The following is an updated nurse staffing plan for Trios Health, submitted to the Washington State Department of Health in accordance with Revised Code of Washington 70.41.420.

The following nurse staffing plan replaces the nurse staffing plan previously submitted to the Washington State Department of Health.
Nurse Staffing Coalition

January 31, 2019

I, the undersigned with responsibility for Trios Health, attest that the attached staffing plan and matrix was developed in accordance with RCW 70.41.420 for 2020, and includes all units covered under our hospital license under RCW 70.41. This plan was developed with consideration given to the following elements:

- 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 patient care 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.

This staffing plan was adopted by the hospital on: March 26, 2020

As approved by

John Solheim, CEO
Nurse Staffing Plan Purpose

This plan was developed for the management of scheduling and provision of daily staffing needs for the hospital, and to define a process that ensures the availability of qualified nursing staff to provide safe, reliable and effective care to our patients. This plan applies to all parts of the hospital licensed under RCW 70.41.

Nurse Staffing Plan Principles

- Access to high-quality nursing staff is critical to providing patients safe, reliable and effective care.
- The optimal staffing plan represents a partnership between nursing leadership and direct nursing care staff.
- Staffing is multifaceted and dynamic. The development of the plan must consider a wide range of variables.
- Data and measurable nurse sensitive indicators should help inform the staffing plan.

*These principles correspond to The American Nursing Association Principles of Safe Staffing.

Nurse Staffing Plan Policy

- The nurse staffing committee (committee) is responsible for the development and oversight of the nurse staffing plan to ensure the availability of qualified nursing staff to provide safe, reliable and effective care to our patients.
- The committee’s work is guided by its charter.
- The committee meets on a regular basis as determined by the committee’s charter.
- The committee’s work is informed by information and data from individual patient care units.
  Appropriate staffing levels for a patient care unit reflect an analysis of:
    - Individual and aggregate patient needs;
    - Staffing guidelines developed for specific specialty areas;
    - The skills and training of the nursing staff;
    - Resources and supports for nurses;
    - Anticipated absences and need for nursing staff to take meal and rest breaks;
    - Hospital data and outcomes from relevant quality indicators; and
    - Hospital finances.

*The American Nurses Association does not recommend a specific staffing ratio, but rather to make care assignments based on acuity, patient needs and staff competencies.

- The analysis of the above information is aggregated into the hospital’s nurse staffing plan. Each individual patient care unit may use the Nurse Staffing Committee Checklist to guide their work.
- Staff continuously monitor individual and aggregate patient care needs and make adjustments to staffing per agreed upon policy and collective bargaining agreement (if applicable).
- The committee will perform a semiannual review of the staffing plan. If changes are made to the staffing plan throughout the calendar year, an updated staffing plan will be submitted to DOH.
- The hospital is committed to ensuring staff are able to take meal and rest breaks as required by law, or collective bargaining agreement (if applicable). The committee considers breaks and
strategies to ensure breaks when developing the plan. A global break policy may be used, or individual patient care units may have discretion in structuring breaks to meet specific needs while meeting the requirements of the law. Data regarding missed or interrupted breaks will be reviewed by the committee to help develop strategies to ensure nurses are able to take breaks.

**Nurse Staffing Plan Scope**

*Acute care hospitals licensed under [RCW 70.41](https://example.com) are required by law to develop a nurse staffing plan. The plan must cover areas of the hospital that: 1) are under the hospital's license (RCW 70.41) and 2) where a nurse(s) provides patient care (i.e., “patient care unit”).*

The following areas of the hospital are covered by the nurse staffing plan:

- Emergency Department
- Ambulatory Care Unit
- GI Lab
- Cardiac Cath Lab
- Perioperative Services
- 2N Medical Unit
- 3N Surgical Unit
- Intensive Care Unit
- Infusion Center
- Family Birthing Center
- Special Care Nursery

**Nurse Staffing Plan Critical Elements**

The following represents critical elements about the nurse staffing plan:

Staffing schedules are based on projected patient census and acuity demands. Adjustments to the schedule are made based on fluctuations in census, activity, and/or acuity, utilizing additional staff as necessary and available. Additional staff is called in by the Nursing Department Leadership or House Supervisor.

