2019 Staffing Plan Overview

Department: Endoscopy Services
Date Updated: November 2019
Author: Karen McLean, Endoscopy Manager

Nursing Department Overview

Description of the types of patients served in this nursing unit, including level of intensity and nature of care delivered: St. Elizabeth Hospital Endoscopy Lab is a 2-procedure room endoscopy suite that provides Gastroenterology (GI) procedures for both outpatients and inpatients. Only one procedure room is used at a time. Hours of operation are Monday-Wednesday and Friday, 0600-1800 (department may close depending on physician availability). *Propofol is being offered as primary sedation for patients. In the even the patient does not qualify for or refuses Propofol sedation, moderate sedation is also available.

For fiscal year 2019 (FY19):
- Average number of admits/discharges per day: Procedures are scheduled for 30-45 minutes. The procedure room can accommodate 15 procedures per day.
- Average length of stay : 2 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 asterix*:  

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Department Specific Data</th>
<th>Acute Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient falls prevalence*</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Patient falls with injury*</td>
<td>Falls with NO Injury</td>
<td>Falls with MINOR Injury</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medication Errors</td>
<td></td>
<td>A = Near Miss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

Updated 05.04.2017
<table>
<thead>
<tr>
<th>Mislabeled Specimens</th>
<th>0</th>
</tr>
</thead>
</table>
| Patient Satisfaction Data* | • Communication with Nurses = 95th Percentile; goal is 75th Percentile  
• Responsiveness of Hospital Staff = 61st Percentile; goal is 75th Percentile  
• Communication about Medicines = 86th Percentile; goal is 75th Percentile  
• Discharge Information = 94th Percentile; goal is 75th Percentile  
• Overall Rating of Hospital = 93rd Percentile; goal is 75th Percentile |
| Living our Mission Dashboard | Budget Metric* = Volume (Endoscopy Procedures)  
• FY19 Target = 3.6500  
• FY19 Actual = 3.6856 |
| Skill Mix* | • RNs = 4  
• Endoscopy Techs = 2-3 |
| Level of Experience (e.g. specialty Certifications and training) | Mandatory training / education:  
• ACLS (All RNs)  
• Safe Patient Handling & Movement (annually)  
• FAIRE Day (annually)  
Specialty Certifications:  
• GI Certification (optional after 2 years as GI nurse) |
| Agency / Traveler Usage | FYTD Average Contract Staff Hours = None |
| Overtime costs (including end of shift, missed meal and rest breaks and incidental OT) | FYTD Average OT Percentage = 3.66% |
| Staff turnover (Note: does not include transfers to other departments or other CHI-FH facilities) | Total Turnover = 19.51% (October 2018 – September 2019)  
• Voluntary Turnover = 2  
• Involuntary Turnover = 0  
• Internal Transfers = 0 |

**Staffing Grid for Patient Census** (Target Nursing Hours per = 3.6500 vs. Actual Nursing Hours = 3.6856)

Use this section to insert staffing grid(s) developed for varying levels of patient census or attached the department staffing grid to this document.

Staffing is determined on the number of procedure rooms in operation.
- The Endoscopy (GI) Lab requires an Admit RN, Documentation RN, Procedure Assistant (RN/Endo Tech) and Recovery RN
- One additional Endo Tech is scheduled to perform cleaning and high-level disinfection of endoscopes.
- A second documentation RN is utilized for efficiency but may be used as a float nurse for breaks.

There is one manager that oversees the Endoscopy Lab and a surgery scheduler at SJMC who is responsible
Nurse Staffing Plan

for charge entry.

- Day Shift = 10-hour shifts

<table>
<thead>
<tr>
<th>Number of Procedure Rooms</th>
<th>RNs</th>
<th>Endo Techs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>2</td>
<td>Float</td>
</tr>
</tbody>
</table>

- There is no evening or night shift
- A float person (usually a tech) has been approved for use on Mondays and Wednesdays, from 9am to 3pm, when the procedure schedule is full.
- Floats on additional days are to be requested and approved by the GI Manager.
- Staffing guidelines are governed and adopted by national nursing profession SGNA.

Above Staffing Plan Contingent Upon the Following Supports / Considerations

List other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

Support Provided:
- None

Support Received:
- Acute Care, ED and FBC will provide support with RRT, Code Blue and Code Gray calls in GI Lab
- Propofol sedation support is provided by Anesthesia MDs and CRNAs
- In the event an Endo Tech is not available to wash scopes, this department can request resources from the Sterile Processing Department (SPD).
- Float Pool CNA can be requested to provide patient transport and bed turn around in the event of low staffing in the department.

