Attestation Form
Nurse Staffing Coalition
December 12, 2018

I, the undersigned with responsibility for CHI Franciscan St. Clare Hospital (hospital/health system name), attest that the attached staffing plan and matrix was developed in accordance with RCW 70.41.420 for the fiscal year FY19 (July 2018-June 2109) (year) and includes all units covered under our hospital license under RCW 70.41. This plan was 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.

Patrick J. Ahearne
Signature

Patrick J. Ahearne
Printed Name

12/12/2018
Date
# 2019 Staffing Plan Overview

**Department:** Emergency Department  
**Date Updated:** September 16, 2019  
**Author:** Stephanie Earnhardt/Mark Blaney

## Nursing Department Overview

**Description of the types of patients served in this nursing unit:**
- Level IV Trauma Center
- Level II Cardiac Center
- Level III Stroke Center
- Decontamination
- All patients regardless of presenting condition – Patients needing specialty care will be transferred to a higher-level care facility.
- Average Daily Census is 120 patients

## Key Quality Indicators

All Data is current for FY19 (February 2019 – August 2019)
- Patient falls with injury - 1
- Hospital acquired C Diff infections - 0
- Hand Hygiene Compliance – 100%
- Mislables – 6 (down from 22 the previous 6 months)
- Med Errors – 0
- Skill Mix-reflected in the below staffing grid
• Anticipation of staffing needs for upcoming shift is addressed throughout the preceding shift, with finalization of decisions happening approximately 2 hours before the next shift starts

Meals and Breaks

• Nurses, ED Techs, and HUCs relieve each other for meal and rest breaks to ensure that all patients are covered.
• ED Techs will rotate meal/rest breaks such that only one ED Tech is on break at a time.
• ED Techs working as 1:1 sitters will be given relief for their meal or rest break by the ED Tech working in that general area, or as directed by the charge RN.
• HUC will take meal and rest breaks alternating with the charge RN.

Annual Nurse Staff Survey

• Survey results reviewed (PCA) with staff at staff meetings. Identified issues addressed:
  Declutter – Department PMs, room re-do, and improved storage solutions
  Engagement – Shared Governance: UBD, Disaster, Critical Skills, CEN

Current concerns

• Volumes of mental health patients requiring 1:1
• Turnover
• Precepting capacity does not meet the demand
• Upcoming surge

Committee Recommendations:

Prepared By  STEPHANIE EARNHARDT / MARK BLANEY, CLINICAL MANAGERS

Approved By

Next Review Date  March 2020
2018 Staffing Plan Overview

Department: Intensive Care Unit
Date Updated: November 8 2018
Author: Mimi Johnson

Nursing Department Overview

The Intensive Care Unit provides nursing care for critically ill adult patients requiring close monitoring and frequent interventions.

Patients served in this unit are: Respiratory failure or airway compromise requiring invasive mechanical ventilation and accompanying sedative infusions, septic shock/hypotensive patients on vasopressors/inotropes, hypertensive crisis, DKA, myocardial infarction, cardiac arrhythmias, post-cardiac arrest care including hypothermia protocol, GI bleed, ETOH withdrawal, acute renal failure requiring dialysis, presence of arterial line, Rotoprone therapy and end of life care following withdrawal of support.

This unit also cares for PCU and Medical/Telemetry overflow patients, particularly those requiring isolation.

ICU staff are required to respond to Rapid Response and Code Blue calls throughout the hospital in addition to supporting conscious sedation procedures throughout the inpatient units.

- Average Daily Census: 8 patients
- Average Length of Stay: 1.83 ICU level of care 4.69 all pts in ICU

Key Quality Indicators

Outcomes - All data is for FYTD (July 2018-November 2018)
   - ICU Mortality Rate = 6.32% Goal = <8.88%
   - ICU Vent Bundle = 94.44% Goal = 95%
   - ICU Glycemic Control Rate in Range 79.17% - Goal = 85%

Safety – All data is for FYTD (July 2018-November 2018)
   - Patient falls with injury = current = 0
   - Patient falls w/o injury = prior 3 current = 2
   - Pressure Ulcers Count = current = 0
   - Unplanned Self Extubation = 6
   - HAIs – CAUTI (1) CLABSI (1) VAE (1) CDIFF (2)

Updated 10.16.2015
- Bar code medication administration – 95% GOAL 95%
- Smart pump compliance – 97.98% Goal 95%
- Specimen and lab mislabels – 2

Staffing – Rolling 12 months of June 2017-2018
  - Turnover – 36.09%
  - Agency/traveler – ongoing usage as open positions continue averaging 332.5 hrs this fiscal year

Staffing Grid for Patient Census | Target Hours per Patient Day = 17.9

ICU is staffed exclusively by RNs. The usual nurse to patient ratio is 2:1.
* grid below does not show 24 hour sitter coverage budgeted within target

<table>
<thead>
<tr>
<th>Patient Census</th>
<th>Charge RN</th>
<th>RN</th>
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Above Staffing Plan Contingent Upon the Following Supports/Considerations

- Addition of a dedicated Manager to the ICU staffing. (previously this was a shared manager covering critical care – both ICU and PCU)
- The Charge nurse will not routinely assume a patient load and therefore is able to assist staff RNs with patient care, oversee quality indicators, provide support to the Progressive Care Unit and respond immediately to Rapid Response and Code Blue calls.
- Availability of CNAs from other departments to accommodate patients needing a 1:1 sitter and/or availability of virtual sitters.
- Availability of support staff: SWAT, Cardiopulmonary, Dietitian, Social Work, Care Management, ET Nurse, Physical Therapy, Occupational therapy, Speech Therapy, Dietary Services, Environmental Services, Central Supply, Security, Laboratory, Diagnostic Imaging, Interventional Radiology, Transports, Virtual ICU, Remote Monitor Technicians, Palliative Care, Chaplain, Life Center Northwest, Patient Advocate, Core Measures RN, Clinical Support Coordinator and Clinical Nurse Specialist.
**Which Situations Require Staffing Variation**

- Skill mix
  - New grad resident vs experienced ICU nurses
- Patient acuity
  - Level 6 ICU (initiation of hypothermia protocol, “Rotoprone” therapy, post-TPA administration) patients require 1:1 nursing
  - Highly unstable patients may require 1:1 ratio based on CN decision
  - PCU and Medical level of care patients can go to 4:1 ratio with CNA support or 3:1 without CNA support
- Full capacity, internal and external disasters.