Basic nurse staffing patterns have been established by each nursing unit. These patterns are based on historical staffing data, patient days, nursing hours per patient day required to deliver safe nursing care, budget information, quality improvement data, acuity, ages of patients served, specialty qualifications, staff competencies, technologies used as well as patient satisfaction data.

The utilization of skill mix is made in accordance with laws governing nursing practice and the scope of the Nurse Practice Act for the State of Washington. The following skill mix and nurse staffing patterns are defined by each unit. Physician clinics have established staffing levels.

**Low Census**

Nursing staff members may be placed on low census and/or on call, according to policy, if scheduled staffing exceeds the need. On call requires the nurse to remain available for immediate recall to duty at
the hospital during the nurse’s regularly scheduled shift. Low census without call releases the nurse from further duty at any time during the nurse’s regularly scheduled shift. The determination is made to either low census or low census on call a nurse based on patient acuity, staff skill mix and competency of nursing staff members.

Meal and Break Coverage:

Trios Health is committed to ensuring that our staff receive rest break and meal breaks. The goal for the Charge Nurses is to have a lighter patient load (or no patient load if at all possible) in order to collaborate with team members to cover breaks and lunches. The nurse assigned to go for his/her break will report off to the Charge and/or Resource Nurse (a role within the staffing matrix—not additional) who will assume responsibility for the group of patients assigned to the nurse taking a meal or rest break. Rest breaks and meal break will either be assigned at the beginning of a shift by the Charge Nurse or have sign-up sheets each shift. Clear communication by the staff nurse with the Charge Nurse when he/she cannot take a scheduled meal or rest break is imperative to ensure all staff receive breaks in a timely manner. Some departments may have a more proscribed assignment of break coverage due to case load/timing such as cardiac catheterization lab, endoscopy, OR and PACU. Reason for missed or interrupted meal or rest breaks are documented by the charge nurse. If a rest break or meal break is interrupted and an employee is able to take a complete rest or meal break at the earliest reasonable time during which the employee is required to receive a rest break, the rest break or meal break is considered to have been taken.

Department Specifics:

Emergency Department
The Emergency Department is staffed with a minimum of three RNs 24 hours per day, seven days a week. One RN is assigned as Charge/Triage Nurse. Additional staff are utilized based on census and acuity, including secretarial clerical support and technicians. Ancillary departments also add to the interdisciplinary patient care team. Staffing ratios for the Emergency Department can range from 1:1 to 1:4 depending on acuity. For periods of time, trauma activations, STEMI activations and stroke activations are 2:1 and some nurses will exceed the 1:4 ration to meet department demand, but this is not a general staffing practice. Emergency Department nurses respond to other departments when Codes (code blue and rapid response team) are called. Generally, start times of various shifts mirror the yearly average patient volume per hour of presentation. Some changes are made to accommodate seasonal fluctuations. Each shift will have a designated Charge Nurse to facilitate throughput, answer EMS calls and to overhead page activations and code calls within the unit and on the floors. Each shift will have a Triage Nurse or direct bedding is utilized to facilitate eyes on patients presenting to the department. Lunch and breaks are scheduled and tracked by the Charge Nurse on each shift. A sheet is posted at the nurse’s station and is submitted to the Director daily with the staffing sheet. If lunches or breaks are missed, the reasons are documented on this sheet.