What Situations Require Variations in Staffing?
Use this section to describe legitimate situations where additional staff may be required in order to provide safe patient care:
- None

How are Deviations in the Staffing Plan Addressed?
Describe ways that day to day staffing shortages are addressed to ensure patient care and safety is not compromised:
- This department employs per diem RNs and Endo Techs to provide PTO/sick call coverage

Chain of Command / Staffing Decision Tree

Process for Staffing Variation

What process is used to determine if extra staff is needed?
- If there is insufficient staff to provide care for patients for the following day, the Admit RN or delegate will call the HRN and request support in form of a Float Pool CNA. If this is unavailable, the
Admit RN or delegate will contact the Manager.

When is extra staff scheduled for the entire shift, versus pulling staff from other areas to help nurses “catch up”?

- When available, a float person is scheduled two days a week, from 9:00am-3:00pm, to help facilitate staff breaks and moving patients through the department. Throughput tends to be provider-influenced; additional support is provided on select days of the week for this reason.

### Meal and Rest Breaks

**What are the meal and rest break requirements for your department?**

- The basic workday shall include a 30-minute meal period on the nurse’s own time. This should be taken between the second and fifth working hour. It cannot be taken at the beginning or end of the shift and cannot be combined with rest breaks.

- Employees shall receive one 15-minute paid rest period for each 4 hours of work. It should be taken at or near the middle of each shift, but no later than 3 hours after the beginning of each half shift. They cannot be taken at the beginning or end of the shift and cannot be combined with meal breaks.

**Describe what the meal and break strategies are for your area and how you measure if they are working.**

- The department is closed for procedures during the 11:30am to 12:30pm hour to facilitate lunch breaks.

- The department provides additional staff two days a week when it is more common for staff to miss breaks.

- Staff are to utilize natural breaks in the schedule (unfilled procedure slots, cancellations, etc.) to get rest breaks.

- This department has a second documentation RN that is utilized for efficiency but may be used as a float RN for breaks.

### Annual Nurse Staff Survey

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

- Performance Culture Assessment (PCA) survey results

- Department staff meetings and email

**What process improvement work has been completed on issues identified?**

- Open discussion with staff to identify barriers to getting 100% of meal and rest breaks

- Staff were offered two options to help with meal and rest breaks — (1) schedule a 15-minute break into the daily schedule or (2) have an extra float person available during shift

**What was the results/plan of action?**

- Staff chose the option of adding a float person to the staffing matrix two days per week.

- This was fully implemented in February 2019.
Layout of Patient Care Unit

See Addendum A – Floor plan for Endoscopy including, placement of patient rooms, treatment areas, nursing stations, medication prep areas, and equipment.

Committee Recommendations:

APPROVAL
Prepared By: KAREN MCLEAN, ENDOSCOPY MANAGER
Approved By: RENEE YANCHURA, COO
Next Review Date: JULY 2019
# 2019 Staffing Plan Overview

**Department:** Family Birth Center  
**Date Updated:** 10.9.2019  
**Author:** Jennifer Duran, Family Birth Center Manager

## Nursing Department Overview

Description of the types of patients served in this nursing unit, including level of intensity and nature of care delivered: OB triage, labor and delivery care, newborn transitions, level 1 nursery, mother baby couplet care, and low acuity med surge overflow.

- Average Daily census – (Last 6mo includes obs and neo) 4.09
- Average number of admits per day – Actual – 2.1
- Average number of transfers per day – 1.5 pts/mo (1 maternal 8 neonates)
- Average number of discharges per day - Actual – 1.8
- Average length of stay – Actual – 1.49 (down from prior of 1.57)

## 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 asterix*:

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>1 CYTD (syncopal episode)</th>
<th>Falls with MINOR injury</th>
<th>Falls with Major Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient falls prevalence*</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patient falls with injury*</td>
<td>Falls with NO injury</td>
<td>Falls with MINOR injury</td>
<td>Falls with Major Injury</td>
</tr>
<tr>
<td>Pressure Ulcer Prevalence*</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Line Infection Prevalence</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter Associated UTI Prevalence</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Onset</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Nurse Staffing Plan

### CDiff

<table>
<thead>
<tr>
<th>Medication Errors</th>
<th>4 CYTD: 1 incorrect handling of med, 1 delay in abx, 1 error in dose administration, 1 adverse drug reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> = Near Miss</td>
<td><strong>B</strong> = Error, Did Not Reach Pt</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### Mislabeled Specimens

2 CYTD

### Patient Satisfaction Data*

- Communication with Nurses = 94 %tile [goal 83.2%]
- Responsiveness of Hospital Staff = 99%tile [goal 73.2%]
- Provider Communication = 95% % tile [goal 84.4%]
- Overall Rating of Hospital = 81%tile (goal 78.2%)
  
  (All values cumulative results since Nov 18)

### Budget Metric*

- Target: 19.06 hours/patient day
- 21.25 actual FYTD (86.8% productivity FYTD)