**Chain of Command/ Staffing Decision Tree**

**Process for Staffing Variation**

- The Charge Nurse, in conjunction with staffing coordinators and the House Supervisor, is responsible for routinely evaluating staffing levels to ensure an appropriate number of staff are working, with consideration to patient census, acuity and skill mix of nurses.
- The charge nurse monitors the need to add or flex down staff every two hours. They contact the staffing office with need to flex. If discrepancy between staff needed and staff available, the charge nurse contacts the unit manager. The unit manager will contact the staffing office directly at that point.
- Every effort is made to “staff up” on days where we are in full capacity, anticipate a high surgical volume, etc.
- When additional nurses are required due to increased census/acuity, the charge nurse will request additional staff from the staffing coordinator/house supervisor. Prior to overtime staff being called in, patient assignments may be adjusted.
- Low census/on-call is typically granted on a voluntary basis. Nurses may be floated outside the unit if staffing dictates

**Meals and Breaks**

- Breaks are arranged within the unit.
- The ICU must have at least 2 ICU RN’s on the unit at all times.
- It is expected that staff will contact their charge nurse and or manager if they are unable to take their breaks.
- Staff are to edit in the KRONOS log if they are unable to obtain their lunches or rest breaks during their shift.

**Annual Nurse Staff Survey**

- PCA survey was done April of this year pending results.
- Items identified as needing Process Improvement work are brought to the Unit Shared Governance team and reviewed at staff meetings.
• Identified areas that are continuing to work on
  o High Turnover
    ▪ New grads/new to critical care
    ▪ Changes to critical care residency schedule
    ▪ Agency / traveler usage
  o Maintain a free CN whenever possible
    ▪ Support to newer nurses and more readily accommodate for the emergent
      transfer of patients to ICU, thereby improving the safety and quality of care
      for our patients and satisfaction/retention of current staff.
  o Census and Acuity Fluctuations
    ▪ It can be difficult to balance staffing: need for an adequate number of
      nurses to staff the unit with consideration to minimize floating outside the
      unit

Committee Recommendations: accepted with discussion on procedural
sedation support

APPROVALS

Prepared By  MINI JOHNSON, CLINICAL MANAGER

Approved By  Patrick J. Ahearn, MSN Vice-President – COO/CNO

Next Review Date: May 2019
2019 Staffing Plan Overview

Department: Interventional Radiology, SCH
Date Updated: 21 February 2019
Prepared by: Stephen Pawlawski, RT and Susan Clark, RN

Nursing Department Overview

- Description of the types of patients served:
  - All age ranges with the exception of infants and patients less than 16 years of age
  - Inpatients, outpatients, and emergent patients

- IR supports patients requiring moderate sedation for invasive procedures: i.e. port, feeding tube placement, fistulagrams, biopsies, abscess drains, IVC filters, etc. May occasionally have procedures requiring anesthesia

- Pain Management patients may require moderate sedation IV

- Patient cases are done one at a time with one IR physician in IR or CT

- IR receives patients through short stay, inpatient units, or ER

- Pain Management patients are outpatients

- IR sometimes requires transfer to higher level of care. Outpatient sedated patients are discharged home post procedure from SADU

- Average length of IR procedure: 60 minutes

- Average length of Pain Management procedure: 20-40 minutes

- Average monthly IR cases: 120

- Average monthly Pain Management cases: 165

Key Quality Indicators

- "Safe" nursing care on this unit includes but not limited to the 5 approved state indicators:
  - Patient falls prevalence - 0
  - Patient falls with injury - 0
  - Pressure ulcer rate/prevalence - NA
  - Nursing care hours per patient day - NA
  - Skill Mix –RN, Interventional Radiology Tech

- Medication errors - 0

- Central line infections: 0

- Staff turnover / orientation costs - None

Confidential
- Overtime costs / end of shift overtime – On call and call back OT varies
- Agency/Traveler Usage – 0
- Patient Satisfaction Data- rolled into overall DI Health Stream data
- Data from professional organizations NA

### Staffing Grid (IR Service)

<table>
<thead>
<tr>
<th>Day Shift</th>
<th>Charge RN</th>
<th>RN</th>
<th>TECH</th>
<th>HUC</th>
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<tr>
<th>Evening Shift</th>
<th>Charge RN</th>
<th>RN</th>
<th>CNA</th>
<th>HUC</th>
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<tr>
<th>Night Shift</th>
<th>Charge RN</th>
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<th>CNA</th>
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### Above Staffing Plan Contingent Upon the Following Supports/Considerations

- Hours: Monday – Friday 0700 – 1730 On call staff 1730 – 0700
- Saturday and Sunday on-call 0700 – 0700
- Core staffing is set; meets the needs of the department
- Staff share call after hours and on weekends. Core staff for call back 1 RN and 2-RT
- Average call back hours per month: 4 hours