Medical Surgical Units (2North Medical and 3N Surgical)
There must be at least two RNs on each shift. Other skill mix utilized consists of nursing assistants with support from secretarial staff. Staffing is based on acuity, census and patient care needs. Ancillary departments also add to the interdisciplinary patient care team. The staffing for Med/Surg RN staff to patients is 1:5 on day shift and 1:6 on night shift. Each shift will have a designated Charge Nurse. Day
shift Charge RNs should not be assigned a patient team but they may take patients transitionally
to facilitate throughput or if they deem they have the ability to accept a patient(s) while meeting the
responsibilities of the Charge RN role. Night shift Charge Nurse patient pre-assignment should be no
greater than 2 and they may also take a patient assignment transitionally or if they deem they have the
ability to take an additional patient(s). The Charge Nurse duties may include but not be limited to:
respond to emergencies, answer overhead page activation and code calls throughout the house and act
as a resource to staff. There is a posted signup sheet at the nurse’s station. Meal and breaks will follow
the process outlined above under heading “Meal and Break Coverage.”

Perioperative Services
Pre-Anesthesia- at least one RN, supplemented by a CNA when warranted by patient volume. Breaks
and meal breaks are scheduled between patient visits.

Operating Room- One RN is assigned as Charge Nurse. The scrub may be
an RN, LPN or surgical technician. Additional support staff include a scheduler and anesthesia assistant,
as well as OR environmental services employees. Case scheduling and complexity of cases determine
the daily assignments including the specific complement of staff assigned to each case. Breaks and
lunches are assigned by the OR Supervisor or the Charge Nurse. If a scheduled break time falls during a
case the Charge will assign a nurse to relieve the RN scheduled for break.

Post Anesthesia Care Unit (PACU)
At least two RNs must be staffed in PACU at all times of operation. One RN must be Phase I competent.
Charge Nurse assigns breaks and meal breaks based on the anticipated time between arriving cases
from OR.

Ambulatory Care Unit
The ACU is open Monday thru Friday from 5:45 a.m. to 7:00 p.m. and on Saturday and Sunday from 6:30
a.m. to 7:00 p.m. Schedules include 8 hour and 12 hour shifts.
At least two RNs must be in the unit during hours of operation. One RN is assigned as Charge Nurse.
Other personnel utilized include CNAs and HUCs. Staffing is based on acuity, staffing matrix, and nursing
hours adjusted for rapid turnover of outpatient beds. Overall, the ACU will have a nurse-patient ratio of
1:3 or 1:4 and our core staffing model will be 7-11 RNs supported by a CNA/HUC and a Scheduler
(Monday-Friday). On Saturdays and Sundays, there will be two RN’s to provide patient care. Staffing will
flex up or down as needed based on daily volume and complexity. There is a posted signup sheet at the
nurse’s station. Meal and breaks will follow the process outlined above under heading “Meal and Break
Coverage.”

Endoscopy
One RN and a second RN or GI tech is assigned to Endoscopy Monday through Friday 7:00am-3:30pm.
One RN and a second RN or GI tech will cover call after 3:30pm weekdays and on weekends.

Cardiac Cath Lab
Two Cath Lab trained RNs shall be assigned to the Cath Lab Monday through Friday 7:00am-3:30pm.
Four Cath Lab trained Special Procedures Techs shall be assigned to the Cath Lab, Monday through
Intensive Care Unit (ICU)/ Intermediate Care/Pediatrics
There are to be at least two qualified RNs on each shift. Two ICU trained RNs shall be assigned to ICU when Intensive Care Status patients are present. One Pediatric trained nurse shall be assigned when pediatric patients are present. Special circumstances may support augmentation with additional ancillary staff. The staffing ratio for ICU RN staff to patients is 1:2. The staffing ratio for Pediatric RN staff to patients is 1:4. Intermediate Care RN staff to patient ratio is 1:4. Pediatric/IMC total care assignment will be 1:3. Each shift will have a designated Charge Nurse and the goal is they will not be assigned any patients in order facilitate throughput. The charge nurse may take up to 2 patients transitionally. There is a posted signup sheet at the nurse’s station. Meal and breaks will follow the process outlined above under heading “Meal and Break Coverage.”