### OB Specific Quality Data for the last 12 mo

- Term Singleton Vertex (TSV) Cesarean Birth Rate: 7.0% (goal <=20.8%)
- Early Elective Delivery: 0% (Franciscan 0.8%, WSHA MDC 1.4%)
- Nulliparous TSV C/S rate: 14.3% (goal <=19.4%)
- Exclusive Breast feeding: 80.5% (Franciscan 71.5%, WSHA MDC 69.9%)
- Severe Unexpected Newborn Complications: 16.9 per 1000 (WSHA rate of 24.7)
- Severe Maternal Morbidity 2.3% (WSHA rate of 1.8%)

### Skill Mix*

- Charge RN = no
- RNs = 2-3+ (2 is minimum staffing at all times, 3 are scheduled most shifts)
- CNAs = 0
- Techs = 0
- HUCs = 0

### Level of Experience (e.g. specialty Certifications and training)

- Mandatory training / education: BLS, NRP, ACLS-OB, STABLE, External Fetal Monitoring
- Specialty Certifications:
  - Inpatient OB, External Fetal Monitoring, International Board Certified Lactation Consultant, Low Acuity Nursery = 33% of staff certified (Up from 21% last report)

### Agency / Traveler Usage

- None this FY
- Travel RNs from HealthTrust are contracted to help cover staff on long-term medical leave (e.g. maternity leave) or to cover other full-time vacancies.
### Nurse Staffing Plan

| Overtime costs (including end of shift, missed meals and rest breaks and incidental OT) | • FYTD Average OT Percentage = 0.89%  
• Average OT Hours (08/11/19-10/05/19) = 11.4 hours |
|---------------------------------------------|---------------------------------------------------------------|
| Staff turnover (Note: does not include transfers to other departments or other CHI-FH facilities) | Total Turnover = 17.45%  
• Voluntary Turnover = 4  
• Involuntary Turnover = 0  
• Internal Transfers = 0 |

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**Staffing Grid for Patient Census**

**Target Nursing Hours per patient day = 18.7**

Use this section to insert staffing grid(s) developed for varying levels of patient census or attach the department staffing grid to this document.

<table>
<thead>
<tr>
<th>Couplets</th>
<th>Any Labor (active or 1:1 care)</th>
<th># of RNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>3* (if scheduled (call in 3rd RN o/c for breaks/active labor)</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>3* (Add 1 RN for each additional hour meeting 1:1 AWHONN requirements)</td>
</tr>
</tbody>
</table>

- RN Staff on shift come to a consensus and make a recommendation to the HRN
- When no HRN is in house and an active labor is admitted 3 RNs will be staffed until recovery.
- Flexing can be at the discretion of the staff due to acuity or risk factors of patients in the unit or scheduled for procedures
- For questions regarding staffing levels the FBC manager or manager on call can be a resource for staff.
- Staffing guidelines are governed and adopted by national nursing profession Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN)
Above Staffing Plan Contingent Upon the Following Supports / Considerations

List other supports that your unit either receives from other units/departments or provides to other units and departments that impact staffing.

**Support Provided:**
- FBC supports the hospital by floating to assist with tasks as needed during high census
- FBC supports Code RRT / Code Blue calls throughout hospital
- FBC supports the all other units by doing OB evaluations, lactation support and perinatal loss support for patients with other medical needs throughout the hospital

**Support Received:**
- ED and ACU provides support with Code RRT / Code Blue calls in FBC
- Respiratory Therapy provides support with attending delivery for newborn transitions, EKGs, SVNs, Incentive Spirometry, etc.
- SWS provide support with social needs of patients and coordination for discharge
- Float RNs or CNAs provide occasional help with phones, locked unit door and tasks on high volume days
- HRN provides support for emergent situations until minimal staffing can be met and assistance with coordinating services for OR or higher level of care transfers

**What Situations Require Variations in Staffing?**
Use this section to describe legitimate situations where additional staff may be required in order to provide safe patient care:
- Any high acuity patient with complex care or high risk conditions (preterm, non-reassuring fetal status, maternal compromise, infants with respiratory, temperature, or glucose instability)
- Multiple heavy care patients (fresh post-op, pain control, un-medicated childbirth, near term or feeding issue newborns, CPS or mental health concerns)
- Multiple outpatient triages
- RNs in OR for newborn care up to 3 hours off of floor
- See AWHONN ratios (addendum B)

**How are Deviations in the Staffing Plan Addressed?**
Describe ways that day to day staffing shortages are addressed to ensure patient care and safety is not compromised:
- On call or non-scheduled staff will come in at premium pay if able. RNs may stay past scheduled shifts on a voluntary basis.
- Scheduled procedures may be rescheduled or put on hold
- The FBC manager will take patients if we are short staffed due to short notice occurrence and no other staff are available.
- The HRN, float staff, or other staff being cut from other departments may come to help with tasks.
Chain of Command / Staffing Decision Tree

**Process for Staffing Variation**

What process is used to determine if extra staff is needed?
- Staff identifies needs per AWHONN guidelines, current acuities and anticipated acuities.