Support that IR provides to other units and departments that impact staffing:

*Short stay does admitting for outpatient IR cases requiring extended post-procedure care*

IR assists US with paracentesis and thoracentesis exams, Echo bubble studies, CT biopsies and abscess drains, renal hydration prior to CT, assist with defacography, manage inpatient and outpatient abscess drains, assist all DI modalities with IV starts and port access when needed, RN resource for all DI modalities for any patient concerns, IR nurses also available for IV starts in inpatient setting and PICC lines when available. RNs also administer narcotics for certain nuclear medicine HIDA patients.
Chain of Command/ Staffing Decision Tree

<table>
<thead>
<tr>
<th>Process for Staffing Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Staff on duty work together in conjunction with the physician and/or PA on duty to plan patient flow and work load</td>
</tr>
<tr>
<td>o Staff low census when patient load is light. Low census is shared in a voluntary manner</td>
</tr>
<tr>
<td>o Staff report to Diagnostic Imaging Manager for daily operations</td>
</tr>
</tbody>
</table>

Areas of questions or concerns

<table>
<thead>
<tr>
<th>Current concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>o No regional DI/IR Nurse Manager</td>
</tr>
<tr>
<td>o For patient care concerns we use Beverly Howe, Director Peri-Operative Services as a resource</td>
</tr>
</tbody>
</table>

Committee Recommendations: Accepted as presented.

APPROVALS

Approved By  Stephen Pawlawski
Manager, Imaging Services

Approved By  Patrick J. Ahearne, MSN Vice President – COO/CNO

Next Review Due:
2018 Staffing Plan Overview

Department: IV Therapy
Date Updated: November 2018
Author: Erin Riggs RN, MN Clinical Manager, Med-Tele & IV Therapy

Nursing Department Overview
- SWAT/IVT team provides a resource throughout the hospital
- Specialized training for inserting PICC lines, midlines, ultrasound guided IV, IV starts
- Able to assist with procedures requiring procedural sedation
- Responds and assists with codes
- Float to department to assist with staffing needs
- Educate staff on PICC line/IV line care and management
- Audit of Central lines and participate in prevalence studies to ensure compliance with policy and procedures.

Key Quality Indicators
- Hospital acquired infections – CLABSI
  - 75 days since last CLABSI
  - Complete weekly audits of central lines
- Bar code medication administration
  - SWAT RNs maintain >95% compliance
- Medication Errors
- Specimen and lab mislabels
- Pain management

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Unit of Service “NEW”</th>
<th>M-Total Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Day Shift</strong></td>
<td><strong>Evening Shift</strong></td>
<td><strong>Fri, Sat, Sun Shift</strong></td>
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<tr>
<td>1 (8 hours)</td>
<td>1 (8 hours)</td>
<td>1 (12 hours)</td>
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Confidential
2018 IV Therapy Staffing Plan November07192017
### Above Staffing Plan Contingent Upon the Following Supports/Considerations

- IV Therapy department to place, monitor PICC lines and start peripheral IV lines
- Staffing plan not based on patient census but more of a fixed staffing grid.

### Chain of Command/Staffing Decision Tree

#### Process for Staffing Variation

- The manager, in conjunction with staffing coordinators and the House Supervisor, is responsible for routinely evaluating staffing levels to ensure an appropriate number of staff is working, with consideration to patient census, acuity and skill mix of nurses.
- If needed, the SWAT nurse will float to departments and/or TBLs to help with staffing needs.
- Low census/on-call is typically granted on a voluntary basis. Nurses may be floated outside the unit if staffing dictates.

### Meals and Breaks

- IV Therapy Staff have autonomy in their scheduling of breaks. They prioritize their responsibilities to include their breaks.
- Monitored by missed breaks in KRONOS and incremental OT. JIT training provided to staff unable to take breaks

### Committee Recommendations: accepted

### APPROVALS

**Prepared By**  
ERIN RIGGS RN, MN CLINICAL MANAGER, MED-TELE & IV THERAPY

**Approved By**  
Patrick J. Ahearné, MSN Vice-President – COO/CNO

**Next Review Date:** May 2019
2019 Staffing Plan Overview

Department: Medical Telemetry
Date Updated: July 18, 2019
Author: Heather Epperson

Nursing Department Overview

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

- **Cardiac/telemetry**: CHF, rapid rule-out MI, medications requiring telemetry monitoring, post-heart cath patients with no sheath present.
- **General surgery**: overflow (when unable to be placed on ortho surgical unit) laparoscopic and open procedures such as cholecystectomy, appendectomy, orthopedic surgery, and gynecology/urology surgery. Also this unit cares for patients undergoing incision and drainage of an abscess.
- **Other diagnoses treated on MTU**: electrolyte imbalances, diabetic crises (hyper/hypoglycemia), stable CVA/TIA, end stage renal/liver diseases, gastrointestinal conditions, acute and chronic respiratory diseases, infectious diseases, altered mental status/psych conditions, failure to thrive, seizure disorders, end of life/hospice/palliative care, and alcohol and drug withdrawal.
- **All patients must be 15 years of age at minimum.**
- Average Daily Census is 37 patients

Key Quality Indicators

All Data is current for FY19 (January 2019-July 2019)

- Patient falls with injury—4 (9)
- Pressure ulcer rate—0 (0)
- CAUTI and CLABSI rate—1 and 0 (0 and 0)
- Hospital acquired MRSA infections—3 (1)
- Hospital acquired Cdiff infections—1 (2)
- Hand Hygiene Compliance—100%
- Nursing care hours per patient day—10.987
- Skill Mix-reflected in the below staffing grid
<table>
<thead>
<tr>
<th>Census</th>
<th>Dayshift &amp; Nightshift</th>
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<tbody>
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**Note:**
- Only staff 5 CNAs if there are 1:1s otherwise 4 CNAs to staff the floor.
- Any "safety" 1:1s need to be absorbed by the scheduled staffing grid above.
Which Situations Require Staffing Variation?