Family Birthing Center
A minimum of six RN/LPN trained Labor and Delivery/Post-Partum of which one should be a Special Care Nursery RN for high risk deliveries if only single RN required in Special Care Nursery. Minimum of 1 trained scrub tech in house at all times. Staffing ratios for the Family Birthing Center can range from 1:1 to 1:3 depending on acuity of the patient. Acuity is based on the AWHONN guidelines. Each shift will have a designated Charge Nurse to facilitate the flow of the department, provide primary care for triage and antepartum testing, assist with C/Sections and emergencies, be a staff resource and provide secondary well baby catching. Each shift will have a Resource nurse to be the designated well baby catcher, provide meal breaks, and be the secondary triage and antepartum testing nurse. Meal and breaks will be scheduled and tracked by the charge nurse on each shift. If lunches or breaks are missed, the Charge nurse will document the reason on the staff assignment sheet. There is a posted signup sheet at the nurse’s station. Meal and breaks will follow the process outlined above under heading “Meal and Break Coverage”.

Special Care Nursery
A minimum of two RNs required in house if minimum of 1 infant in Special Care Nursery. Second RN available in house for high risk deliveries to be floated to Family Birthing Center as part of the core staffing. Ancillary departments also add to the interdisciplinary patient care team. Staffing ratios for the Special Care Nursery can range from 1:1 to 1:3 depending on acuity of the patient. Acuity is based on the AWHONN guidelines. Each shift will have a designated Charge Nurse (unless only one nurse needed) to facilitate the flow of the department and be a resource to other staff. Depending on acuity in the Special Care Nursery and staffing, an additional Special Care Nursery RN will be floated to the Family Birthing Center to assist with high risk deliveries. Lunch and breaks are provided with collaboration with other team members. There is a posted signup sheet at the nurse’s station. Meal and breaks will follow the process outlined above under heading “Meal and Break Coverage.”
Infusion Center
The nurse patient ratio for the Infusion Center is based on the complexity of nursing service required. Staffing will flex up and down based on volume and intensity of service. The Infusion Center offers outpatient services to Trios Medical Group Oncology and Hematology patients. Patients are scheduled for chemotherapy and biotherapy infusions/injections, symptom management, growth factors, central line blood draws and flushes, iron infusions, phlebotomy, and other services as needed. Outpatient oncology nursing includes treatment administration, patient and family teaching, psychosocial support, patient counseling, care of central lines, pumps, patient assessments, toxicity management and facilitating referrals for community resources and understanding of oncology, immunology, community health, rapid assessment skills, as well as expert competency in outpatient treatment regimens and their side effects, leadership as direct caregiver, and collaborator. Acuity levels vary by severity of patient illness, the complexity of nursing service required, and the complexity of the treatment regimen. The nurse to patient ratio for patients actively receiving chemotherapy is 1:4. Some infusions may require 1:1 patient care for a period of time. The patient turn-over rate in the outpatient setting is high. Staffing will flex up or down as needed based on daily volume. Staffing includes two RNs with one designated as Charge Nurse. Additional support staff include NAC/HUC staff, Scheduler, and Charge Specialist. Breaks and Meal breaks will follow the process outline above under “Meal and Break Coverage.”

Float Team
The float team includes RN and unlicensed sitter positions. Assignments and patient ratio is dependent on the department to which they are assigned for the shift. Meal and Rest Breaks will follow the assigned department’s process.

House Supervisor
There is one RN House Supervisor 24 hours per day, 7 days per week.
Nurse Staffing Plan Matrices

The following matrices are to be used in conjunction with the description of ratios in the above departmental narratives.