Who notifies whom?
- Staff notify HRN, then manager of FBC or manager on call as needed.

When in the shift should this occur?
- Ongoing, minimum of 2 hrs prior to shift change.

When is extra staff scheduled for the entire shift, versus pulling staff from other areas to help nurses “catch up”
- N/A

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**Meal and Rest Breaks**

What are the meal and rest break requirements for your department?
- The basic workday shall include a 30-minute meal period on the nurse’s own time. This should be taken between the second and fifth working hour. It cannot be taken at the beginning or end of the shift and cannot be combined with rest breaks.
- Employees shall receive one 15-minute paid rest period for each 4 hours of work. It should be taken at or near the middle of each shift, but no later than 3 hours after the beginning of each half shift. They cannot be taken at the beginning or end of the shift and cannot be combined with meal breaks.

Describe what the meal and break strategies are for your area and how you measure if they are working.
- Staff break each other or sometimes use on call staff if census has increased. Edits in the Kronos log are written when they are not completely relieved for duty for meal breaks or are unable to take any break due to census or pt load.

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**Annual Nurse Staff Survey**

Are survey results reviewed with staff? What format was used? (staff meetings, shift huddles, e-mail)
- PCA and Safe Staffing Survey results are reviewed at staff meetings.
- Key areas for improvement are identified and action plans developed as a group to address them.
- Suggestion box has been implemented for staff to have easy access to communication with dept manager and shared governance rep for any staffing or satisfaction concerns.

What process improvement work has been completed on issues identified?
- OR/OB workouts:
  - C-section urgency standard communication
  - Algorithm for competing cases and OR call crew with labor in house
- ED/FBC standard work for OB patients presenting for care
- SBAR to administration regarding frontline staff concerns for safety-net during no HRN shifts
What was the results/plan of action?

- Emergent OB drills crash C-section training and competency annually
- Safety huddle for shift to shift safe handoff implemented
- Standard staffing for active labor with no HRN in house.

**Layout of Patient Care Unit**

- See Addendum A – Floor plan for Family Birth Center including, placement of patient rooms, treatment areas, nursing stations, medication prep areas, and equipment.

**Committee Recommendations:**

**APPROVAL**

Prepared By  

[Signature]

Jennifer Duran RNC, FBC Manager

Approved By  

[Signature]

Renee Yanchura, Interim COO

Next Review Date  

[Signature]
Addendum B: Per AWHONN guidelines

2 RNs: 1 pt for the following:
- Delivering Woman (1 maternal, 1 NRP provider)
- Critically ill, documented unstable mother
- Critically ill, documented unstable newborn

1 RN: 1 pt for the following:
- 1hr post epidural
- 2hr post initiation of Mag Sulfate
- Each infant until stable
- Active labor 5cm or > without pain intervention or receiving intermittent auscultation for fetal assessment
- 2nd and 3rd stage of labor
- Triage for the first 20 mins
- Active labor with documented obstetric or medical complications and/or comorbidities
- Any woman on insulin drip
- Oxytocin induction or augmentation
- 1 hr after PACU from cesarean birth
- Intermediate unstable newborn
- 2 hr post vaginal birth or until hemodynamically stable, perineal repair and initial assessment complete
- Fetal distress/Documented category 3 fetal tracing

1 RN: 2 pts
- Woman receiving cytotec for cervical ripening
- Woman in active labor without complications
- Woman with epidural >1 hour post placement
- Women recovering from cesarean on 1st post op day
- Antepartum women on Magnesium Sulfate >2hrs from initiation

1 RN: 3 pts
- Triage after initial 20 min assessment
- Non-stress test patients
- Antepartum with complications documented as stable condition
- Postpartum with complications documented as stable

1 RN: 4 stable “couplets” (mother baby pair) with the following considerations:
- If a woman is receiving magnesium sulfate the nurse should have no more than one other stable couplet or patient.
- If a mother is a 1st time mother or on her 1st postoperative day the nurse should have no more than 2 other stable couplet or patients.
2019 Staffing Plan Overview

Department: Acute Care Services
Date Updated: August 15, 2019
Author: Anne Kent, Acute Care Nurse Manager

Nursing Department Overview

Description of the types of patients served in this nursing unit, including level of intensity and nature of care delivered: Acute Care is a combined Medical-Surgical and Critical Care unit. We serve inpatient, observation and extended recovery status patients under med-surg, med-tele, PCU, and ICU level of care. We also serve swing bed inpatients. Patients can range in age from 4-years-old to 100+ years old and may be admitted for a variety of medical or surgical diagnoses.

