTO coverage is to established P&P.**
- When is extra staff for the entire shift scheduled, versus pulling staff from other areas to help nurses “catch up” **Prior day or same day communications.**

### Meals and Breaks

- Use this section to describe what the meal and break strategies are for your area and how you measure if they are working.
- **Staff work together and schedule meals and breaks on a daily basis. This is sometimes flexed due to volume or issues of concern in the department. Monitored daily, on KRONOS log sheet and rounding.**

### Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Survey results reviewed with staff? What format was used? (Staff meetings, shift huddles, e-mail): **Staff meetings, rounding.**
- Staff Participation: % of RN’s, CNA’s, ED Techs, RT’s, OR Tech’s etc...
  - RN’s, IR Tech’s, CAN
- What was the theme of the results;
  - **IR previously did not have good survey participation. While rounding and through staff meetings, one relayed concern is specialty RN and IR Tech recruitment.**
- Department work planned to address themes
  - **Ongoing communication on position approvals, posting and recruitment efforts.**

### Committee Recommendations:
Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

Tami Green, RN Co-Chair
Mental Health Unit

Syd Bersante, Market President/Pierce County
President SJMC
## Nursing Department Overview

Description of the types of patients served in this nursing unit, 9 units spread out over 2 ½ floors:

- **3300**: 8A/8D Progressive Care (PCU) 18 beds
- **3400**: 6A Neuro PCU, 6B Neuro ICU, 6C, Neuro/Onc/Surgical ICU 6D Medical /Trauma ICU 32 beds
- **3405**: 5B Cardiac PCU, 5C Cardiac/Vascular ICU, 5D Cardiothoracic Surgical ICU (Open Heart Unit) 24 beds

Total of 40 intensive care level and 34 progressive care level rooms.

Critical Care:
### ADC

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>17.17</td>
<td>17.40</td>
<td>17.38</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>27.89</td>
<td>28.42</td>
<td>28.48</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>21.46</td>
<td>21.57</td>
<td>21.79</td>
</tr>
</tbody>
</table>

### Occupancy

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>95.4%</td>
<td>96.7%</td>
<td>96.5%</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>87.2%</td>
<td>88.8%</td>
<td>89.0%</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>89.4%</td>
<td>89.9%</td>
<td>90.8%</td>
</tr>
</tbody>
</table>

### Avg Daily Admits

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>4.16</td>
<td>4.15</td>
<td>6.64</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>5.32</td>
<td>5.86</td>
<td>8.63</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>3.79</td>
<td>4.04</td>
<td>6.27</td>
</tr>
</tbody>
</table>

### Avg Daily Discharges

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>2.569863</td>
<td>2.77</td>
<td>1.23</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>2.1534247</td>
<td>2.55</td>
<td>0.68</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>2.8410959</td>
<td>2.96</td>
<td>0.69</td>
</tr>
</tbody>
</table>

### Avg Daily Transfers (In/Out)

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>1.14</td>
<td>1.85</td>
<td>1.44</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>1.42</td>
<td>2.16</td>
<td>1.72</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>1.57</td>
<td>2.57</td>
<td>1.81</td>
</tr>
</tbody>
</table>

### Total Volume (EPD)

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>6,268</td>
<td>6,351</td>
<td>6,360</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>10,181</td>
<td>10,374</td>
<td>10,422</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>7,831</td>
<td>7,873</td>
<td>7,976</td>
</tr>
</tbody>
</table>

### ALOS

<table>
<thead>
<tr>
<th></th>
<th>FY18</th>
<th>FY17</th>
<th>FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3300 8th Floor</td>
<td>2.69</td>
<td>2.73</td>
<td>2.68</td>
</tr>
<tr>
<td>3400 6th Floor</td>
<td>3.39</td>
<td>3.24</td>
<td>3.38</td>
</tr>
<tr>
<td>3405 5th Floor</td>
<td>3.48</td>
<td>3.42</td>
<td>3.63</td>
</tr>
</tbody>
</table>
Specialty Care that is managed in Critical Care at SJMC that supports FHS:

- Cardiac surgery; Advanced Heart failure (Impella heart support, intra-aortic balloon pump; high risk cardiac procedures (Transfemoral aortic valve replacement)
- Neuro/Level 1 Primary Stroke Center
- Vascular
- Level 2 Trauma
- Complex GI surgeries
- Complicated Respiratory management

All patients in Critical Care receive cardiac monitoring. All ICU quads conduct daily rounds with the MD Intensivists.

The Cardiothoracic Surgical ICU (5D) admits post op patients directly from OR, so this unit functions as the recovery room for these patients. Patients in the recovery phase immediately post op receive 1:1 nursing, typically for the first 6 hours, but this can change with patient acuity / instability. 5D also cares for patient’s pre and post op with intra-aortic balloon pumps. Most patients admitted to 5D are prescheduled surgeries; however, 5D does receive emergent cases from the Cath Lab and with interfacility transfers. The most frequent diagnoses include CABG and valve replacements. New technologies utilized include: Transfemoral aortic valve replacement; microsurgical techniques, e.g. minimally invasive procedures or thoracotomy approach. The goal for uncomplicated cases is a one day LOS, with subsequent transfer to a Progressive Care Unit. Staffing needs can vary greatly depending upon the number of surgical cases scheduled that day. 5th floor charge nurses can be pulled to 5D to recover open hearts requiring 1:1 nursing.

CCU (5C) primarily admits complex medical cardiac cases including complex heart failure and post MI patients requiring mechanical support using a ventricular assist device (Impella) or the intra-aortic balloon pump.

Neuro ICU (6B) is designed to serve patients with the diagnoses of acute stroke, head trauma, neurosurgical conditions, i.e., craniotomies, and patients who have received interventions from Interventional Neuroradiologists (cerebral vascular stents, cerebral aneurysm coilings, Mercy clot retrievals). Patients may have ICP monitors, ventricular drains and may or may not be intubated. Neuro ICU may admit some general ICU overflow. Post op coilings are 1:1 for the first 2-4 hours. Acute Stroke patients treated with intravenous IPA are managed in this unit with 1:1 staffing for 4 hours. Neurological patients in Neuro ICU require a close level of nursing observation, with frequent emergent head CT scans for deteriorating neurological status in addition to surveillance CT. Patients may convert back and forth between ICU and PCU status as vasoactive medications are used for blood pressure management.

The Med/Surg/Trauma Intensive Care units (6C/6D) serve a variety of patients, but mostly medical and surgical. Most patients are admitted from the Emergency Department with life threatening illnesses requiring emergent life support – mechanical ventilation, vasoactive medications, and invasive hemodynamic monitoring. Severe Sepsis and Respiratory Failure, Thoracic surgeries and complex GI surgeries. Trauma Surgery patients are admitted to 6C and 6D.

6C is now also designated for Surgical Oncology patients and Neurosurgical cases to support the increased volume of specialty surgical cases.

Technologies utilized in 6C/6D include induced hypothermia with the Alsius catheter, 1:1 staffing is maintained until hypothermia goal is achieved and ultrafiltration for CHF. Patients
and their families often present in crisis, and can require significant emotional support from staff.

PCU (5B, 6A, 8A, and 8D) provides intermediate critical care monitoring and nursing care for patients with moderate or potentially severe physiological instability requiring nursing support and has the potential for rapid intervention, but not artificial life support. Vasoactive / anti-arrhythmic drips administered in PCU include Dopamine, Nitroglycerine, Amiodarone, Diltiazem, Dobutamine, Milrinone, Lidocaine, and Procainamide.

Patients are admitted to these units from ED, ICU downgrade, PACU, cath lab, intrafacility transfers as well as direct admits from outpatient areas.

5B: Cardiac PCU focusing on care of the post operative open heart patient and other cardiac specific diagnoses.
6A: Neuro PCU focusing on acute stroke patient population and other neuro diagnoses.
8A/D: Med/Surg PCU focusing on care of complex medical, complex surgical cases including Thoracic and trauma step down patients.

**Critical Care Residency:**
The Critical Care Residency Program is a program that newly hired nurses without Critical Care experience attend. They are held 3 times per year. The residency program is a combination of classroom/clinical/ and web-based learning activities.

- PCU Residency consists of 9 weeks or more of training which includes 200 bedside hours.
- ICU Residency Program includes an additional 7 weeks of classroom and clinical training, which includes approximately 400+ bedside hours. One of the features of this program is the “ICU Fast Track” where highly qualified new graduates are trained directly for the Intensive Care Units, which is still an area of greatest need.

**Critical Care Charge Nurse support:**
There 3 Critical Care charge nurses, 1 for each of the designated floors (8A/D, 6th & 5th). The Critical Care charge nurse team is responsible not only for their designated floors but to manage a variety of issues throughout the inpatient area as described below.

Code Blue and Rapid Responses are typically managed by the dedicated Code RN team, however the 5th and 6th floor Critical Care charge nurses continue to support the Code RN when they are not available (due to multiple emergencies) as well as taking full coverage of Codes when there is not a Code RN for the shift (the Code RN program was only approved for 5 days per week coverage).

The Critical Care charge nurses also provide procedural support to the med/surg areas. Additionally, if a patient is to be transferred to PCU or ICU as a result of the emergent situation and a Critical Care bed is not immediately available, the Critical Care Charge Nurse remains with the patient until a Critical Care bed is available.