- Patients requiring 1:1 observation (for safety)
- Acutely ill patients
- Census
- Number of patients being held in the Emergency Department/alternate holding areas (waiting for inpatient beds)
- Staffing of other units (floating)
- Availability of SWAT, transporter, lab, cardiopulmonary, environmental services, physical therapy, occupational therapy, dietary, dietitian, diagnostic imaging, pharmacy, chaplain, patient advocate, interventional radiology, social work, care management, speech therapy, wound/skin care nurses, monitor technicians, biomed, clinical support coordinators, volunteer services, and security

Chain of Command/ Staffing Decision Tree

Process for Staffing Variation

- Staffing will be sufficient at all times to assure safe and effective patient care
- Staffing will be adjusted based on the needs of the department and hospital—charge RN reviews current staffing against staffing grid every 2 hours to assess for need to flex up or down with changing census.
- If the Patient Care Services Director, manager, or charge RN determines there is a need to change staffing, they will consult one another as needed. The house supervisor and the staffing office will also be contacted to collaborate and help accommodate changes in staffing needs.
- Anticipation of staffing needs for upcoming shift is addressed throughout the preceding shift, with finalization of decisions happening approximately 2 hours before the next shift starts.

Meals and Breaks

- When possible, 2 nurses and 1 CNA are assigned as a "triad", a primary team to recruit one another when help is needed. These 2 nurses are also designated as "break buddies", so that one would help cover the other's patients during a meal or rest break.
- CNAs will rotate meal/rest breaks such that only one CNA is on break at a time.
- CNAs working as 1:1 sitters will be given relief for their meal or rest break by the CNA or RN working in that general area, or as directed by the charge RN.
- HUC will take meal and rest breaks alternating with the charge RN during dayshift.
Annual Nurse Staff Survey

- Survey results reviewed (PCA) with staff at staff meetings.
- Process Improvement work completed on issues identified—increased employee engagement and retention through unit engagement activities, appointing various unit champions, encouraging participation in unit based council meetings.

Current concerns

- Long stay patients often bring the concern of heavy care and behavior issues that are taxing to staff and sometimes present safety concerns.
- Vacancy rate of 3% currently (3 open positions of 103 total positions)
- Turnover rate of 15.57% (from 15.5%)

Committee Recommendations: Accepted and approved as written 7/11/2019

Prepared By

HEATHER EPPERSON, RN

Approved By

Lois Erickson, COO

Next Review Date

January 2020
2018 Staffing Plan Overview

Department: Ortho Surgical Services
Date Updated: 10/16/2018
Author: Connie Luu and Amanda Mackey

Nursing Department Overview

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

- **Orthopedics:** Hip/knee/shoulder replacements, vertebroplasty for spinal fractures, surgical repair of bone fractures, non-surgical repair of bone fractures.
- **General Surgery:** Laparoscopic and open surgical procedures including vascular surgery.
- **Cardiac/telemetry:** CHF, rapid rule out patients, medications requiring telemetry monitoring.
- **Other:** Electrolyte imbalances, diabetic crisis (hyperglycemia/hypoglycemia), stable cerebral vascular accidents, end stage renal/liver disease, gastrointestinal diagnosis, acute and chronic respiratory disease, circulatory impairments, altered mental status, failure to thrive, heart failure, seizure disorders, infectious disease (non-isolation), alcohol withdrawal, psychiatric, suicidal ideation patients, social/placement admissions, and overflow from the Med/Tele unit and patient placement center.

**All patients must be age 15 or greater.**
- Average Daily census: 31 patients
- Average number of admits: 9 admits/day
- Average number of discharges: 10 discharges/day
- Average number of transfers: 3 transfers/day
- Average length of stay 2.93 from 4.01 days

Data is for a 6 month period of 7/1/17-12/1/17 Unable to obtain current data.

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*
- *Patient falls with injury (April- September 2018) 18 falls with 5 injuries*
- *Pressure ulcer rate/prevalence (April- September 2018) 0 HAPU*
- *Nursing care hours per patient day 10.78*
- *Skill Mix: 31% of RN staff have less than 2 years’ experience*
- Medication errors: 5 for 2018
- Staff turnover/orientation costs: 11% turnover rate
- Overtime costs / end of shift overtime / missed breaks incidental overtime
- Agency/ Traveler Usage

Updated 12.20.2016
Project Overview Statement—Executive Summary

- Patient Satisfaction Data
- Data from professional organizations
- NDNQI Data (Relevant reporting units)

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census 34 Target Nursing Hours per Patient Day 10.78- Off Grid Hours 10.38</th>
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</table>

See grid attached.

Above Staffing Plan Contingent Upon the Following Supports/ Considerations

- Resource Nurse, SWAT, Transporters, Lab, Cardiopulmonary, Housekeeping, Environmental Services, Physical Therapy, Occupational Therapy, Dietary, Dietitian, Diagnostic Imaging, Pharmacy, Chaplain, Palliative care, Hospice, Patient Advocate, Interventional Radiology, Social Workers, Care Management, Speech Therapy, ET nurses/wound care nurses, Monitor technician, Biomed, Clinical Support Coordinator, Volunteer services, and security.
- Charge Nurse supports Rapid Response/ Code Blue throughout hospital.

Which Situations Require Staffing Variation?