For fiscal year 2019 (FY19):
- Average Daily census (including observation) – 14.30 patients (↑ from 13.82) – Goal 15.5 patients
- Average number of admits per day – 4.50 patients (↑ from 4.20)
- Average number of transfers per day – Data not available
- Average number of discharges per day – 4.37 patients (↑ from 4.22)
- Average length of stay (excluding swing bed) – 3 days (↓ from 3.75) – Goal ≤ 4 days (96 hrs)

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 asterix*:

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Department Specific Data Acute Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient falls prevalence*</td>
<td>FY19 Total = 13 falls</td>
</tr>
<tr>
<td>Patient falls with injury*</td>
<td>Falls with NO Injury</td>
</tr>
<tr>
<td></td>
<td>Falls with MINOR Injury</td>
</tr>
<tr>
<td></td>
<td>Falls with MAJOR Injury</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Pressure Ulcer Prevalence*</td>
<td>FY19 = 0 HAPUs</td>
</tr>
<tr>
<td>Central Line Infection Prevalence</td>
<td>FY19 = 0 CLABSIs</td>
</tr>
<tr>
<td>Catheter Associated UTI Prevalence</td>
<td>FY19 = 0 CAUTIs</td>
</tr>
<tr>
<td>Hospital Onset C. diff</td>
<td>FY19 Total = 2 hospital acquired infections (HAIs)</td>
</tr>
</tbody>
</table>

Updated 05.04.2017
### Nurse Staffing Plan

<table>
<thead>
<tr>
<th>Medication Errors</th>
<th>FY19 Total = 37 med errors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34 errors in Med Surg</td>
</tr>
<tr>
<td></td>
<td>3 errors in Critical Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A = Near Miss</th>
<th>B = Error, Did Not Reach Pt</th>
<th>C = Reached Pt, No Harm</th>
<th>D = Reached Pt, No Harm, Required Monitoring / Intervention</th>
<th>E = Reached Pt, Cause Harm, Required Monitoring / Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>10</td>
<td>18</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

| Mislabeled Specimens | FY19 = 2 mislabeled specimen |

<table>
<thead>
<tr>
<th>Patient Satisfaction Data*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses = 86.2% (Goal = 83.2%)</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff = 71.7% (Goal = 73.2%)</td>
</tr>
<tr>
<td>Communication about Medicines = 72.0% (Goal = 68.9%)</td>
</tr>
<tr>
<td>Discharge Information = 92.5% (Goal = 83.2%)</td>
</tr>
<tr>
<td>Care Transitions = 57.8% (Goal = 57.4%)</td>
</tr>
<tr>
<td>Overall Rating of Hospital = 79.1% (Goal = 78.2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living our Mission Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget Metric*</td>
</tr>
<tr>
<td>Budget Metric = Hours Per Patient Day (HPPD)</td>
</tr>
<tr>
<td>FY19 Target = 14.38</td>
</tr>
<tr>
<td>FY19 Actual = 15.14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skill Mix*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge RN = 1 each shift</td>
</tr>
<tr>
<td>RNs = 5 staffed each shift, ratios based on patient mix</td>
</tr>
<tr>
<td>CNAs = 2 staffed each shift working at 10:1 patient ratios</td>
</tr>
<tr>
<td>Techs = Not applicable</td>
</tr>
<tr>
<td>HUCs or CA/HUCs = 1 staffed 0700-1530; 1 staffed 1500-2330</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of Experience (e.g. specialty Certifications and training)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory training / education:</td>
</tr>
<tr>
<td>Charge RNs &amp; Critical Care RNs</td>
</tr>
<tr>
<td>o ACLS Certification</td>
</tr>
<tr>
<td>o PEARs or PALS Certification</td>
</tr>
<tr>
<td>o Essentials of Aggression Management</td>
</tr>
<tr>
<td>o Procedural Sedation Competency</td>
</tr>
<tr>
<td>o NIH Stroke Scale Certification</td>
</tr>
<tr>
<td>Medical Surgical RNs</td>
</tr>
<tr>
<td>o BLS Certification</td>
</tr>
<tr>
<td>o PEARs Certification</td>
</tr>
<tr>
<td>o Essentials of Aggression Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Certifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMSRN = 6 Med Surg RNs (32%)</td>
</tr>
<tr>
<td>PCCN = 1 ICU RN (6%)</td>
</tr>
</tbody>
</table>
Nurse Staffing Plan

Agency / Traveler Usage
- FYTD Average Contract Staff Hours = 655.25
- Agency RNs from Favorites Staffing are used on a per diem basis. There is 1 Med Surg RN who pick up an average of 4 shifts each month prior to taking an FTE in ICU.
- Travel RNs from HealthTrust are contracted on a regular basis to help cover staff on long-term medical leave (e.g. maternity leave) or to cover other full-time vacancies.