**New Service Coming in 2019:**
5A office will be converted to an 8 bed Advanced Heart Failure ICU. Expected to open in early 2019. Management of complex heart failure patients requiring intensive treatment will be the primary population to include implantation and long term management of left ventricular assist devices.
Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

*Patient falls all (with or without injury): FY18: 1.85 45 total  FY17  2.7 (66 total)
  - 8th floor: 3.10 (19)  FY17: 3.19 (20)
  - 6th floor: 1.67 (17)  3.18 (30)
  - 5th floor: 1.16 (9)  1.67 (13)

*Patient falls with injury rate (minor and above): FY18: 0.20 5 total  FY17 0.75 (17)
  - 8th floor: 0.33 (2)  FY17: 1.28 (8)
  - 6th floor: 0.30 (3)  0.67 (7)
  - 5th floor: 0  0.26 (2)

*Hospital acquired pressure ulcer rate (all stages): FY18: 0.28 7 total  FY17: 0.55 (13 total)
  *excludes present on admission
  - 8th floor: 0/0.0  FY17: 0.324 (2)
  - 6th floor: 0.389 (4)  0.58 (6)
  - 5th floor: 0.389 (3)  0.647 (5)

  *Skill Mix:
  Registered Nurse-Progressive Care and Intensive Care
  Care Assistant
  - Medication error rate: 3.5  (FY17 3.19)
  - Staff turnover: 49 RNs  (FY17 49)
  *Agency/ Traveler Usage: Currently using no travelers. FY18 used max of 9.9 FTEs to cover gaps during residency and in preparation for winter surge.
  *Patient Satisfaction Data: Overall hospital rating: FY19 current: 72.4%**
  (FY17: 77.8%)
  - 8th floor: 80%  (FY17 72.6%)
  - 6th floor: 69%  (FY17 83.1%)
  - 5th floor: 71%  (FY17 81.3%)
  **FY19 Press Gainey, FY18 Healthstream
  *AACN certification: 28%  (64/226) CCRN, PCCN, CNRN, SCRN, CMC, CSC

Staffing Grid for Patient Census  Target Hours per Patient Day

See attachments

*Nursing care hours per patient day (current FY19):
  3300 8A/D: 13.087  (FY18: 12.5)
Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

Critical Care receives extensive support from several departments and staff reductions in these departments would impact the delivery of services in Critical Care.

- Code RN and ED RNs for Rapid Response and Code Blue response and support.
- Virtual ICU team: All ICU level patients are reviewed by an ICU RN at the FESC an Epic program that trends patients status and alerts the virtual RN when a patient is getting sicker and alerts the bedside staff of the trend. vICU staff are available 24x7 via phone two way cameras in all of the ICU rooms.
- Intensivist program: Pulmonary Critical Care providers are staff on site Monday-Friday for 8-10hrs daily and the on call MD is supports the ICUs at all 5 hospitals via the Virtual ICU with immediate access to the MD.
- Virtual FIT program: FIT is available onsite 24/7 and virtually between 2000-0700.
- Virtual FIT and VICU are moving towards co-management of ICU patients.
- IV Therapy places PICC lines in the majority of ICU patients. Most ICU level patients are on multiple IV infusions which require central access. Current infection control guidelines require close monitoring of central line duration.
- Respiratory Therapy works closely with Critical Care managing ventilators and drawing arterial blood gases. Respiratory Therapy manages the airway and ventilation of respirator dependent patients going off the unit for procedures.
- Critical Care receives extensive support from the satellite Pharmacy on the 6th floor which is open all day until midnight daily. Pharmacists respond to all Code Blues and have helped with Rapid Response.
- Social Work and Care Management for discharge planning.

Which Situations Require Staffing Variation?

Anticipated variations:
The number and scheduling of Open Heart surgical cases (will require 1:1 nursing post-op) and the number of scheduled Neurological Interventional Radiology patients (may also require 1:1 nursing).

Stroke patients that have received tPA require 1:1 nursing care.
Post cardiac arrest, proning patients; patients with IABP; and patients being actively titrated on multiple drips may require 1:1 nursing care.

Patients with ventricular assist devices require 1:1 nursing care.
Life Center patients may require 1:1 nursing care.

Unplanned variations: Code Blue, Rapid Response transfers from outside Critical Care;, emergency admissions and transfers (Code Neuro), and emergency procedures (Open Heart, Cath lab etc).
During high census periods where the appropriate ICU or PCU bed is not available, post procedure, post op and/or ED patients may be cared for in the PACU with an ICU or PCU RN.

**Chain of Command/ Staffing Decision Tree**

**Process for Staffing Variation**

- **Manager On Call:** Each of the 4 clinical managers rotates this call each week. They are at point to communicate with the 3 Charge nurses regarding staffing and patient placement issues 24hrs/day while on call. There is a minimum of 1 charge-manager huddle each shift in person or on the phone.
- Staffing levels are assessed every 4 hours or more frequently as needed.
- The Charge Nurse uses rounds to assess patient care needs, assess for possible transfers/discharges out of the units, plan for any scheduled upcoming procedures, and to assess if any patients require continued 1:1 staffing. The Charge Nurse makes final rounds on the quads before setting the final staffing levels for the oncoming shift.
- Any staff member can contact the charge nurse via page, Vocera or call via cell phone at any time to discuss changing patient care needs or staffing needs.
- When staff notify the Charge Nurse that extra help is needed, the Charge nurse will assess the situation and temporarily reassign staff if able. Charge Nurses also attempt to balance admissions to the quads to equalize the workload. If staffing issues cannot be resolved at the Charge Nurse level, the Charge Nurse will notify the Manager on call and/or Unit Manager.

**Meals and Breaks**

- Meal and rest breaks are discussed with all new hires and it is reviewed during residency specifically regarding time management- building in meal and rest breaks into the shift routine.
- **Break RNs are utilized in Critical Care as follows:** 2 Break RNs each of the following shifts 0800-1630/2000-0430.
- **Extra Break RN shifts are posted in CVS weekly to fill Break RN role until all Break RN positions are filled.**
- **Staff are encouraged to sign up for their break times at the beginning of the shift,**
if not they are assigned. They are coached to be prepared to handoff to a peer or the Break RN at their designated time to stay on schedule.

- Charge RNs, UBEs and managers can and have assisted with breaks if needed.
- Manager's track the end of shift overtime report for missed breaks.

### Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Survey results reviewed with staff? Yes
  - What format was used? Email, Daily management boards, rounding, 1:1 discussions

  - Staff Participation:
    - 8th floor: 4 RNs, 0 CNAs
    - 6th floor: 16 RNs, 1 CNAs, 1 RT
    - 5th floor: 8 RNs, 0 CNAs

- What was the theme of the results:
  - 8th: Breaks
  - 6th: Breaks, CA workflow
  - 5th: Breaks, staffing

- Department work planned to address themes: Fill Break positions; implement CA walking rounds.
Committee Recommendations:

Approved By
Karen Cook, MSN, RN, Co-Chair
Clinical Manager Peri-Op Services

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

Syd Bersante, Market President/Pierce County
President SJMC
Welcome to the Cardiac Progressive Care Unit. This unit is designed to serve patients transitioning from Intensive Care level of care or meeting Progressive Care criteria with primarily cardiac related conditions. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring a Progressive Care level of nursing is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>PCU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>4</td>
<td>1-2</td>
<td>0.6</td>
</tr>
<tr>
<td>5-6</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>7-8</td>
<td>2-3</td>
<td>0.6</td>
</tr>
</tbody>
</table>

**Staffing for the Division includes 3 Charge RNs for both day and night shifts.** 5th floor Critical Care Charge RN is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

______________________________
Greg Bishoff, RN
Clinical Manager

______________________________
Teresa Montoya, RN, BSN, CCRN
Director
Welcome to the Cardiac Intensive Care Unit. This unit is designed to serve patients recovering from cardiac related procedures. Patients are assigned a level of nursing care based on medical or surgical need. The typical nurse ratio for patients requiring an Intensive Care level of nursing is 1 nurse per 2 patients. For Progressive Care level of nursing, it is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>ICU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>7-8</td>
<td>4</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Staffing for the Division includes 3 Charge RNs for both day and night shifts. 5th floor Critical Care Charge RN is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

Greg Bishoff, RN  
Clinical Manager

Teresa Montoya, RN, BSN, CCRN  
Director
5D

CARDIAC SURGERY INTENSIVE CARE UNIT

STAFFING PLAN

Welcome to the Cardiac Surgery Intensive Care Unit. This unit is designed to serve patients recovering from cardiac surgery or related procedures. Patients are assigned a level of nursing care based on medical or surgical need. The typical nurse ratio for patients requiring an Intensive Care level of nursing is 1 nurse per 2 patients. For day of surgery cardiac patients, it is 1 nurse per patient for the first 6 hours. For Progressive Care level of nursing, it is 1 nurse per 3 patients. The unit is supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>ICU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
<td>0.6</td>
</tr>
<tr>
<td>7-8</td>
<td>4</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Staffing for the Division includes 3 Charge RNs for both day and night shifts. 5th floor Critical Care Charge RN is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

______________________________
Greg Bishoff, RN
Clinical Manager

______________________________
Teresa Montoya, RN, BSN, CCRN
Director
NEURO PROGRESSIVE CARE UNIT

STAFFING PLAN

Welcome to the Neuro Progressive Care Unit. This unit is designed to serve patients transitioning from Intensive Care level of care or meeting Progressive Care criteria with primarily neurological diagnoses. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring a Progressive Care level of nursing is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>PCU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>4</td>
<td>1-2</td>
<td>0.5</td>
</tr>
<tr>
<td>5-6</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>7-8</td>
<td>2-3</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Staffing for the Division includes 3 Charge RNs for both day and night shifts.** The 6th floor Critical Care Charge RNs is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

___________________________  __________________________
David Hart, RN, CCRN        Teresa Montoya, RN, BSN, CCRN
Clinical Manager            Director