### Emergency Department Staffing Matrix

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Days 0600</th>
<th>Days 0700</th>
<th>Days 0800</th>
<th>Evenings 1100</th>
<th>Evenings 1200</th>
<th>Evenings 1300</th>
<th>Nights 1700</th>
<th>Nights 1800</th>
<th># Staff</th>
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<tr>
<td>RN (12 hrs)</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<td>MUC (10 hrs)</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>15</td>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<td>15</td>
</tr>
</tbody>
</table>

Total: 3 shifts 5 days 24 hr 5 days 24 hr 5 days

### 2 North Medical/3 North Surgical Units Staffing Matrix

<table>
<thead>
<tr>
<th>Days/Shifts</th>
<th>No. of Patients</th>
<th>Charge</th>
<th>Med/Surg RN</th>
<th>MUC</th>
<th>Total DAY staff</th>
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</thead>
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</tr>
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<td>Evenings 1100</td>
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<td>Nights 1700</td>
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<td>Nights 1800</td>
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</table>

24 hr Staff: 2 | 4 | 6 | 10 | 10

Highlight: Indicates patients that could include up to two transitional patients that will discharge from the unit and if the Charge RN feels that the unit does not need additional staff to accommodate the patient population during the transition period they will staff according to the lower number.
Operating Room Matrix

Standard Surgical Cases
- 1 RN Circulator/1 patient
- 1 Scrub (either RN or Tech)/1 patient

Complex Surgical Cases (ex: Robotics, Total Hip/Knee, Urology Laser, Neuro/Spine, Trauma)
- 1 RN Circulator/1 patient
- 2 Scrub (either RN or Tech)/1 patient

Non-Anesthetic Provider Cases (Local Anesthesia)
- 1 RN Circulator/1 Patient
- 1 Scrub (either RN or Tech)/1 patient
- 1 RN Local Anesthesia Monitor

Ancillary Staff
1 RN Supervisor
1 RN Charge (Supervisor may act in this role as volumes dictate)
1 Pre-Anesthesia Clinic RN
1.5 Scheduler/Biller
1 Anesthesia Tech
4 Environmental Services Tech (adjusted based on volumes)

On-Call
1 RN Circulator/1 patient
1 Scrub (either RN or Tech)/1 patient
*3:15pm-6:45am Monday pm – Friday am, 3:15pm-7:00am Friday pm – Monday am

Staffing reflects AORN staffing guidelines

PACU Matrix

Phase 1 Level of Care:
- 2 RN’s, 1 of whom is an RN competent in Phase 1 post anesthesia nursing, are in the same unit
  where the patient is receiving Phase 1 level of care.
  - Phase 1 level of care:
    - Class 1: 2—1 nurse to 2 patients who are
      - 1 unconscious, stable, without artificial airway, and over the age of 8
        years; and 1 conscious, stable, and free of complications.
      - 2 conscious, stable, and free of complications.
      - 2 conscious, stable, 8 years of age and under, with family or competent
        support staff member present.
- Class 1:1—1 nurse to 1 patient
  - At the time of admission, until the critical elements are met.
  - Unstable airway.
  - Any unconscious patient 8 years of age and under.
  - A 2nd nurse must be available to assist as necessary.
- Class 2:1—2 nurses to 1 patient
  - 1 critically ill, unstable, complicated patient.

Critical elements can be defined as:

- Report has been received from the anesthesia professional, questions have been answered, and the transfer of care has taken place.
- Patient has a secure airway.
- Initial assessment is complete.
- Patient is hemodynamically stable.

Examples of an unstable airway include, but are not limited to, the following:

- Requiring active interventions to maintain patency, such as manual jaw lift or chin lift.

Phase 2 Level of Care:

- 2 competent personnel, one of whom is an RN competent in Phase 2 post anesthesia nursing, are in the same room where the patient is receiving Phase 2 level of care. An RN must be in the Phase 2 PACU at all times while a patient is present.
  - Phase II level of care
    - Class 1:3—1 nurse to 3 patients who are
      - Over 8 years of age.
      - 8 years of age and under with family present.
    - Class 1:2—1 nurse to 2 patients who are
      - 8 years of age and under without family or support staff member present.
      - Initial admission of patient post procedure.
    - Class 1:1—1 nurse to 1 patient
      - Unstable patient of any age requiring transfer.