- Heavy surgery schedule/ high numbers of fresh post op patients.
- Increased number of isolation patients.
- Increased number of Glucommander/Accucheck patients.
- High discharge and admission rates—may utilized floor nurse as resource nurse.
- EPIC downtime.
- Census of department impacts staffing target: must maintain over 25 patients to meet target.
- Increased 1:1 sitters—more than 1 physical sitter requires RNs to go to a 5:1 ratio with no use of resource RN. Average two physical sitters a pay period (may observe more than one patient). Charge nurse often combines sitter patients.

Chain of Command/ Staffing Decision Tree

<table>
<thead>
<tr>
<th>Process for Staffing Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The charge nurse utilizes the nurses scheduled to work that day as floor or as resource depending on the needs of the department i.e. multiple discharges or Glucommander patients on Day shift. The charge nurse also monitors the need to add or flex down staff every two hours for the 24 hour period. They contact the staffing office with need to flex. If discrepancy between staff needed and staff available, the charge nurse contacts the unit manager. The unit manager will contact the staffing office directly at that point.</td>
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</table>
Meals and Breaks

- Breaks are arranged using the "break buddy system" where nurses are paired off with a CNA and cover each other's lights while the other takes a break.
- OSS has a policy of no more than two nurses taking a break from the floor at one time and no more than one CNA from the floor taking a break at a time.
- It is expected that staff will contact their Charge Nurse and or manager if they are unable to take their breaks. If Resource Nurse assigned, the resource duties include to ensure every staff member has had their breaks.
- OSS has noted a decrease in staff Kronos Edit Logging “missed meal breaks” and since adding the Resource Nurse to assist in ensuring breaks are taken by staff. Without a Resource more staff miss breaks.

Annual Nurse Staff Survey

- Annual PCA Staff Survey results are reviewed with staff at the staff meetings.
- Items identified as needing Process Improvement work are brought to the Shared Governance team and reviewed at staff meetings.
- 2018 PCA Items for Improvement:
  - Staff Development: Planned competency training each staff meeting
  - Staff Recognition: OSS employee of the Quarter. Kudos read at DMB and staff meetings.
  - Conflict resolution: Planned for Winter staff meeting.
  - Reduce turnover: Outside team activities, role development as Resource or mentor or charge nurse.

Committee Recommendations:

- One SWAT to be staffed for day/evening shift to be used as support for the entire hospital.
- One Transporter to be staffed for day/evening shift to be used as support for the entire hospital.
- Unable to support more than one physical sitter with new staffing target

APPROVALS

Prepared By  AMANDA MACKEY RN AND CONNIE LIU CLINICAL MANAGER

Approved By  Patrick J. Ahearné, MSN Vice-President – COO/CNO

Next Review Date  APRIL 2019
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Updated 12.20.2016
# 2018 Staffing Plan Overview

**Department:** Perioperative Services- Operating Rooms  
**Date Updated:** 12/1/2018  
**Author:** Carrie Jensen RN  

## Nursing Department Overview

- Average census 15+ patients in 5 OR suites, Average monthly volume 350+ cases  
- Cases can range from 5 minutes to in excess of 4 hours  
- Patient acuity ranges from healthy to critically ill. Age of patients supported is 6 years and older  
- Hours of operation, Monday-Friday 0715-2130 except Wednesday 0815-2130, 5 OR’s 0715-1700, 2 OR’s 1700-1900, 1 OR 1900-2130 for emergent/urgent cases  
- After hours, weekends and holidays is staffed with on-call staff for urgent/emergent cases  
- Cases supported: Orthopedics, Total Joints, General, Podiatry, Urology, Gynecology, Robotics, Plastics, Minor Vascular, and ENT.

## Key Quality Indicators

- Surgical Never Events (1 noted in November 2018, 1 noted in December 2018)  
- Quality Measures, AHRQ Safety Measures, Readmissions and Surgical Site Infections  
- Patient Satisfaction (HCAHPS)  
- On Time starts  
- Turnover times  
- Prime Time utilization  
- Productivity; Nursing care hours measured per every 1 OR hour; overtime and traveler usage included  
- Staffing/Skill Mix, Staff Turnover/Orientation Costs  
- Employee Satisfaction  
- Patient Falls

Updated 12/20/2016
Project Overview Statement—Executive Summary

Staffing Grid for Patient Census

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<th>Target Variable per 1 OR Hour: 7.51</th>
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<tbody>
<tr>
<td>• Each OR team consists of at least one surgeon, one anesthesiologist, one registered nurse and one scrub technologist.</td>
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<td>• Staffing will be adjusted as needed for more involved cases that require additional support, such as a second scrub tech or circulating RN.</td>
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<td>• Staffing and surgery schedule has oversight by a Charge RN 0600-1930.</td>
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<td>• The OR has additional support staff available: Specialty Resource Nurses, Float RN, and a Float Technologist to retrieve supplies, turn over rooms, and provide breaks to staff to facilitate operational efficiencies and ensure patient safety.</td>
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<td>• 1 Anesthesia Technician (0530-1800) supporting the anesthesia providers</td>
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<tr>
<td>• OR Aides (0700-2030) are scheduled daily supporting the operating rooms and transporting of patients.</td>
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Above Staffing Plan Contingent Upon the Following Supports/Considerations

- Availability of surgeons, anesthesiologists, and surgical assistants
- Availability of specialty equipment and vendor supplies
- Add-on urgent/emergent surgical cases
- Patient census and bed availability in the hospital and PACU
- Acute care rooms and staff availability
- Unit depends on laboratory, cardiopulmonary, material management, patient transport, housekeeping, pharmacy and radiology availability for support

Which Situations Require Staffing Variation?