______________________________
Vanessa Cameron, MSN, RN-BC, CNL
Clinical Manager
6B

NEURO INTENSIVE CARE UNIT

STAFFING PLAN

Welcome to the Medical-Surgical Trauma Intensive Care Unit. This unit is designed to serve patients recovering from acute critical conditions or procedures. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring an Intensive Care level of nursing is 1 nurse per 2 patients. For Progressive Care level of nursing, it is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>ICU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>7-8</td>
<td>4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Staffing for the Division includes 3 Charge RNs for both day and night shifts. 6th floor Critical Care Charge RN is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

David Hart, RN, CCRN
Clinical Manager

Teresa Montoya, RN, BSN, CCRN
Director

Vanessa Cameron, MSN, RN-BC, CNL
Clinical Manager
Welcome to the Medical-Surgical Trauma Intensive Care Unit. This unit is designed to serve patients recovering from acute critical conditions or procedures. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring an Intensive Care level of nursing is 1 nurse per 2 patients. For Progressive Care level of nursing, it is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>ICU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>7-8</td>
<td>4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Staffing for the Division includes 3 Charge RNs for both day and night shifts. 6th floor**

Critical Care Charge RN is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

Vanessa Cameron, MSN, RN-BC, CNL  
Clinical Manager

Teresa Montoya, RN, BSN, CCRN  
Director

David Hart, RN, CCRN  
Clinical Manager
MEDICA-SURGICAL TRAUMA
INTENSIVE CARE UNIT

STAFFING PLAN

Welcome to the Medical-Surgical Trauma Intensive Care Unit. This unit is designed to serve patients recovering from acute critical conditions or procedures. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring an Intensive Care level of nursing is 1 nurse per 2 patients. For Progressive Care level of nursing, it is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>ICU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>7-8</td>
<td>4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

**Staffing for the Division includes 3 Charge RNs for both day and night shifts.** 6th floor Critical Care Charge RN is part of the Rapid Response, Code Blue, and Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

Vanessa Cameron, MSN, RN-BC, CNL
Clinical Manager

Teresa Montoya, RN, BSN, CCRN
Director
MEDICAL – SURGICAL PROGRESSIVE CARE UNIT

STAFFING PLAN

Welcome to the Progressive Care Unit. This unit is designed to serve patients transitioning from Intensive Care level of care or meeting Progressive Care criteria. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring a Progressive Care level of nursing is 1 nurse per 3 patients. The unit is also supported by a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>PCU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>1</td>
<td>0.5-1</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1-2</td>
<td>0.5-1</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>2</td>
<td>1 days 0.5 nights</td>
</tr>
<tr>
<td>7-8</td>
<td>2-3</td>
<td>1 days 0.5 nights</td>
</tr>
<tr>
<td>8-9</td>
<td>2-3</td>
<td>1 days 0.5 nights</td>
</tr>
</tbody>
</table>

**Staffing for the Division includes 3 Charge RNs for both day and night shifts.** The 8th floor PCU charge nurse supports Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

Shane McElwrath, RN, BSN, CCRN
PCU Clinical Manager

Teresa Montoya, RN, BSN, CCRN
Director
MEDICAL – SURGICAL PROGRESSIVE CARE UNIT

STAFFING PLAN

Welcome to the Progressive Care Unit. This unit is designed to serve patients transitioning from Intensive Care level of care or meeting Progressive Care criteria. Patients are assigned a level of nursing care based on medical need. The typical nurse ratio for patients requiring a Progressive Care level of nursing is 1 nurse per 3 patients. The unit is also staffed with a certified nursing assistant (CA) to assist with both secretarial and patient care tasks under the supervision of the RN. See below staffing plan for this unit:

<table>
<thead>
<tr>
<th>PCU Census</th>
<th>RN</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 4</td>
<td>1</td>
<td>0.5-1</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1-2</td>
<td>0.5-1</td>
</tr>
<tr>
<td></td>
<td>Consolidate quads if possible</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>2</td>
<td>1 days</td>
</tr>
<tr>
<td>7-8</td>
<td>2-3</td>
<td>1 days</td>
</tr>
<tr>
<td>8-9</td>
<td>2-3</td>
<td>1 days</td>
</tr>
</tbody>
</table>

Staffing for the Division includes 3 Charge RNs for both day and night shifts. The 8th floor PCU charge nurse supports Disaster Preparedness Teams (Code Triage) throughout the hospital. Staffing model that varies from the staffing plan includes close collaboration with the manager.

Our goal is to provide excellent patient care, therefore we welcome your ideas and comments. Please contact the Shift Charge Nurse if you have any questions and concerns or would like more details on staffing plan for the current shift.

Thank you for entrusting your loved ones to our care.

____________________________  ________________________
Shane McElwrath, RN, BSN, CCRN  Teresa Montoya, RN, BSN, CCRN
PCU Clinical Manager  Director
# 2018 Staffing Plan Overview

**Department:** Ambulatory Care Center  
**Date Updated:** April 6, 2018  
**Author:** Stephanie Brazil & Amy Hander

<table>
<thead>
<tr>
<th><strong>Nursing Department Overview</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of the types of patients served in this nursing unit,</td>
</tr>
<tr>
<td>- 36 Hour Observation/Inpatient Acute Care Unit</td>
</tr>
<tr>
<td>- Capacity of 44 patients, whom must be the age of 15 or older.</td>
</tr>
<tr>
<td>- Short stay medical, surgical and cardiac patients from Cath Lab, PACU, Walter’s Same Day Surgery, DI and ED. In addition, accepts direct admits from physician’s offices.</td>
</tr>
<tr>
<td>- Patient populations include but is not limited to:</td>
</tr>
<tr>
<td>o All Ortho/Neuro Spine Surgeries</td>
</tr>
<tr>
<td>o Post Procedure (heart caths, stents, biopsies, device implantations, etc.)</td>
</tr>
<tr>
<td>o Short Stay surgeries (home within 36 hours)</td>
</tr>
<tr>
<td>o Observation/trauma patients</td>
</tr>
<tr>
<td>o Short stay medical patients</td>
</tr>
<tr>
<td>o Other patients admitted for procedures or nursing care for 36 hours or less (blood transfusions, cardioversions, etc.)</td>
</tr>
<tr>
<td>o Medical-Surgical Overflow</td>
</tr>
<tr>
<td>o Designated area for medical psychiatric detained patients</td>
</tr>
<tr>
<td>- Inclusion criteria for stent patients include:</td>
</tr>
<tr>
<td>o No MI this admission</td>
</tr>
<tr>
<td>o Vital signs stable (patient must not require active/aggressive titration of</td>
</tr>
<tr>
<td>o vasoactive drugs)</td>
</tr>
<tr>
<td>o No significant arrhythmias, i.e., V tach/V fib during procedure</td>
</tr>
<tr>
<td>o Integrilin and ReoPro at standard/reduced dose. Must already be infusing. Not to be initiated in ACC.</td>
</tr>
<tr>
<td>- Patients with presence of any of the following infusions and boluses to include titration within these parameters:</td>
</tr>
<tr>
<td>o Dilitiazem up to 15mg/hr</td>
</tr>
<tr>
<td>o Dobutamine up to 5mcg/kg/min</td>
</tr>
</tbody>
</table>
Dopamine up to 5mcg/kg/min
Eptifibatide up to 15mg/hr
Nitroglycerin up to 30 mcg/min

- Private rooms with beds and adjoining shared bathroom- 30 (inpatient)
- Private observation rooms without bathroom- 12 (observation rooms)
- Average Daily census = 41
- Average number of daily admits/discharges/transfers =
  - Admits/Transfers in = 13.2; Discharges/Transfers Out = 14.1
- Average length of stay = 3.25 Days

**Key Quality Indicators**

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

- Patient falls prevalence
  - Total FY 18 YTD = 60

- Patient falls with injury (minor or above)
  - Total FY 18 YTD = 7; 1 Reportable YTD

- Pressure ulcer prevalence
  - Total FY 18 = 1

- Medication errors
  - Medication errors are looked at on an individual basis and as trends. Incident “D” (any incident that increases monitor or can cause harm) are all reviewed at the nursing pharmacy committee. Managers also review medication errors and follow up appropriately.
    - ACC RN participates in the nursing pharmacy committee.
    - Voluntary Turnover Rate: YTD = 22.65% (w/Per Diems)
    - Report represents rolling 12 month term
    - 5.2 FTE’s of RN’s in Residency
- **Overtime costs/End of Shift Overtime**
  - YTD OT% of worked hours = 4.36%
  - Average End of shift OT = Avg = 30.75 (last 6 pay periods)

- **Agency/ Traveler Usage**
  - Agency/Traveler hours: FY18 YTD = 212

- **Infection Control Rounds** = 98.4% & 98.4% quarterly FY 18 YTD

- **Nursing care hours per patient day** = 12.69

- **Skill Mix**
  - RN’s, CNAs

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Target Hours per Patient Day 12.69</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert developed staffing grid for varying levels of patient census or attach to this document</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Days</th>
<th>Evenings</th>
<th>Nights</th>
<th>24-hr Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge RN</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Resource RN</td>
<td>0.75</td>
<td>0.25</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>RN</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>CNA</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>CA</td>
<td>0.75</td>
<td>0.75</td>
<td>0.5</td>
<td>2</td>
</tr>
<tr>
<td>Transporter</td>
<td>0.75</td>
<td>0.25</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge/Resource</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Shift</td>
<td>Charge/Resource</td>
<td>RNs</td>
<td>CNAs</td>
<td>Other</td>
</tr>
<tr>
<td>Census</td>
<td>Charge/Resource</td>
<td>RNs</td>
<td>CNAs</td>
<td>Other (Transporter 0900-1730)</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>-----</td>
<td>------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>44-41</td>
<td>1 0.25</td>
<td>11</td>
<td>5</td>
<td>0.25 Transporter 0.75 CA</td>
</tr>
<tr>
<td>40-37</td>
<td>1 0.25</td>
<td>10</td>
<td>5</td>
<td>0.25 Transporter 0.75 CA</td>
</tr>
<tr>
<td>36-33</td>
<td>1 0.25</td>
<td>9</td>
<td>4</td>
<td>0.25 Transporter 0.75 CA</td>
</tr>
</tbody>
</table>

Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge/Resource</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other (Transporter 0900-1730)</th>
</tr>
</thead>
<tbody>
<tr>
<td>44-41</td>
<td>1 0.75</td>
<td>11</td>
<td>5</td>
<td>0.75 CA; 0.75 Transporter</td>
</tr>
<tr>
<td>40-37</td>
<td>1 0.75</td>
<td>10</td>
<td>5</td>
<td>0.75 CA; 0.75 Transporter</td>
</tr>
<tr>
<td>36-33</td>
<td>1 0.75</td>
<td>9</td>
<td>4</td>
<td>0.75 CA; 0.75 Transporter</td>
</tr>
<tr>
<td>32-29</td>
<td>1 0.75</td>
<td>8</td>
<td>3</td>
<td>0.75 CA; 0.75 Transporter</td>
</tr>
<tr>
<td>28-25</td>
<td>1 0.75</td>
<td>7</td>
<td>3</td>
<td>0.75 CA; 0.75 Transporter</td>
</tr>
<tr>
<td>24-21</td>
<td>1 -</td>
<td>6</td>
<td>3</td>
<td>0.75 CA; 0.75 Transporter</td>
</tr>
<tr>
<td>20-17</td>
<td>1 -</td>
<td>5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>16-15</td>
<td>1 -</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>14-11</td>
<td>-</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10-9</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8-7</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Less than 7</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Census</td>
<td>Charge/Resource</td>
<td>RNs</td>
<td>CNAs</td>
<td>Other</td>
</tr>
<tr>
<td>--------</td>
<td>----------------</td>
<td>-----</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>44-41</td>
<td>1 -</td>
<td>11</td>
<td>3</td>
<td>0.5 CA</td>
</tr>
<tr>
<td>40-37</td>
<td>1 -</td>
<td>10</td>
<td>3</td>
<td>0.5 CA</td>
</tr>
<tr>
<td>36-33</td>
<td>1 -</td>
<td>9</td>
<td>3</td>
<td>0.5 CA</td>
</tr>
<tr>
<td>32-29</td>
<td>1 -</td>
<td>8</td>
<td>2</td>
<td>0.5 CA</td>
</tr>
<tr>
<td>28-25</td>
<td>1 -</td>
<td>7</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>24-21</td>
<td>1 -</td>
<td>6</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>20-17</td>
<td>1 -</td>
<td>5</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- SW/Care management (M-F)
- Critical Care supports Rapid Response/Code Blue/Code Nurse throughout the hospital
- Respiratory Care supports CPAP, BIPAP and some respiratory assessment on changing patient conditions.
- IV Therapy department to place, monitor PICC lines and start peripheral IV lines.
- Break RN to assist with RN break

Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care.

- Heavy surgery schedule/ high numbers of fresh post op patients
- Increased number of isolation patients
- Increased number admissions/discharges during the shift
- Increased number of 1:1’s (suicidal/detained) needing break coverage
- Increased number of confused patients or patients on restraints requiring frequent

Chain of Command/ Staffing Decision Tree

<table>
<thead>
<tr>
<th>Process for Staffing Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this section to describe what process is used to determine if extra staff is needed.</td>
</tr>
<tr>
<td>- Charge nurse will round on the unit every 2-4 hours to assess acuity of the floor and facilitate problem-solving and patient flow of the unit. The charge nurse will also communicate the unit’s status to the rest of the ACC team and the House Supervisor.</td>
</tr>
<tr>
<td>- The Charge nurse in collaboration with Clinical manager (when applicable) determines the need for staffing variation – which may include but is not limited to, RN &amp; CNA The charge nurse will notify staffing to request for additional staff. The need for staffing up is assessed before the beginning of the next shift and every 4 hours during the shift.</td>
</tr>
<tr>
<td>- If the patient is assessed to require more acute nursing care and/or treatment than can safely be provided in the Ambulatory Care Center, the RN assigned to the patient will notify the attending physician/practitioner, and obtain orders to transfer the patient to a higher level of care.</td>
</tr>
<tr>
<td>- Still awaiting work to be utilizing acuity-based staffing software available in CVS in combination with EPIC.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meals and Breaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meals and Breaks</td>
</tr>
</tbody>
</table>
- All Break Relief RN positions filled
- RN’s who are assigned a break time by break RN complete a brief report sheet to be handed off prior to leaving for break.
- Charge RN to assign RN’s to the break nurse assignments based on acuity/flow of unit.

- Charge and Resource Nurse round every to ensure breaks/meal breaks have occurred.

- Regular Touch bases with residency RNs

- Charge RN provided with report indicating those most frequently missing meal/rest breaks per kronos edit log

- If nursing staff are unable to take a break, they are to notify the charge nurse who will cover or delegate a designee to relieve them.
Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Survey results emailed out to all staff
- 21% staff participation in survey 25 RN's/6 CNA's
- Adjusted CA start/stop times based on last year’s safe staffing survey
Committee Recommendations:

Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

_______________________________________  __________________

Tami Green, RN Co-Chair
Mental Health Unit

_______________________________________  __________________

Syd Bersante, Market President/Pierce County
President SJMC

_______________________________________  __________________

Date

Date

Date
2018 Staffing Plan Overview

Department: 4400
Date Updated: 7/23/18
Author: S Layne

Nursing Department Overview

Description of the types of patients served in this nursing unit, Delivery of surgical care to inpatient and outpatient populations. All service lines

- Average Daily census: 25-30
- Average number of admits/discharges/transfers: All patients transfer to another level of care
- Average length of stay: 1-8 hours depending on case acuity/type

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

- *Patient falls prevalence: NA
- *Patient falls with injury: NA
- *Pressure ulcer rate/prevalence: 1 HAPU S/P Tumor Resection
- *Nursing care hours per patient day: NA
- *Skill Mix: 1:1 RN to patient ratio. Ratio of RN:ST – 59% / 41%
- Medication errors: NA
- Staff turnover/orientation costs:
- Overtime costs / end of shift overtime
- Agency/ Traveler Usage: Two AST travelers
- Patient Satisfaction Data: No department specific data
- Data from professional organizations: NA
- NDNQI Data (Relevant reporting units): 

Staffing Grid for Patient Census | Target Hours per Patient Day

Insert developed staffing grid for varying levels of patient census or attach to this document

Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>Techs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-30</td>
<td>1</td>
<td>25</td>
<td>21</td>
<td>10</td>
</tr>
</tbody>
</table>
### Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>Techs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-9</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

### Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>Techs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1+1 on call</td>
<td>1+1 on call</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Above Staffing Plan Contingent Upon the Following Supports/Considerations

Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- Floating of staff between Walter’s and Main OR is significantly beneficial to both units. Staff flexibility and sharing of expertise is very positive. Staffing flexibility increased between CVOR and Main OR staff, especially when cardiac surgeons are out of town.
- IR & Cath Lab support interventional and minimally invasive procedures in hybrid room.

### Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Surgery volume growth = 3% for FY 2018
- High acuity patients, trauma, vascular (hybrid, trauma, and cardiac surgeries)
- Night shift vacancy for this level two trauma center
- Critical staffing levels in the Main OR

### Chain of Command/Staffing Decision Tree

**Process for Staffing Variation**

The Charge RN and Manager determine the need for extra staff based on acuity, needs of the unit or for known sick calls. The schedule is reviewed by the Charge RN up to a week ahead and staffing is planned and determined based on known OR case volumes. Staff are flexed down based on volumes the day before or day of to meet productivity margins. Staff may be asked to come in early from a mid-shift as day shift staff calls in sick or we are short due to vacation or FMLA. The Main OR and Walters Charge RNs communicate needs to see if either unit can help the other with staffing. Certain types of cases require additional staff; thoracic, vascular and cardiac cases have 2nd circulator. Depending on the case load and
acuity levels the Charge RN collaborates with providers, anesthesia and leadership to obtain optimal staffing levels.

### Meals and Breaks

- Use this section to describe what the meal and break strategies are for your area and how you measure if they are working.

- The OR has shifts staggered through the day to meet the needs of the team for meal and rest periods. Support staff are part of staffing matrix and are assigned daily. Staff cannot leave an OR case in progress, thus must be relieved to accommodate this.

- Printed assignment and schedule is used to plan meals and break periods with check off process.

- Periodic audit demonstrates that staff receive breaks/rest periods in a timely manner 93% of the time

### Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Survey results reviewed with staff? What format was used? (staff meetings, shift huddles, e-mail)

- Staff Participation: % of RN’s, CNA’s, ED Techs, RT’s, OR Tech’s etc...