Overtime costs (including end of shift, missed meal and rest breaks and incidental OT)
- FYTD Average OT Percentage = 2.45% (Target is ≤ 2.00%)
- FYTD Average OT Hours PPE 7/27/2019= 70.13 hours

Staff turnover (Note: does not include transfers to other departments or other CHI-FH facilities)
- Total Turnover = (July 2018 – June 2019)
  - Voluntary Turnover = 7 employees
  - Involuntary Turnover = 4 employees
  - Internal Transfers = 3 employees

Staffing Grid for Patient Census  (Target Nursing Hours per = 14.38 vs. Actual Nursing Hours = 15.26)

Nurse to patient ratios are as follows:
- Medical-Surgical & Telemetry = 5 patients per MS RN
- Progressive Care Unit = 3 patients per CCU RN
- Intensive Care Unit = 2 patients per CCU RN

Based on the current average daily census of 14.30 patients, the department would be staffed with the same number of Charge RNs, bedside RNs, CNAs, and HUCs, but the nurse to patient ratios would be adjusted based on skill mix needed to accommodate patient level of care.

The Acute Care Charge RN is responsible for following department staffing guidelines as well as contract guidelines when determining staffing needs and assignments. The Charge RN may adjust staffing levels to meet patient care needs, including but not limited to call for additional staff as needed.

The Charge RNs have more detailed staffing guidelines they follow to determine the number of staff required based on patient census and skill mix needed. Except for night shift, which does not have a HUC scheduled from 2300 to 0700, nurse staffing needs do not change between day shift and night shift. Ideally, all RNs should be maxed at their respective ratios BEFORE a standby RN is called back into work.
Although Acute Care can accommodate up to 6 critical care patients at one time, using med-surg rooms 300 and 301 as PCU overflow, it does not mean the department can always have 6 critical care patients. The nurse to patient ratios for ICU and PCU are different, and critical care patient accommodations are based on the number of critical care staff available, not the number of rooms.

Of note, WAC 246-320-261 does not differentiate between PCU and ICU patients, and two critical care nurses are still required to be on staff. Specifically, the WAC states, “if providing a critical care unit or services, hospitals must assure at least two licensed nurses skilled and trained in critical care, on duty and in the hospital at all times, when patients are present, and immediately available to provide care to admitted patients.”

Below is a table that demonstrates how many critical care patients can be bedded at SEH based on the minimum of 2 ICU RNs on staff at one time.

<table>
<thead>
<tr>
<th></th>
<th>Maximum ICU &amp; PCU Patient Mix Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If we have ((X)) ICU patients,</td>
</tr>
<tr>
<td></td>
<td>then we can have ((X)) PCU patients</td>
</tr>
<tr>
<td></td>
<td>for a combined ICU &amp; PCU census of...</td>
</tr>
<tr>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Above Staffing Plan Contingent Upon the Following Supports / Considerations

List other supports that your unit either receives from other units/departments or provides to other units.
and departments that impact staffing.

**Support Provided:**
- Acute Care supports the ED by providing 1:1 sitters (CNAs and RNs as available)
- Acute Care supports RRT, Code Blue and Code Gray calls throughout the hospital
- Acute Care Charge RNs provide support for discharge planning
- Acute Care Charge RNs provide Pharmacy support when there is no HRN coverage

**Support Received:**
- ED and FBC provide support with RRT, Code Blue and Code Gray calls in Acute Care
- CNA Float Pool provides support when there are sitter needs, sick calls, medical leave, or CNA shortages for any other reasons
- Hospital Resource Nurse (HRN) provides support when there are sitter or staffing needs
- Respiratory Therapy provides support with codes, EKGs, SVN1s, CPT, IS, etc.
- IV Therapy trained RNs provide support with PICC placements
- PT/OT/Speech Therapy provide support with rehabilitation services and therapy needs of patients
- Dietitian provides support for nutritional needs and education of patients
- Care Management provides support with utilization review and discharge planning
- Social Work provides support with mental health evaluations and discharge planning
- Virtual Health Services provide support with cardiac monitoring, virtual companions for 1:1 sitters, critical care monitoring (PICU), and patient admissions and care needs (vFIT)

**What Situations Require Variations in Staffing?**
Use this section to describe legitimate situations where additional staff may be required in order to provide safe patient care:
- Multiple high acuity patients with complex treatments (e.g. blood transfusions, insulin drips, cardiac drips, frequent suctioning, pain management issues, etc.)
- Multiple heavy care patients (e.g. comatose, turn q2h, frequent incontinence, 2 person assist, bowel preps, frequent linen changes, etc.)
- Multiple confused patients (e.g. Rainier School, impulsive, sitter, restraints, behavioral health/detained, etc.)

**How are Deviations in the Staffing Plan Addressed?**
Describe ways that day to day staffing shortages are addressed to ensure patient care and safety is not compromised:
- If staffing shortages involve inadequate ICU staffing (e.g. less than 2 CCU RNs on staff) then patient transfers are pursued for PCU and ICU patients and the hospital closes to critical care admissions.
- The Charge RN may take a patient assignment of either med surg or critical care patients depending on their skills set and the department needs.
- The CA/HUC may be reassigned CNA duties to provide more direct patient care.
- Staff are floated from other hospital departments into Acute Care, including CA/HUCs, RNs and HRNs.
- The Clinical Coordinator or Manager help with Charge Nurse functions or sitter needs when necessary.
Chain of Command / Staffing Decision Tree

Process for Staffing Variation

What process is used to determine if extra staff is needed?