*Staffing will reflect ASPAN’s “Patient classification/recommended staffing guidelines”, and will vary dependent upon surgical volumes.*
### Cardiac Cath Lab Staffing Matrix

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<th>Day of the Week</th>
<th>RN 0700-1530</th>
<th>RN 1530-0700</th>
<th>Special Procedures Tech 0700-1530</th>
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### ICU Staffing Matrix

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<th># of Patients</th>
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<th>NAC/HUC</th>
<th>Manager</th>
<th>Total Day Staff</th>
<th>Charge</th>
<th>RN</th>
<th>NAC/HUC</th>
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<td>12</td>
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<td>2</td>
<td>0.33</td>
<td>9.33</td>
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<td>13</td>
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<td>14</td>
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<td>1</td>
<td>7</td>
<td>2</td>
<td>0.33</td>
<td>10.33</td>
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<tr>
<td>Day of the Week</td>
<td>Charge Nurse 0700-1730</td>
<td>RN 0700-1730</td>
<td>NAC 8 hour Shift start times may vary</td>
<td>HUC *Per Diem Shift start times may vary</td>
<td>Scheduler 10 hour</td>
<td>Charge Specialist 7 hour</td>
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<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<td>1</td>
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<tr>
<td>Wednesday</td>
<td>1</td>
<td>3</td>
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<td>1</td>
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<tr>
<td>Thursday</td>
<td>1</td>
<td>3</td>
<td></td>
<td>1</td>
<td>1 (8 hr)</td>
<td>1 (8 hr)</td>
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<tr>
<td>Friday</td>
<td>1</td>
<td>1</td>
<td>1 (4 hours)</td>
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<tr>
<td>Staff/Pt Ratio</td>
<td>Family Birthing Center Worksheet</td>
<td># Pts</td>
<td>#Staff Needed</td>
<td># Pts Added</td>
<td>Staff Added</td>
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<tr>
<td></td>
<td>Unit Secretary</td>
<td>N/A</td>
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<td></td>
<td>Charge RN</td>
<td>N/A</td>
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<td></td>
<td>Resource RN</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Scrub</td>
<td>N/A</td>
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<td>1</td>
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<td></td>
<td>Circulator</td>
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<td></td>
<td>Recovery RN</td>
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<td>SCN RN</td>
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<td></td>
<td>2nd Scrub Tech(if &gt;2 C Sections/BTL scheduled and/or anticipate 5+ discharges OR scheduled NST, 4+ labors, VBAC, SCN assist (may be on call for partial shifts)</td>
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<table>
<thead>
<tr>
<th>Staff/Pt Ratio</th>
<th>Family Birthing Center Worksheet</th>
<th># Pts</th>
<th>#Staff Needed</th>
<th># Pts Added</th>
<th>Staff Added</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1</td>
<td>Active labor patients with Pitocin/&gt;3cm/Epidural</td>
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<td></td>
<td>Patients on Magnesium (except stable PP mom or non contracting antepartum)</td>
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<td></td>
<td>Unstable antepartum patients(preterm labor progressing, PIH with frequent assessments, unstable blood sugars, active vaginal bleeding, non-reassuring FHR, patients receiving &gt;4 medications/shift</td>
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<td></td>
<td>VBAC/TOLAC</td>
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<td></td>
<td>C section admission (2 hours prior to surgery to 2 hours post surgery or until stable)</td>
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<tr>
<td></td>
<td>Recovery x2 hours ALL PATIENTS</td>
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<td></td>
<td>Fetal demise up until 3 hours post partum</td>
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<tr>
<td>1:2-3</td>
<td>Stable antepartum patients</td>
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<tr>
<td></td>
<td>Stable postpartum mom on magnesium</td>
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<td></td>
<td>Induction with prostaglandins: Cytotec, Cervadil</td>
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<td></td>
<td>Normal PP moms and babies (each couplet counts as 2 patients, so 3 couplets = 6 patients)</td>
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</tbody>
</table>

Recovery Room Care-RN will be in constant attendance until criteria met. One RN for mom and one staff member to monitor infant recovery for each infant. Minimum 2 RNs will attend every birth (vaginal or c section). One for mom, one for each baby. Also, a person able to intubate must be present (RT or CRNA)