- What was the theme of the results: Staffing shortages

- Department work planned to address themes
  Leadership is looking at innovative scheduling and ways to provide a higher level of care safely and consistently

### Committee Recommendations:

Approved By

Karen Cook, MSN, RN, Co-Chair

Date 12/18/2018
Clinical Manager Peri-Op Services

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

Syd Bersante, Market President/Pierce County
President SJMC

<table>
<thead>
<tr>
<th>Number of Cases - Fiscal Year To Date (FYTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>FY17</td>
</tr>
<tr>
<td>FY18</td>
</tr>
<tr>
<td>% Change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Start Day</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>Mon</td>
</tr>
<tr>
<td>Tue</td>
</tr>
<tr>
<td>Wed</td>
</tr>
<tr>
<td>Thu</td>
</tr>
<tr>
<td>Fri</td>
</tr>
<tr>
<td>Grand Total</td>
</tr>
</tbody>
</table>
Description of the types of patients served in this nursing unit,

- **Average Daily census:** 17
- **Average number of admits/discharges/transfers:** Monthly Admissions: 44.3
- **Average length of stay:** FY2018

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Cases</th>
<th>Pt Days</th>
<th>ALOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Immaturity or Respiratory Distress Syndrome, Neonate</td>
<td>47</td>
<td>1,664</td>
<td>35.4</td>
</tr>
<tr>
<td>Prematurity with major problems</td>
<td>112</td>
<td>1,944</td>
<td>17.36</td>
</tr>
<tr>
<td>Neonates, died or transferred to another acute care facility</td>
<td>69</td>
<td>640</td>
<td>9.28</td>
</tr>
<tr>
<td>Prematurity w/o major problems</td>
<td>202</td>
<td>1,062</td>
<td>5.26</td>
</tr>
<tr>
<td>Neonates with other significant problems</td>
<td>914</td>
<td>1,605</td>
<td>1.76</td>
</tr>
</tbody>
</table>

- **FY2019 to present**

<table>
<thead>
<tr>
<th>NICU Newborns (Less than 750 gm)</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NICU Newborns (751-1000 gm)</td>
<td>37</td>
<td>23</td>
<td>59</td>
<td>39</td>
<td>158</td>
</tr>
<tr>
<td>NICU Newborns (1001-1500 gm)</td>
<td>128</td>
<td>182</td>
<td>130</td>
<td>140</td>
<td>580</td>
</tr>
<tr>
<td>NICU Newborns (1501-2500 gm)</td>
<td>384</td>
<td>292</td>
<td>219</td>
<td>223</td>
<td>1118</td>
</tr>
<tr>
<td>NICU Newborns (Greater than 2500 gm)</td>
<td>68</td>
<td>83</td>
<td>84</td>
<td>51</td>
<td>286</td>
</tr>
</tbody>
</table>
Quality Indicators

Use this section for a delineation of what constitutes "safe" nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target worked hours per unit</td>
<td>16.25</td>
</tr>
<tr>
<td>Skill Mix</td>
<td>RN, RT, CA, NT</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>FY2017 = 2 FY2018 = 6</td>
</tr>
<tr>
<td>Staff turnover</td>
<td>FY2018 = 24%</td>
</tr>
<tr>
<td>Overtime hours</td>
<td>77.85 hours FYTD/ pay period</td>
</tr>
<tr>
<td>Sick call hours</td>
<td>59.55/ pay period since</td>
</tr>
<tr>
<td>Agency/Travelers</td>
<td>0</td>
</tr>
<tr>
<td>Patient Satisfaction-Recommend the hospital</td>
<td>Definitely yes = 65.8%</td>
</tr>
<tr>
<td>VON Data</td>
<td>See next page</td>
</tr>
</tbody>
</table>
### Center 1146 - Infants 501 to 1500 Grams Born in 2017: At Birth

<table>
<thead>
<tr>
<th></th>
<th>Center Cases</th>
<th>All Infants</th>
<th>All Hospitals</th>
<th>Trend '13 '14 '15 '16 '17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>Median (Q1, Q3)</td>
</tr>
<tr>
<td>Antenatal Steroids</td>
<td>55</td>
<td>83.6</td>
<td>57,635</td>
<td>86.1 (78.9, 91.8)</td>
</tr>
<tr>
<td>Multiple Gestation</td>
<td>10</td>
<td>18.2</td>
<td>57,925</td>
<td>25.0 (18.2, 32.4)</td>
</tr>
<tr>
<td>Cesarean Section</td>
<td>45</td>
<td>81.8</td>
<td>57,898</td>
<td>74.1 (66.7, 80.6)</td>
</tr>
<tr>
<td>Any Major Birth Defect</td>
<td>2</td>
<td>3.6</td>
<td>57,897</td>
<td>3.3 (0.0, 6.3)</td>
</tr>
<tr>
<td>Small for Gestational Age</td>
<td>16</td>
<td>55</td>
<td>57,809</td>
<td>24.4 (19.0, 31.0)</td>
</tr>
<tr>
<td>APGAR at 1 Minute &lt;4</td>
<td>15</td>
<td>54</td>
<td>57,175</td>
<td>24.1 (15.9, 32.2)</td>
</tr>
<tr>
<td>Admission Temperature &lt;36°C</td>
<td>12</td>
<td>54</td>
<td>54,940</td>
<td>6.4 (1.2, 17.5)</td>
</tr>
<tr>
<td>Any Initial Resuscitation</td>
<td>48</td>
<td>55</td>
<td>57,821</td>
<td>91.7 (86.0, 95.7)</td>
</tr>
<tr>
<td>Chorioamnionitis</td>
<td>1</td>
<td>53</td>
<td>57,082</td>
<td>7.7 (2.7, 16.1)</td>
</tr>
<tr>
<td>Maternal Hypertension</td>
<td>23</td>
<td>53</td>
<td>57,543</td>
<td>31.9 (22.2, 40.0)</td>
</tr>
</tbody>
</table>

### Weight - Grams (%) and Gestational Age - Weeks (%)

<table>
<thead>
<tr>
<th></th>
<th>501-750</th>
<th>751-1000</th>
<th>1001-1250</th>
<th>1251-1500</th>
<th>&lt; 24</th>
<th>24-26</th>
<th>27-29</th>
<th>30-32</th>
<th>&gt; 32</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Steroids</td>
<td>100.0</td>
<td>80.0</td>
<td>78.9</td>
<td>88.0</td>
<td>*</td>
<td>100.0</td>
<td>84.2</td>
<td>82.6</td>
<td>77.8</td>
</tr>
<tr>
<td>Multiple Gestation</td>
<td>0.0</td>
<td>10.0</td>
<td>10.5</td>
<td>28.0</td>
<td>*</td>
<td>0.0</td>
<td>15.8</td>
<td>26.1</td>
<td>11.1</td>
</tr>
<tr>
<td>Cesarean Section</td>
<td>0.0</td>
<td>80.0</td>
<td>84.2</td>
<td>84.0</td>
<td>*</td>
<td>50.0</td>
<td>78.9</td>
<td>82.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Any Major Birth Defect</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>8.0</td>
<td>*</td>
<td>0.0</td>
<td>5.3</td>
<td>0.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Small for Gestational Age</td>
<td>0.0</td>
<td>30.0</td>
<td>31.6</td>
<td>28.0</td>
<td>*</td>
<td>0.0</td>
<td>0.0</td>
<td>30.4</td>
<td>100.0</td>
</tr>
<tr>
<td>APGAR at 1 Minute &lt;4</td>
<td>0.0</td>
<td>40.0</td>
<td>36.8</td>
<td>16.7</td>
<td>*</td>
<td>50.0</td>
<td>26.3</td>
<td>22.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Admission Temperature &lt;36°C</td>
<td>0.0</td>
<td>33.3</td>
<td>21.1</td>
<td>20.0</td>
<td>*</td>
<td>0.0</td>
<td>11.1</td>
<td>21.7</td>
<td>55.6</td>
</tr>
<tr>
<td>Any Initial Resuscitation</td>
<td>100.0</td>
<td>100.0</td>
<td>89.5</td>
<td>80.0</td>
<td>*</td>
<td>100.0</td>
<td>94.7</td>
<td>91.3</td>
<td>55.6</td>
</tr>
<tr>
<td>Chorioamnionitis</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>4.2</td>
<td>*</td>
<td>0.0</td>
<td>5.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Maternal Hypertension</td>
<td>0.0</td>
<td>30.0</td>
<td>66.7</td>
<td>33.3</td>
<td>*</td>
<td>0.0</td>
<td>31.6</td>
<td>47.6</td>
<td>77.8</td>
</tr>
</tbody>
</table>

**Staffing Grid for Patient Census**

**Target Hours per Patient Day**
Insert developed staffing grid for varying levels of patient census or attach to this document

### Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>Staffed RNs</th>
<th>CNAs</th>
<th>RT</th>
<th>Nurse Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>7 daily</td>
<td>1</td>
<td>1</td>
<td>0-1</td>
</tr>
</tbody>
</table>

### State Guidelines for RNs

**Nurse:Patient Ratio**

Staffing parameters should be clearly delineated in a policy that reflects:

1. staff mix and ability levels;
2. patient census, intensity, and acuity; and
3. plans for delegation of selected, clearly defined tasks to competent assistive personnel.

It is an expectation that allocation of personnel provides for safe care of all patients in a setting where census and acuity are dynamic.^

**Newborns**

- 1:1 to 8 neonates requiring only routine care
- 1:4 recently born neonates and those requiring close observation
- 1:3 to 4 neonates requiring continuing care
- 1:2 to 3 neonates requiring intermediate care

- Reflects traditional newborn nursery care. A nurse should be available at all times, but only one may be necessary, as most healthy neonates will not be physically present in the nursery. Direct care of neonates in the nursery may be provided by auxiliary personnel under the nurse’s direct supervision. Additional staff is needed to respond to acute and emergency situations. The use of assistive personnel is not considered in the nurse:patient ratios noted here.

See attachments for proposed guidelines form NICU night shift

### State Guidelines for RTs in NICU’s

#### Respiratory Therapy

- The role of a Respiratory Care Practitioner is prescribed by the medical director and clearly delineated in a written protocol. If attending deliveries or providing neonatal respiratory care will have current NRP Provider status.