- Patient acuity and complexity of surgical procedure could necessitate additional staff or variations from usual staffing.
- Local only anesthesia requires 2 RNs per case.
- Often Robotic, Minimally invasive, Total Joint replacement, major abdominal general surgery and some plastic surgery cases require additional scrub personnel.
- On-call cases have only core staffing (1 RN and 1 ST) per operating room

Chain of Command/Staffing Decision Tree

Process for Staffing Variation

- Daily review of surgery schedule to determine staffing needs by Charge RN/Manager
- Flexing shifts up or down depending on surgery schedule.
- Charge RN collaborates with Manager for staffing shortages/overages as they arise.
Meals and Breaks

For the staff members in the operating room with direct patient care responsibilities, meal and rest breaks are provided by float and replacement staff unassigned to other duties. Float personnel are rotated out for rest and meal breaks by other team members not assigned to patient care.

Annual Nurse Staff Survey

- PCA results are reviewed at a minimum of 3 staff meetings per year.

Action Plan items:
- Converted OR Aide to PST positions.
- Promote proper use of Urgent/Emergent blocks and minimize staff fatigue from keeping call team to staff evening hours: moved resident RN moved to evening shift to support case load. Urgent/emergent cases are being reviewed by SCH Periop Operating Committee for appropriateness. Also, staff encouraged to use the IRIS system if appropriate.
- Utilize Smoke evacuation equipment: National Go Clear Award received 4/2017
- Education focus: Increase base knowledge of ENT service line for all staff. Increase core robotic staff. CE Direct available to certified staff to maintain requirements for certification.

Committee Recommendations:

APPROVALS

Prepared By CARRIE JENSEN, RN, CNOR, CLINICAL MANAGER

Approved By Patrick J. Ahearn, MSN Vice-President – COO/CNO

Next Review Date: June 2019
2018 Staffing Plan Overview

Department: Perianesthesia Staffing
Date Updated: 11-18-2018
Author: Nola Byrd and Dana Murphy

<table>
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<tr>
<th>Nursing Department Overview</th>
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<td>o The Perianesthesia department consists of</td>
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<tr>
<td>o Preadmission Clinic</td>
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<tr>
<td>o Surgical Admission/Discharge Unit (SADU) (a.k.a. Short Stay Surgery)</td>
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<tr>
<td>o Post Anesthesia Care Unit (PACU) (a.k.a. Recovery Room)</td>
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<td>o The primary mission is to support the Perioperative Department as a whole by preparing and recovering surgical patients (both in-patient and out-patient).</td>
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<td>o Additionally, GI and IR services are supported.</td>
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**Preadmission Clinic**

| o The preadmission clinic’s role is to prepare patients for surgeries by providing education, obtaining history, and performing/arranging testing prior to the day of surgery. |
| o Two primary pathways: |
|   o Phone calls are used for less complex patients |
|     ▪ Patients are called and questioned regarding their history and provided instruction regarding how to prepare |
|   o Visits |
|     ▪ Patients are seen in person to provide additional opportunity for face to face teaching and diagnostic tests such as labs and ECG |

**Surgical Admission/Discharge Unit**

| o SADU’s roles include: |
| o Preoperative: |
|   ▪ Admission of scheduled inpatients and outpatients |
|   ▪ Holding in-house patients at telemetry or lower levels of care |
| o Post-operative: |
|   ▪ Provision of Phase II/III levels of PACU care (e.g. discharging outpatient surgeries) |
|   ▪ Occasional holding of post-op patients prior to transfer to floor when beds are unavailable |

**Post Anesthesia Care Unit**

| The PACU’s roles include |
|  – Phase I recovery |
|  – Phase II recovery when SADU unavailable. |
|  – Recovery of inpatient GI cases when possible |
|  – Preoperative holding when SADU unavailable (also routinely for isolation cases) |
|  – Support for OR team, esp. during off hours |
Key Quality Indicators

- The American Society for PeriAnesthesia Nurses provides guidelines for staffing:
  Based upon acuity of patients (Phase I vs. Phase II), census, patient flow processes and physical facility
- Surgical Never Events Board (1695 days as of Nov 26, 2018)
- Productivity Review
- Bar Code Medication Administration/Medication Safety
- Patient Satisfaction (HCAHPS)
- Board Rounds with staff involvement to reduce errors and never events and improve safety for staff and patients
- Falls in the last 6 Months: 0
- 1 Traveler used in this last 6 month review to support staff needs while filling vacant positions

Staffing

Pre-admission Clinic Staffing

- Personnel (Dependent on volume and patient health status)
  - 1 Chart Rep/HUC/CNA
    • Provides cross-coverage for SADU and surgery scheduling
  - 1-2 RNs
- Hours:
  - Monday-Friday 0800-1830 except holidays (flex hours as needed)

Standards for Pre-op, Phase II and Phase III

- Varied, based on patient safety, acuity and complexity
- Scheduled Coverage:
  06-2130 Monday-Friday
  1-2 CNAS (between PACU/SADU) and 4-5 RNs Per Day
  (flexible time in; with 8, 10, and 12)
- Pre-op: Patients arrive 2 hours prior to procedure, prep time is 45 minutes to 11/2 hours
- Phase 2: 1 RN to 3 Patients
  » Over 8 years of age
  » 8 years and younger with family present
  1 RN to 2 patients
  » 8 years and younger with no family present
  » Initial admission of patient post procedure
Surgical Admission/Discharge Unit Staffing

- Personnel
  - Staff/ RN/ CAN-HUC
    - Varies dependent upon daily need
    - 4-5 RNs scheduled per typical day
    - Time staggered to meet needs of OR schedule
    - 1-2CNA/HUC (for Perianesthesia unit)
  - Hours:
    - Monday-Friday 0530-1830 except holidays