CORE STAFFING: Charge, Resource, Scrub, Circulator, Recovery, SCN=Total 6 RN/LPN staff members
Special Care Nursery

*Score each baby’s acuity according to the highest level of care given for time period.
**For shift of admission, discharge, or CPS meeting day, increase to next level for that shift ONLY. (i.e. F1 to F2, and at least an F2)

<table>
<thead>
<tr>
<th>Code for Admission</th>
<th>Status</th>
<th>Example of Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>Wellborn Infant 0.25 FTE</td>
<td>Needs to stay in nursery due to maternal absence or illness. Ex: awaiting adoption or CPS placement. Baby catching for high risk deliveries (0.25 each shift)</td>
</tr>
</tbody>
</table>
| F                  | Newborn Level I Focused #0171 1:3-4 Nursing Care AWHONN F1 0.25 FTE < 5 items F2 0.33 FTE ≥ 5 items | Low Complexity Care needs are stable but require frequent evaluation and observation during the immediate PP period:  
- Routing bilirubin and blood glucose monitoring (or single therapy)  
- Observation post resuscitation care  
- Initiation of phototherapy and no IV needed  
- NAS management (un-medicated) new or score 1-5  
- Isotole or warmer for thermoregulation and stable  
- Septic workup no treatment  
- Growing premature infant with no oxygen or IV needed |
| M                  | Newborn Level II Intermediate Care #0172 1:2-3 Nursing Care AWHONN M1 0.33 FTE ≤ 4 (0.33) items M2 0.5 FTE ≥ 4 (0.33) items, or any 0.5 item | Moderate Complexity Needs:  
- IV meds, IV fluids-hydration only (0.33)  
- Stable, or wearing O2 nasal cannula or CPAP (0.33)  
- Feeding intolerance and/or fed by NG or OG for lack of nipping (0.33)  
- Intensive Phototherapy-multiple phototherapy lights (0.33)  
- Temperature instability requiring adjustments to isotole temp. (0.33)  
- Sepsis evaluation and sepsis treatment (0.33)  
- Apnea/bradycardia within 72 hours, or that requires tactile stimulation or periodic oxygen < 60%/shift (0.33)  
- Drug withdrawal therapy (receiving medications) and/or NAS score ≥ 5 (0.5)  
- Occasional de-saturates with feedings (0.5)  
- Infant in isolation (0.5) |
| L                  | Newborn Level III Intensive Care #0173 1:1-2 Nursing Care AWHONN L1 0.5 FTE ≤ 3 (0.5) items L2 0.75 ≥ 3 (0.5) items OR one 0.75 FTE items If total of all items for baby is ≥ 0 move to C | Hemodynamically unstable or infants with complex medical conditions that require invasive therapy:  
- Unstable-titrating O2% or pressure via nasal cannula or CPAP: extended PPV (0.5)  
- Desaturations with most feedings (0.5)  
- Blood Transfusion (0.5)  
- Peripheral titration or bolus of Glucose (Hypoglycemia Tx), or TPN and/or Lipids infusion, not to including weaning (0.5)  
- Apnea/bradycardia that requires tactile stimulation or periodic oxygen ≥ 60%/shift (0.5)  
- Pharmacologic treatment of apnea or bradycardia episodes (0.5)  
- Early stages of NEC (presenting with green bile, abdominal girth, distension, need for suctioning (0.75)  
- NIV or intubation with mechanical ventilation-stable (0.75)  
- Central line IAC and/or UVC (0.75) |
| C                  | Newborn level IV Critical Infants to be transferred #0174 1:1.0 FTE | Infant requiring transfer to a Level III hospital. Requires advanced intervention or technical care.  
- Severe congenital malformations or acquired conditions, active/passive cooling, heart defects, surgical intervention, late stage NEC, gastrostomy, mechanical ventilation unstable. IV bolus or continuous drip therapy for severe physiologic metabolic instability (dopamine, insulin, Prostin) |