- Same as Level I plus:
  - When CPAP in use:
    - In-house and immediately available RCP with documented competence and experience in the management of neonates with cardiorespiratory disease

- Level II plus:
  - One Respiratory Care Practitioner for every six or fewer ventilated neonates with additional staff for procedures
  - RCP skilled in neonatal airway management immediately available for every high-risk delivery

### Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>Staffed RNs</th>
<th>CNAs</th>
<th>RT</th>
<th>Nurse Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>8-9 nightly</td>
<td>1</td>
<td>2</td>
<td>0-1</td>
</tr>
</tbody>
</table>
Use this area to list other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

- The NICU team attends all high-risk deliveries in L&D
- They are responsible for attending to deliveries in the ED and any unusual high risk needs in the midwifery center
- The NICU is supported by:
  - Pharmacy Services
  - Nutrition/lactation
  - OT/PT
  - Social Services/Case Management
  - Nurse Educator/Clinical Nurse Specialist
  - Xray/Ultrasound
  - Laboratory and blood bank

**Which Situations Require Staffing Variation?**

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- High acuity neonates that are classified as “Extreme Immaturity or Respiratory Distress Syndrome, Neonate”

---

**Chain of Command/ Staffing Decision Tree**

**Process for Staffing Variation**

- Use this section to describe what process is used to determine if extra staff is needed.
- Staffing is evaluated every 4 hours and adjusted as needed. The manager on call is consulted if staffing becomes complexed or difficult.
- There is a small group of per-diem/supplemental staff that supports the unit.
- Most of the staff work a 0.75 FTE, with a small team of 0.9 and 0.6 FTE

---

**Meals and Breaks**

- Use this section to describe what the meal and break strategies are for your area and how you measure if they are working.
- The NICU had a full 1.0 FTE filled to support the dayshift team. Both these RNs returned to bedside nursing and presently only 50% of the position is filled. The team members sign up on the break sheet so everyone knows who is on break.
Night shift has a charge nurse who can relieve them for breaks and they can also adjust their care times to accommodate taking breaks.

---

**Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)**

- Survey results reviewed with staff? Yes, laminated results, added cliff notes to huddle, and rounded with staff

- **Staff Participation: % of RN**
  - NIGHTS = 65%
  - DAYS = 35%

- **CNA**
  - DAYS = 50%
  - NIGHTS = 50%

- **RT**
  - DAYS = 100%
  - NIGHTS = 0

- What was the theme of the results: The theme from 10% of the staff was dissatisfaction with caring for the smaller gestational aged newborns with other patients in the same assignment and the fact the night shift was not assigned a break nurse. 25% of the staff felt that their assignment could not accommodate changes in pt. conditions

- Department work planned to address themes: Starting a safe staffing committee which meets monthly and is led by night shift. Day shift does not participate as they state they do not have issues with staffing and assignments

---

**Committee Recommendations:**
Approved By

Jakki Stodola, MBA, BSN, RNC, Co-Chair
Director, Family Birth Center

_____________________________________

__________________

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

_____________________________________

__________________

Syd Bersante, Market President/Pierce County
President SJMC

_____________________________________

__________________
2018 Staffing Plan Overview

Department: Walter Day Surgery
Date Updated: 7/20/18
Author: Yvette Tawfik

Nursing Department Overview

Walters Day Surgery performs surgeries, but are not limited to, for the following services:
- Gynecology
- Urology
- General
- Plastics
- Ortho
Walters Day Surgery also provides robotic surgery services for Gynecology, Urology and General Cases.
Case load varies between 14 and 30 cases with an average of 20 cases.
Admissions correspond to number of cases

Key Quality Indicators

- **Patient falls prevalence**: Patients come to OR on a stretcher with side rails up. Once on the OR table we secure with a safety belt during surgery.
- **Patient falls with injury**: No falls with injury
- **Pressure ulcer rate/prevalence**: Patients are positioned with gel pads, foam pads, pressure reduction dressings for buttock, heels, and elbows to reduce pressure. Alignment is actively determined based on the patients’ surgical position to assure there is not undue pressure on nerve points during the surgery.
- **Nursing care hours per patient day**: Our hours of service is 6.8 per case.
- **Skill Mix**: We have one RN and one scrub tech in each case with additional staff as needed for patient safety or room flow, holding limbs, retractors or manipulation. There is a Charge RN on each shift and scheduler/Health Coordinator at the desk.
- **Medication errors**: Anesthesia delivers most medications
- **Staff turnover/orientation costs**: Staff turnover is currently at 22.5% primarily due to the clinical groups and new staff who come to Walters now taking inpatient call with the main OR. This has led to dissatisfaction for current and past staff who left. Recruiting is difficult now as day surgery units as a practice don’t usually take call.
- **Overtime costs / end of shift overtime**: Current OT is at 2.43% due to vacancy rate and inability to fill open positions. This leads to inadequate coverage for the volumes and times of cases. A new staff schedule will be implemented 7/30/18 to improve coverage of the surgery schedule.
**Agency/ Traveler Usage.** Current usage of travelers has been 1.0 FTE of RN with the contract ending 7/11/18. Traveler hours averaged 78 per pay period.

**Patient Satisfaction Data.** Currently Walters is at 87.5% (40th % tile) Threshold is 90% or top box of 75% tile.

**Data from professional organizations.**

**NDNQI Data** (Relevant reporting units):

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Target Hours per Patient Day</th>
<th>6.8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Shift. <strong>Example below of standard staffing available at each time frame to accommodate 7 OR rooms from 6:30-15:00, 5 OR rooms from 15:00-17:00 and 2 OR rooms from 17:00-19:00.</strong> Actual schedule is in Care Values.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RN CHG 0630-1500</strong></td>
<td><strong>OR TECH CC 0600-1430</strong></td>
<td><strong>RN CENTER CORE</strong></td>
</tr>
<tr>
<td>Jeanette 1.0</td>
<td>Jodie .8</td>
<td>Judy</td>
</tr>
<tr>
<td>OR TECH 0600-1630</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR TECH 0630-1500</td>
<td>Deanna .875</td>
<td></td>
</tr>
<tr>
<td>Diane G. .9</td>
<td>Jill .875</td>
<td>AST II 1130 - 1930</td>
</tr>
<tr>
<td>Pam .6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen 1.0</td>
<td>OR TECH 0630-1500</td>
<td>Gina</td>
</tr>
<tr>
<td>Nina .9</td>
<td>Tama .8</td>
<td>PST I 0600 - 1430</td>
</tr>
<tr>
<td>Shannon .6</td>
<td>Mary 1.0</td>
<td>Gary</td>
</tr>
<tr>
<td>Linda .9</td>
<td>Vanessa 1.0</td>
<td></td>
</tr>
<tr>
<td>Rebekah .9</td>
<td>Jim .8</td>
<td>PST I 1130 - 2000</td>
</tr>
<tr>
<td>Terrilynn .9</td>
<td>Leslie 1.0</td>
<td>Arlene</td>
</tr>
<tr>
<td>Shannon .8</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RN 0630-1700</strong></td>
<td>Christine .8</td>
<td>OR TECH CORE</td>
</tr>
<tr>
<td>Nancy .875</td>
<td>Support Staff</td>
<td></td>
</tr>
<tr>
<td>Allie 1.0</td>
<td>OR TECH 0630-1700</td>
<td>Marsha</td>
</tr>
<tr>
<td>Katie 1.0</td>
<td>Trish 1.0</td>
<td>Shannon</td>
</tr>
<tr>
<td>Lisa 1.0</td>
<td>Michelle 1.0</td>
<td>Marva</td>
</tr>
<tr>
<td><strong>RN 0830-1700</strong></td>
<td>OR TECH 830-1700</td>
<td>Stats</td>
</tr>
<tr>
<td>Rowena 1.0</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>Peggy .8</td>
<td>OR TECH 0830-1900</td>
<td>Techs</td>
</tr>
<tr>
<td>Chelsea .8</td>
<td>Support Staff</td>
<td></td>
</tr>
<tr>
<td><strong>RN 0830-1900</strong></td>
<td>Ashlee 1.0</td>
<td>Cases</td>
</tr>
<tr>
<td>Carly .875</td>
<td>Support Staff</td>
<td></td>
</tr>
<tr>
<td><strong>RN 1030-1900</strong></td>
<td>OR TECH 1030-1900</td>
<td>LATE CASES</td>
</tr>
<tr>
<td>Haley 1.0</td>
<td>Becky .8</td>
<td>1)</td>
</tr>
<tr>
<td>Francie .6</td>
<td>2)</td>
<td></td>
</tr>
</tbody>
</table>

Based on OR volumes staff may be low censuses or ask to come in early or stay late.

This grid shows the scheduled rooms for each time period and correlated staffing.
[Table]

<table>
<thead>
<tr>
<th>Number of ORs running.</th>
<th>RN circulators</th>
<th>Scrub Tech</th>
<th>Other staff desk, charge RN, Core tech, PST, AT</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 day shift 6:30-15:00</td>
<td>7-8</td>
<td>8-9</td>
<td>4</td>
</tr>
<tr>
<td>5 Mid shift 15:00-17:00</td>
<td>5-6</td>
<td>6-8</td>
<td>4</td>
</tr>
<tr>
<td>2 eve shift 17:00-19:00</td>
<td>2-3</td>
<td>3-4</td>
<td>3</td>
</tr>
</tbody>
</table>

**Above Staffing Plan Contingent Upon the Following Supports/ Considerations**

Walters Day Surgery provides an Anesthesia Tech support to the GI unit
Staff float to main OR if they need help and we have extra staff
Staff float from main OR to Walters if we need help and they have extra staff
EVS cleans OR
Diagnostic imaging
Material management
SPD
Perianesthesia
Lab

**Which Situations Require Staffing Variation?**

- Heavy surgery schedule or type of surgery being performed that may need additional support
- Acuity of the patient
- Cases that require additional scrub tech to manipulate or hold and RN to run the room and document.