Standards for Phase I

- Minimum of two RNs, one of whom must be competent in Phase I care, must be present whenever a patient is receiving Phase I care
- 1 RN to 2 patients
  - Two conscious, stable patients
  - One conscious stable patient and an unconscious, stable patient with a secure airway
- 1 RN to 1 patient
  - At time of admission into PACU from OR (usually 10-15 minutes)
  - Patient requiring manual airway support or OPA
  - Patient with respiratory obstruction or distress
  - Any unconscious child under 8.
- 2 RNs to 1 patient
  - A critically ill, unstable patient

Post Anesthesia Care Unit Staffing

- Scheduled coverage
  - 0730 to 2130 Monday through Friday except holidays
  - Generally 4-5 RNs per day staggered to cover cases
- Call coverage of 2 RNs
  - 24/7 except during scheduled hours

Daily Patient Census

Last 3 Months as of 11/26/18: Cases (per Epic Report)

- SCH GI Services Supported Cases
  - OP 69
- SCH OR Cases
  - IP 348
  - OP 679
  - Total: 1027
- Average Daily Census:
  - OR Cases (based on open 5 days a week) Per Day: 17.11
  - GI Cases (based on open 5 days a week) Per Day: 1.15
Support of GI and IR services (increase of outpatient GIs on Monday- Thursday as of Jan 2017)

Frequent holding of post-op patients prior to transfer to floor when beds are unavailable
Preoperative holding in PACU when SADU unavailable

**Chain of Command/ Staffing Decision Tree**

**Process for Staffing Variation**

- 1 charge nurse shared between all three areas
- The Charge nurse is responsible for routinely evaluating staffing levels to ensure an appropriate number of staff is working, with consideration given to patient census, acuity and skill mix of nurses.
- Communication between departments to reallocate resources. Nurses are floated between units to meet the needs of the patients.
- When additional nurses are required due to increased census/ acuity, the Charge nurse will call in resources
- The staff in perianesthesia is cross-trained in all areas to provide flexibility in staffing needs.

**Areas of questions or concerns**

**Current concerns**

- Productivity is 95.7% YTD and 96.7% Current Pay Period
- Huddles take place to help problem solve the daily staffing situation and support the team.
- Staff often feel they are working short staffed even though our productivity states otherwise. We need to have minimum staffing requirements as per ASPAN standards. Add on cases affect this staffing.
Committee Recommendations:

APPROVALS

Prepared By  NOLA BYRD RN AND DANA MURPHY RN

Approved By  Patrick J. Ahearne, MSN Vice-President – COO/CNO

Next Review Date: June 2019
2018 Staffing Plan Overview

Department: Progressive Care Unit
Date Updated: November 2018
Author: Dawn Van Horn and Natasha Fish

### Nursing Department Overview

- The Progressive Care Unit provides monitoring and care for patients with moderate or potentially severe physiological instability requiring technical support with the potential for rapid intervention such as cardiac arrhythmias, DKA, ETOH Withdrawal, MI, Sepsis, Pneumonia, etc.
- Vasoactive / anti-arrhythmic drips such as Dopamine, Nitroglycerine, Amiodarone, Diltiazem and Dobutamine
- PCU does not provide artificial life support
- Average daily Census: 18, down from 19 FY18

### Key Quality Indicators

Outcomes – data available via IRIS system and Quality Dashboard YTD FY19
- Patient falls prevalence - 11 (29 in FY18)
- Patient falls with injury – 2 (5 in FY18)
- Pressure ulcer rate/prevalence - 0 (1 in FY18)
- CAUTI rate – 0 (0 in FY18)
- CLABSI rate – 0 (0 in FY18)
- C diff – 1 (17 in FY18)
- Medication Errors – 2

Safety
- Bar code medication administration – GOAL Nov 2018 95%
- Smart pump compliance – over last FY as low as 92%, upward trend with current rate of 95%

Staffing – Rolling 12 months of June 2018
- Turnover – 16.3 down from 18.5%
- Agency – ongoing usage as open positions continue

<table>
<thead>
<tr>
<th>Staffing Grid for Patient Census</th>
<th>Target Hours per Patient Day</th>
</tr>
</thead>
<tbody>
<tr>
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<td>12.3</td>
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</tbody>
</table>
24 hour coverage with 12 hour shifts during both days and nights for RN and CNA HUC coverage for 12 hours each day (0800-2000)
* no sitter hours budgeted due to decrease in target

<table>
<thead>
<tr>
<th>Patient Census</th>
<th>Charge RN</th>
<th>RN</th>
<th>CNA</th>
<th>HUC</th>
</tr>
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<tbody>
<tr>
<td>18 - 21</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15 - 17</td>
<td>1</td>
<td>5</td>
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<td>1</td>
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<td>12 - 14</td>
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<td>4</td>
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<td>1</td>
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<tr>
<td>9 - 11</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8 or less</td>
<td>1</td>
<td>2</td>
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</table>

Above Staffing Plan Contingent Upon the Following Supports/Considerations
- SWAT, Virtual Companions, Transporters, Lab, Cardiopulmonary, Housekeeping, Environmental Services, Physical Therapy, Occupational Therapy, Dietary, Dietitian, Diagnostic Imaging, Pharmacy, Chaplain, Palliative care, Hospice, Patient Advocate, Interventional Radiology, Social Workers, Care Management, Interventional Radiology, Speech Therapy, ET nurses/wound care nurses, Monitor technician, Biomed, Clinical Support Coordinator, Volunteer services, and security.
- Charge Nurse supports Rapid Response/Code Blue throughout hospital.
- Appropriate skill level mix/assignments
- Anticipated unit activity (admits, discharges, transfers)
- Transportation of patients to imaging when there is no transporter available.