- Frontline staff (HUCs, CNAs, and RNs) can express their concerns to the Charge Nurse if they feel their workload is not manageable and can request that additional staff be brought in.
- Charge Nurses use the “Rationale for Staffing Outside of Guidelines” form to help justify the need to bring in extra staff or to be able to articulate to frontline staff why they are not bringing in extra staff.

Who notifies whom?

- Charge Nurses are often in direct communication with the Acute Care Nurse Manager when they feel assistance is needed with staffing.
- The Charge Nurse notifies the HRN if they are calling in staff placed on standby.
- The Charge Nurse also notifies the HRN before sending staff home on low census or placing them on standby due to low census.

When in the shift should this occur?

- Charge Nurses are expected to evaluate staffing levels on an ongoing basis during their shift and flex appropriately for low census, even if it is mid-shift.
- At a minimum, staffing levels should be assessed every 4 hours.

When is extra staff scheduled for the entire shift, versus pulling staff from other areas to help nurses “catch up”?

- Staff are rarely pulled from other areas to Acute Care if there is extra Acute Care staff already available. If needed, the Charge Nurse may schedule an additional RN or CNA for the entire shift.
- When Acute Care is short staffed due to sick calls, medical leave, bereavement, etc. then staff may be pulled from other areas, most often Family Birth, to help nurses catch up.

Meal and Rest Breaks

What are the meal and rest break requirements for your department?

- The basic workday shall include a 30-minute meal period on the nurse’s own time. This should be taken between the second and fifth working hour. It cannot be taken at the beginning or end of the shift and cannot be combined with rest breaks.
- Employees shall receive one 15-minute paid rest period for each 4 hours of work. It should be taken at or near the middle of each shift, but no later than 3 hours after the beginning of each half shift. They cannot be taken at the beginning or end of the shift and cannot be combined with meal breaks.

Describe what the meal and break strategies are for your area and how you measure if they are working.

- Staff cover one another for meal and rest breaks; med-surg RNs cover med-surg patients and critical care RNs must cover critical care patients.
- Acute Care Break Nurse utilized during 1100-1500 and 2300-0300 to ensure break coverage.
- Staff are expected to notify their Charge Nurse if they need assistance getting their meal or rest
breaks.
- The Acute Care Charge Nurse may be responsible for covering the critical care RN for breaks if they have critical care competencies.
- The Acute Care Charge Nurse coordinates with the HUC to take their breaks at separate times.

**Annual Nurse Staff Survey**

Are survey results reviewed with staff? What format was used? (staff meetings, shift huddles, e-mail)
- Performance Culture Assessment (PCA) survey results are shared with staff via power point during the department staff meetings.
- Department staff meetings are the main forum where survey results are shared. Other survey results shared have also included the Culture of Safety survey.

What process improvement work has been completed on issues identified?
- Identify vacancies and prioritize replacement of personnel
- Submit FTE requests within one week of employee resignation or termination
- Increase the number of staff in the RN and CNA per diem pools
- Increase the number of critical care RNs scheduled on a daily basis
- Build non-productive coverage into the staffing schedule for day shift and night shift

What was the results/plan of action?
- Increasing the number of per diem nurses to 8 RNs (4 Med Surg and 4 ICU)
- Increased the number of per diem float pool care assistants to 11 CNAs
- When all positions are filled, we have 3 critical care RNs scheduled on day shift 6-7 days each week and 3 critical care RNs scheduled on night shift 6-7 days each week
- When all positions are filled, we have 6 days each week with non-productive coverage on day shift and 6 days each week with non-productive on night shift

**Layout of Patient Care Unit**

See Addendum A – Floor plan for Acute Care including, placement of patient rooms, treatment areas, nursing stations, medication prep areas, and equipment.