**Chain of Command/ Staffing Decision Tree**

**Process for Staffing Variation**

The Charge RN and Manager determine the need for extra staff based on acuity, needs of the unit or for known sick calls. The schedule is reviewed by the Charge RN up to a week ahead and staffing is planned and determined based on known OR case volumes. Staff are flexed down based on volumes the day before or day of to meet productivity margins. Staff maybe asked to come in early from a mid-shift as day shift staff calls in sick or we are short due to vacation or FMLA. The Main OR and Walters Charge RNs communicate needs to see if either unit can help the other with staffing.
Meals and Breaks

Charge RNs provide meal and breaks for staff that are part of the scheduling matrix to assure meals and breaks are accomplished. These roles are listed on the daily assignment sheets. In the core there is a white board and assigned breaks and lunches are put on the board to know who is assigned and which room they should give lunches and breaks. If an employee misses a break or meal they should notify leadership, clock it in Kronos and document in the daily acceptations log.

Annual Safe Nurse Staffing Survey (Not Hospital PCA Survey)

- Staff Participation 2017: 29/40 staff participated in the survey or 70%.
- Adequate staffing was a high concern. Recognition, promotions, physician departure creating excessive low census due to low surgical volumes. Concerned that upper management is not looking at physician losses and how it impacts department work and hours.
- Department work planned to address themes scheduled for 8/1/18

Committee Recommendations:

Approved By
Karen Cook, MSN, RN, Co-Chair
Clinical Manager Peri-Op Services

John Gustafson, RN Co-Chair
Med/Surg 7th Floor

Syd Bersante, Market President/Pierce County
President SJMC
2018 Staffing Plan Overview

Department: 9th Floor Medical Telemetry
Date Updated: January 29, 2018
Author: Cyril Elep and Jennifer Schmidt

Nursing Department Overview

Description of the types of patients served in this nursing unit.

- Medical Telemetry services consists of a 38-bed unit providing care to patients who are acute and chronically ill with one or multiple systems involvement.
- Accepts patients from ED, and med surg transition areas. Also accepts direct admits and transfers coordinated by FPPC and transfers from Inpatient rehab, Critical Care and other Med-Surg Units.
- Patient populations include:
  - Rapid Rule-Out MI patients
  - Diabetes Mellitus
  - Congestive Heart Failure
  - Acute and Chronic Respiratory Disease
  - Acute and Chronic Renal Disease
  - Gastrointestinal Disorders
  - Infectious Disease
  - Circulatory Impairments
  - Seizure Disorders
  - Surgical overflow
  - Peritoneal Dialysis
  - Any medical or surgical patients requiring telemetry monitoring
- Patients with presence of any of the following infusions and boluses to include titration within these parameters:
  - Dobutamine up to 5 mcg/kg/min
  - Dopamine up to 5 mcg/kg/min
  - Nitroglycerin up to 30 mcg/min
  - Diltiazem drip up to 15 mg/hr for patients already on chronic oral Diltiazem who are not able to ingest oral medications. Diltiazem may not be used for new onset heart arrhythmias on the unit.

- Average Daily census = 35
- Average number of admits = 4.49 per day
Average number of Discharges = 4.79 per day
Average number of Transfers = 0.64
Average Length of Stay = 3.72

Key Quality Indicators

Use this section for a delineation of what constitutes “safe” nursing care on this unit including but not limited to the five approved state indicators which are designated with an asterisk*:

- **Patient falls prevalence**
  Total Falls FY17 = 71, FY18 YTD = 37
- **Patient falls with injury (minor and above)**
  Total falls with injury FY17 = 13, FY18 YTD = 2
- **Pressure ulcer prevalence**
  FY17 reportable HAPU: 2
  9th Floor had 1 reportable HAPU for FY18 (stage 3 coccyx)
  RCA and process improvement initiatives related to skin care done as a result of HAPU
- **Nursing care hours per patient day**
  We provide 10.69 hours of nursing care per patient day
- **Skill Mix**
  RN/CNA see below for the breakdown of staffing
- **Medication errors**
  Total med errors for FY17 = 28, FY18 YTD = 13
- **RN turnover**
  Voluntary turnover rolling 12 months Jan 2017-Dec 2017 = 7.58%, less per diem = 4.71%
- **Overtime costs**
  FY17 OT = 3%, FY18 YTD OT = 3.7%
- **Agency/ Traveler Usage**
  FY17 = 20, FY18 YTD = 320 hours

**Staffing Grid for Patient Census**

<table>
<thead>
<tr>
<th>Target Hours per Patient Day 10.69</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peritoneal Dialysis Staffing</strong></td>
</tr>
<tr>
<td>PD Patient</td>
</tr>
<tr>
<td>1 PD patient on the 9th floor or off unit, uncomplicated case</td>
</tr>
<tr>
<td>2 PD patients on the 9th floor or off unit, uncomplicated case</td>
</tr>
<tr>
<td>1-2 PD patients off unit, complicated</td>
</tr>
<tr>
<td>3 PD patients on the 9th floor or off unit, complicated or uncomplicated</td>
</tr>
</tbody>
</table>
### Day and Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>CA</th>
</tr>
</thead>
<tbody>
<tr>
<td>38-37</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>0.5</td>
</tr>
<tr>
<td>36-33</td>
<td>1</td>
<td>9</td>
<td>3.5</td>
<td>0.5</td>
</tr>
<tr>
<td>34-32</td>
<td>1</td>
<td>8</td>
<td>3.5</td>
<td>0</td>
</tr>
<tr>
<td>31-27</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>26-23</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>22-19</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>18-16</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

### Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>38-36</td>
<td>1</td>
<td>9</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>35-34</td>
<td>1</td>
<td>8</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>33-30</td>
<td>1</td>
<td>7.5</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>29-27</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>26-23</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>22-19</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>18-16</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

### Above Staffing Plan Contingent Upon the Following Supports/Considerations

- 9<sup>th</sup> floor PD-trained nurses to do peritoneal dialysis treatments throughout the whole hospital
- Neuroscience trained RN’s to complete NIHSS evaluation for stroke patients throughout the hospital.
- IV therapy department to place, monitor PICC lines and start peripheral IV lines
- Critical Care supports rapid responses/code blue throughout the hospital
- Respiratory care supports CPAP, BIPAP and some respiratory assessment on changing conditions
- Centralized transporters assist with transport needs throughout the hospital.
- Break relief nurses provide breaks to staff nurses for 8 hours daily
- Monitor techs provide 24/7 telemetry monitoring to all telemetry patients in med surg
- Virtual Services provides additional support and monitoring to patients as needed

### Which Situations Require Staffing Variation?

Use this section to describe legitimate situations where additional staff are required to provide safe patient care

- Increased number of confused patients or patients on restraints requiring frequent checks
- Increased number of mental health patients on unit that may or may not require restraints
- Increased number of isolation patients
• Increased number of admissions and discharges during the shift
• Full capacity including usage of temporary bed locations
• Increased number of 1:1’s needing break coverage
• Increased number of heavy care patients (2 or more person to assist/ambulate, skin protocol turn every 2 hours, total feeders, incontinent, multiple bed changes, comatose patient care)
• Increased number of patients on complex treatments (tube feedings, dressing changes, multiple drains, multiple central lines, chest tubes, pain management, multiple blood draws, trach care, frequent suctioning, accuchecks every 2 hours for insulin drip management, CBI, multiple patients needing blood transfusions)
• Increased number of bedside procedures needing assist by Charge RN (bronchoscopy, TEE, chest tube placement, colonoscopy, endoscopy, lumbar puncture)
• Increased number of Code Blue/ RRT during the shift
• Increased number of peritoneal dialysis patients on active treatment

Chain of Command/ Staffing Decision Tree

**Process for Staffing Variation**

- Staffing will be sufficient at all times to assure safe, effective patient care delivery. Staffing may be adjusted according to acuity, type and skill of caregivers and availability of staff.
- Charge nurse will round each unit every 2 hours to assess acuity of the quad and facilitate problem-solving and patient flow in the unit. They will also communicate the unit’s status to the rest of the unit and the House Supervisor to help assess the unit’s ability to accept new patients.
- If the charge nurse determines that extra staff is needed, Charge Nurse will notify management and staffing to request for additional staff. The need for staffing up is assessed before the beginning of the next shift and every 4 hours during the shift.
- 9th floor management share an on-call schedule which is available to the charge team if they need additional unit support.
- Staffing changes are based on staff input to the Charge Nurses, patient acuity, procedures, skill mix and census needs.
- If the patient is assessed to require more acute nursing care and/or treatment than can safely be provided in the unit, the RN assigned to the patient will notify the attending physician/practitioner, and obtain orders to transfer the patient to a higher level of care

**Meals and Breaks**

- 9th Floor has two break relief RNs providing meal and rest break coverage for 8 hours 24/7 (1100-1930).
- The staff on 9th communicate with each other to establish a break time for lunch breaks and rest breaks. The charge RN rounds frequently and checks with staff to ensure that our teams are getting their breaks. Staff are encouraged to let the charge RN know if they are running behind to help aid in preventing missed lunch breaks or rest breaks.
Annual Nurse Staff Survey

- Annual Nurse Staff Survey results were reviewed with staff during mandatory staff meeting, which covered 95% of 9th floor employees. Employees were encouraged to share feedback and concerns regarding the survey results.
- Positive responses were related to manager support when safety concerns regarding staffing are brought up, unit has necessary supplies and equipment to allow safe patient care.
- Issues identified were related to workload and heavy acuity of patients on the units especially during full capacity, long term patients with placement issues, and patients with behavioral or psychiatric issues.
- Survey also showed that our unit did not have a structured process for breaks, which was addressed with the implementation of the Break Relief RNs starting in July 2017.