Which Situations Require Staffing Variation?
- Surgical/Emergency department/Patient Placement Center transfer volume variation.
- Increased number of confused patients, high fall risk, or patients on restraints requiring frequent assessment.
- 1:1 sitters for Suicide Monitoring, Detained Psychiatric Patients and confused patients.
- Full capacity, internal and external disasters.
- Increased number of patients requiring complex treatments such as: full physical assistance, tube feedings, dressing changes, multiple drains, central lines, chest tubes, acute pain management, nursing blood draws, trachea care with frequent suctioning, accu checks every 2 hours, continuous bladder irrigation, blood product transfusions, epidural infusions, skin care protocol requiring turning every 2 hours, 1:1 feed patients, incontinence, multiple bed changes, bariatric patients, use of translators, comatose patients, confused/combative, extra support to patient family, or mental health patients.
- Increased complex bedside procedures needing assistance by ICU or SWAT RN: TEE, TTE, bronchoscopy, PICC line placement.
- Increased number of code blue/rapid response calls during the shift.
- Number of newly hired employees in the residency program.
- Increased number of isolation patients.
## Chain of Command/Staffing Decision Tree

### Process for Staffing Variation

- The Charge Nurse, in conjunction with staffing coordinators and the House Supervisor, is responsible for routinely evaluating staffing levels to ensure an appropriate number of staff are working, with consideration to patient census, acuity and skill mix of nurses.
- The charge nurse monitors the need to add or flex down staff every two hours. They contact the staffing office with need to flex. If discrepancy between staff needed and staff available, the charge nurse contacts the unit manager. The unit manager will contact the staffing office directly at that point.
- Every effort is made to "staff up" on days where we are in full capacity, anticipate a high surgical volume, etc.
- When additional nurses are required due to increased census/acuity, the charge nurse will request additional staff from the staffing coordinator/house supervisor. Prior to overtime staff being called in, patient assignments may be adjusted or the SWAT nurse may be pulled to work in the unit.
- Low census/on-call is typically granted on a voluntary basis. Nurses may be floated outside the unit if staffing dictates

### Meals and Breaks

- Breaks are arranged using the "break buddy system" where staff are paired off with another like staff and cover each other while the other takes a break.
- It is expected that staff will contact their charge nurse and or manager if they are unable to take their breaks.
- PCU utilizes the Kronos Edit log to monitor whether or not the "break buddy system" is working.

### Annual Nurse Staff Survey

- PCA survey was completed in April 2018
- Items identified as needing Process Improvement work are brought to the Shared Governance team and reviewed at staff meetings.
- Identified areas that are on PCA Action Plan
  - Keeping Staff, Communication, Personal Recognition
Committee Recommendations: Accepted as submitted

APPROVALS

Prepared By  DAWN VANTHORN, CLINICAL MANAGER

Approved By  Patrick J. Ahearné, MSN Vice-President – COO/CNO

Next Review Date: May 2019
2018 Staffing Plan Overview

Department: SCH Specialty Outpatient Infusion
Date Updated: October 8, 2018
Author: Deberie Connor, Manager

Nursing Department Overview

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

- Average Daily census: 17 – 26 patients
- Average length of stay: 30 minutes to 7 hours
- Services include: Administration of chemotherapy, antibiotics, biologics/immunologics, bisphosphonates, blood and blood product transfusion, Darbepoetin alfa, Denosumab, hydration, IVIG, SQ and IM injections, therapeutic phlebotomy, patient teaching and education, plasma exchange and apheresis
- Serving patients age 14 and up and weighs at least 100 lbs.

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 procedure: 1.128
- *Skill Mix: RNs, PAR, CA2 (vacant)
- Medication errors: 1 in 6 months
- Staff turnover/orientation costs: None
- Overtime costs / end of shift overtime: 0.77%
- Agency/ Traveler Usage: 1
- Patient Satisfaction Data: Press Ganey
- Data from professional organizations
- NDNQI Date (Relevant reporting units):

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<th>Target Hours per Procedure 1.128</th>
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<tr>
<td>Day Shift</td>
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<table>
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<th>Charge</th>
<th>RNs</th>
<th>PAR</th>
<th>CA2</th>
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</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>2 then review for possible reduction</td>
<td>1</td>
<td>1 then review for possible reduction</td>
</tr>
<tr>
<td>15 – 16</td>
<td>1</td>
<td>2 then review for possible reduction</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>&lt; 14</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
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</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 Tech for medication preparation
- Laboratory Services
- Diagnostic Imaging
- Environmental Services
- Nurse Navigators and Nurse Coordinator

Which Situations Require Staffing Variation?

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

- Patient cancellation, reschedule or No Show
- New patients with High Alert Medication requiring frequent monitoring
- Sick calls

Chain of Command/Staffing Decision Tree

Process for Staffing Variation

- The charge RN 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 staffing depending on patient volume and acuity
- The manager and charge nurse are notified when staffing shortages exist and every attempt is made to ensure staffing does not affect the care of the patients.
- Schedule may be adjusted if the department is not able to accommodate the volume due to low staffing level.

Meals and Breaks

- Staffs are provided breaks and lunches as required and are encouraged to do so after safely handing off their patients to another RN.
- 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 12 and 1 pm unless approved by the charge nurse
- If staffing 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.
Committee Recommendations:

Approved By

[Signature]

Patrick J Ahearne, MSN
Vice President – COO/CNO
St Clare Hospital

Date

10/19/2018