**Committee Recommendations:**

**APPROVAL**
Prepared By: **ANNE KENT, ACUTE CARE NURSE MANAGER**

Approved By: **Renee Yanchura, COO**

Next Review Date: **February 2020**
2019 Staffing Plan Overview

Department: Perioperative Services and Infusion Center
Date Updated: 5/10/2019
Author: Cindy Bess

Nursing Department Overview

Description of the types of patients served in this nursing unit,
- Average Daily census - 8 surgery patients including inpatient surgeries and outpatient surgeries, in room OR minutes up 4.6% from last year; from 2-8 infusion center patients daily.
- Average number of admits/discharges/transfer: 8
- 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*:
- *Patient falls prevalence - 0
- *Patient falls with injury - 0
- *Pressure ulcer rate/prevalence - 0
- *Nursing care hours per patient day – Periop: worked hours/per OR Hours, per unit target 11.6, and worked hours/per PACU hours, per unit target 2.4
- *Skill Mix – RN, Surgical Tech, Supply Coordinator, HUC, Clinical Coordinator, Manager, SPD Tech
- Medication errors – No med errors. PYXIS audits done monthly, two RNs randomly chosen or picked due to classification on PYXIS reports. Pain audits done monthly
- Staff turnover/orientation costs – no orientation hours in six months, stable staff, only one surg tech per diem position posted
- Overtime costs – FYTD 3.06%, 628.07 hours, $42,380
- Agency/Traveler Usage – FYTD 66.30 hours, $2,669
- Patient Satisfaction Data – Press Ganey Patient Satisfaction Survey

Workload Statistic: Operating Room worked hours per unit Target 11.6; or PACU worked hours per unit Target 2.4

Variable Budget FTE 16.2 (Surgery Services) Budget FTE 10.38 Recovery Services

Day Shift

<table>
<thead>
<tr>
<th>Census</th>
<th>Charge</th>
<th>RNs</th>
<th>CAs</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>One OR patient</td>
<td>1 Charge RN</td>
<td>1 RN</td>
<td>1 Surg Tech</td>
<td>1 PACU RN</td>
</tr>
</tbody>
</table>

Evening Shift – No Evening or Night Shift in Periop. One team of OR RN and OR Surg tech
starts at 9:00 am and works until 5:30 to cover cases that run late and urgent add on cases. On call crew of 1 RN, 1 Surg Tech, 1 PACU RN, 1 anesthesia provider. SADU RNs and SPD limited call. SADU call weekdays from 4:30 or 5:00 to 11 pm. Weekends 8 am to 8 pm. SPD call on weekends only from 7:00 to 3:30 Sat and Sun.

Above Staffing Plan Contingent Upon the Following Supports/ Considerations

Which Situations Require Staffing Variation?
Use this section to describe legitimate situations where additional staff are required to provide safe patient care
- Sterile core team or float relief team is the emergency team when there is an emergency case.
- Sick calls require pulling from the sterile core team or float/break team.
- PACU staffing must be assessed for emergent and add on cases as well.
- Currently planning PACU meeting to discuss second call for PACU RNs using per diem RNs as well.
- Heavy surgery schedule/ high numbers of fresh post op patients.
- Increased number of isolation patients.
- Staff on call the previous night who came in and worked are given priority for time off the next day if patient census allows.
- Increased number of Infusion Center patients.
- Heavy FBC potential for C-section patients or epidural needs which the anesthesia providers are required to be available to monitor
- V-BAC program and decision to go to C-section.

Chain of Command/ Staffing Decision Tree

Process for Staffing Variation
- The HRN is notified of sick calls via text or phone calls. If no connection is made by staff, they must then try to reach Surgery Charge RN. They must have contact with a person. Sick calls are absorbed by using sterile core team or float team for resources. If necessary, the Charge RN will be in an OR as a circulator and the Clinical Coordinator or Manager takes over Charge Nurse position.
- Staff must call in 2 hours prior to their scheduled shift
- If there is a pediatric or ICU level patient for PACU there must be two PACU Phase I trained RNs at all time.
- If there is a pediatric patient < or equal to 8 years old there must be two PACU RNs.
- There must be an anesthesia provider for each OR and one available for FRC at all times.
- Huddles are called spontaneously between Charge RNs, leads, and anesthesia when changes in staffing are needed to handle the census or emergencies.
- Charge Nurses are in direct contact with the Manager and Clinical Coordinator for staffing issues and decisions.
### 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.

  Meal and breaks are arranged by the Charge Nurses, using existing staff or in the OR, the float team which is designed for breaks and lunches. Charge nurses step in to act as relief if there are sick calls.
  Morning breaks are given between 8:30 and 10:00 based on when the staff member started their shift. Lunches are given between 11:00 and 1:30. Afternoon breaks are given between 1:30 and 3:30.
  SADU/PACU staffing model slated to change within the next few months with a .9 position from 0800 to 1530 created just for breaks/lunches.

  Please see attached Perioperative Department Staffing Policy.

### Annual Nurse Staff Survey

- **Survey results reviewed with staff?** PCA survey for staff satisfaction is done annually. Normally the survey results are discussed at staff meetings, shift huddles, email and we do a check and adjust meeting partway through the year.

- **Process Improvement work completed on issues identified** – yes, issues identified addressed mid-year with staff.

- **What was the results/plan of action?** Keeping staff informed of changes and asking for input wherever possible

### Committee Recommendations:

### APPROVALS

**Prepared By**  
CINDY BESS, PERIOPERATIVE SERVICES MANAGER

**Approved By**  


Next Review Date