Committee Recommendations:

Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

Tami Green, RN Co-Chair
Mental Health Unit

Syd Bersante, Market President/Pierce County
President SJMC
2018 Staffing Plan Overview

Department: Main PACU
Date Updated: August 13, 2018
Author: Samantha Fentress, Clinical Manager

Nursing Department Overview

- The Main PACU cares for patients in the immediate post-operative period that includes inpatient/outpatient surgical patients, IR cases, DI cases and Cath Lab patients who have received general anesthesia.
- Average daily census: 25-35 cases
- Average length of stay: 2.5 hours. Average bed-hold minutes per month: 40,171 (670 hours per month) Total bed-hold minutes for FY17: 482063 (6034 hours annually).
- Seventeen patient care areas (including 1 isolation room).
- Average stay: 72 minutes without bed-hold time
- Staffed 24/7: Monday-Friday 0730-2330 with scheduled staff. Sunday-Friday nights is staffed with one scheduled staff member 1900-0730 and the 2nd RN on-call. Saturday and Sunday 0800-2030 is staffed with one scheduled staff member and 2nd RN on call. On-call staff covers weekdays (2300-0800) and weekends (1930-0800).
- Charge nurse Monday-Friday 0730-2000.
- CNA/HUC Monday-Friday 0800-2230 (2 CNA 10 hour shifts) Wednesday 0900-1930 (1 CNA) and Friday 1200-2230 (1 CNA)

Key Quality Indicators

- Surgical Site Infections: Did not met quality measures for FY18 on the Living Our Mission dashboard for colon surgery. Did not meet measure for hysterectomies.
- Skill Mix: 10 RNs/2 CA/HUCs between hours of 0800-2230
- Staff Turnover/orientation costs: 8 RN left with 1 on disability, 2 not returning from maternity, 1 left for position at Overlake, 1 left for position at Swedish, 1 left for position at ACS, 2 relocated another state. Positions have been filled with Critical care transfers and 1 from 2018 PACU residency. Currently have (2) 0.9 FTEs for 1900-0730 Sunday-Friday nights to decrease the amount of call for staff. PACU residency program with 1 resident for 6 month orientation starts September 17th. Cost per resident is approximately $80,000 ++ for salary plus educational costs (transfer from MT floor with 11+ experience).
- Overtime cost /end of shift overtime: Due to transition to manager and no access to visionware unable to get full FY18, from 5/19/18-6/30/18: 70.5 hours
- Patient Satisfaction Data: H30 Overall Rating: N/A
- Agency/Travelers: 1 for 26 week contract ($160,418)
- Data from professional organizations: 8 out of 21 are certified.
Staffing Grid for Patient Census  

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35</td>
<td>1</td>
<td>9-10</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Evening Shift  

| Census   | Charge | RNs  | CNAs | Other |

Night Shift  

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
<td>1 (Sunday-Friday 1900-0730)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations  

- OR Schedule.  
- Bed availability/throughout hospital.  
- Cath Lab/IR schedule.  

Which Situations Require Staffing Variation?  

- OR schedule, add-on surgeries, trauma days  
- Cath lab, IR schedules for patient recovery  
- Unexpected staff absences (SNO, FMLA, LOAs etc)  
- Patient acuity (pediatrics, isolation, 1:1 patient care)  
- Bed holds
Chain of Command/ Staffing Decision Tree

### Process for Staffing Variation

- Charge RNs review schedules and adjust staffing as needed on a daily basis. Reviews with the manager on a daily basis.

### Meals and Breaks

- PACU charge RN is not counted in staffing to allow them the ability to cover breaks and lunches.
- Daily sheet to track breaks and lunches.
- Staff document on edit logs when breaks or lunches are missed.

### Annual Nurse Staff Survey

- Reviewed with charge RNs in June with discussion/action plan.
- Safety issues discussed at daily unit huddles.
- Designated representatives from each department to assist manager with safety concerns.

### Committee Recommendations:

Approved By

Renee Yanchura, Co-Chair  
Director Emergency Services, EDO & PCS  
Date

Tami Green, RN Co-Chair  
Mental Health Unit  
Date

Syd Bersante, Market President/Pierce County President SJMC  
Date
2018 Staffing Plan Overview

Department: Main SADU
Date Updated: August 13, 2018
Author: Samantha Fentress, Clinical Manager

Nursing Department Overview

Description of the types of patients served in this nursing unit:
- The Surgery Admit/Discharge Unit prepares inpatients and outpatients for surgery and any invasive/non-invasive procedures for IR and DI who are receiving a general anesthetic. Outpatients are prepared for discharge in this area also.
- Main SADU serves the Main OR, Interventional Radiology, and Diagnostic Imaging patients that require general anesthesia.
- Hours are Mon-Tues-Thurs: 5:00-19:30, Wed 0600-2030, Fri: 0500-2030 Each admission takes 30-60 minutes; discharges take 30-60 minutes.
- Admissions: 25-35 patients daily; discharge 5-15 outpatients daily.
- There are 13 available rooms.

Key Quality Indicators

- Patient fall prevalence: none
- Patient falls with injury: none
- Surgical Site Infections: Did not meet quality measures for FY17 on the Living Our Mission dashboard for colon surgeries. Did not meet the measure for hysterectomies.
- Staff Turnover/orientation costs: 1 to new position in Care Management.
- Overtime costs / end of shift overtime: due to transition to new manager unable to provide, current premier shows 16 hour of daily OT from 5/18/18 to 6/30/18.
- Patient Satisfaction Data: N/A
- Agency/Travelers: 0
- Data from professional organizations: 2 out of 13 RNs are certified

Staffing Grid for Patient Census

<table>
<thead>
<tr>
<th>Day Shift</th>
<th>Target Hours per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Insert developed staffing grid for varying levels of patient census or attach to this document

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35 Admits</td>
<td>2</td>
<td>7-8</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5-15 discharges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evening Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Night Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CNAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations

- OR schedule changes, add-on cases, trauma
- IR schedule
- Number of telemetry patients: require RN to monitor continuously

Which Situations Require Staffing Variation?

- Sick call/FMLA/unexpected staff absences
- Patient acuity
- Heavy OR schedule with high volume of outpatients
- Add on cases

Chain of Command/Staffing Decision Tree

**Process for Staffing Variation**

- Day and evening charge RNs review schedules and adjust staffing as needed on a daily basis.
- Discuss staffing requirements with manager.
- Contact Walters Same Day Surgery for staffing assistance.
- Contact staffing for CA/HUC replacement.
Meals and Breaks

- Daily sheet to track breaks and lunches.
- Staff document on edit logs when breaks or lunches are missed.
- Charge RNs assist with managing breaks and lunches.

Annual Nurse Staff Survey

- Reviewed with charge RNs in June with discussion/action plan.
- Safety issues discussed at daily huddles.
- Designated representatives from each department to assist manager with safety concerns.

Committee Recommendations:

Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

Date

Tami Green, RN Co-Chair
Mental Health Unit

Date

Syd Bersante, Market President/Pierce County
President SJMC

Date
2018 Staffing Plan Overview

Department: Pre-Admit Clinic
Date Updated: August 13, 2018
Author: Samantha Fentress, Clinical Manager

Nursing Department Overview
- The Pre-Admit Clinic screens patients prior to their scheduled procedure. This department supports the Main OR, Walters SDSC, Gig Harbor Same Day Surgery, patients for IR/DI, Cath Lab (ablations, LACCs), and GI who are receiving a general anesthetic.
- There are 5 patient interview rooms.
- Average 16 visits per day and 45-55 phone screens day
- Hours are Mon-Friday 8:00-17:30pm

Key Quality Indicators
- Surgical Site Infections: Did not meet quality measures for FY17 on the Living Our Mission dashboard for colon. Did not meet the measure for hysterectomies.
- Staff Turnover/orientation costs: 1 RN retired, 1 CNA
- Overtime costs / end of shift overtime: unable to get information d/t transition of new manager, current premier shows: 18.75 from pay dates 5/18/18 to 6/30/18
- Patient Satisfaction Data: H30 Overall Rating: N/A
- No Agency/Travelers
- Data from professional organizations: 2 RN of 13 is certified.

Staffing Grid for Patient Census

<table>
<thead>
<tr>
<th>Day Shift</th>
<th>Target Hours per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert developed staffing grid for varying levels of patient census or attach to this document</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CAs</th>
<th>PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>45-60</td>
<td>1</td>
<td>6-7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Evening Shift
### Project Overview Statement—Executive Summary

**Census** | **Charge** | **RNs** | **CNAs** | **Other**
---|---|---|---|---

**Night Shift**

**Census** | **Charge** | **RNs** | **CNAs** | **Other**
---|---|---|---|---

### Above Staffing Plan Contingent Upon the Following Supports/ Considerations

- The work completed by this unit is unique and requires orientation. SPT nurse fills in for vacations and short notice occurrences.

### Which Situations Require Staffing Variation?

- Sick calls/FMLA/unexpected staff absences

### Chain of Command/ Staffing Decision Tree

#### Process for Staffing Variation

- Designated charge nurse reviews pre-admit clinic schedule and adjusts staffing as needed on a daily basis.
- Charge RN discusses with manager appropriate plan.

### Meals and Breaks

- Daily sheet to track breaks and lunches.
- Staff document on edit logs when breaks or lunches are missed.
- 1200-1300 blocked out of clinic schedule to assist staff in relief for lunches.
Annual Nurse Staff Survey

- Reviewed with charge RNs in June with discussion/action plan.
- Safety issues discussed at daily huddles.
- Designated representatives from each department to assist manager with safety concerns.

Committee Recommendations:

Approved By

Renee Yanchura, Co-Chair
Director Emergency Services, EDO & PCS

Tami Green, RN Co-Chair
Mental Health Unit

Syd Bersante, Market President/Pierce County President SJMC