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Hospital Nurse Staffing Interpretive Guidance on Staffing for Acuity & Intensity

The Nurse Staffing Board (NSAB) provides advice to the Oregon Health Authority (OHA) on the administration of nurse staffing laws and reviews OHA's enforcement powers and processes. ORS 441.152(2). In this role, NSAB has drafted and provided guidelines to assist OHA when reviewing unit-level staffing plans for compliance with requirements to recognize differences in patient acuity and nursing care intensity as described in OAR 333-510-0110. In this document, OHA adopts many of the proposed guidelines with some revisions as interpretive guidance.

DISCLAIMER: This document is intended to assist hospitals in complying with the requirement to recognize difference in patient acuity and nurse care intensity but is not legal advice or intended to be legally binding on OHA. Interpretive guidance is provided for general information only and may not be relied upon for purposes of regulatory compliance.

Acuity & Intensity Guidelines for Staffing Plans

"Patient acuity" is defined as "complexity of patient care needs requiring the skill and care of the nursing staff." OAR 333-510-0002(14). In general, acuity is considered the severity of illness, the complexity of medical interventions, and the necessity for nursing assessment, reassessment, and monitoring. There may be other factors not listed here. As a general matter, a "high" acuity patient would require a high amount of nursing interventions and frequent-to-ongoing nursing assessment.

"Nursing care intensity" is defined as the "level of patient need for nursing care as determined by the nursing assessment." OAR 333-510-0002(9). A "high" intensity patient would generally require frequent and/or long periods of psychosocial, educational, and hygiene care from nursing staff members. High intensity patients may also generally have an increased need for safety monitoring, familial support, or other needs.

A unit-level nurse staffing plan should describe how unit staffing is appropriate for the expected patient population. The plan should describe how staffing adjustments are made when acuity or intensity of an individual patient changes to support the provision of safe and effective care for the high acuity/intensity patients and the rest of the patients on the unit.

In preparation for OHA's evaluation of a staffing plan the staffing committee may want to consider how the staffing plan addresses the following questions:

1. How does the unit account for the acuity for any given patient?

2. How does the unit account for the nursing care intensity for any given patient?

3. How does the unit document acuity and intensity, including any changes to acuity and intensity?

4. How does the unit make staffing adjustments when patient acuity or intensity changes? Who is involved in the decision process for these staffing adjustments?

5. How often is patient acuity and nurse intensity data collected, documented and assessed throughout a shift (e.g. at shift change, every 4 hours)?

6. How does the unit incorporate admissions, discharges and transfers, per shift, into the acuity and intensity assessment? (Please note that admissions, discharges and transfers (ADT) are measured elsewhere in the nurse staffing plan, and that this question focuses on the aspects of ADT directly related to acuity and intensity).

7. If there are external acuity and intensity standards relevant to the unit, how does the unit staffing plan utilize these standards?

During a survey, nursing staff interacting with surveyors should be able to provide examples of how the staffing plan addresses the questions above.

Different tools have been developed to track and measure patient acuity and intensity. These tools are often based on elements of care that are universal to all patient populations. We have attached an example here, adapted from Kathy Malloch, that hospitals may consider when developing patient acuity and intensity measures for their staffing plans. The example tool describes certain universal elements of patient care as well as levels of acuity and intensity within each. The example tool does not address all potential elements of care and hospitals should consider other elements including, but not limited to: impact of unit geography; documentation burden; non-direct care requirements; sufficiency of equipment; availability of ancillary services such as transportation; and new regulatory requirements.

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Patient Acuity & Intensity of Nursing Work (Adapted from Malloch, 2000)

1. POPULATION: (Describe)

Rating scale, 1 = normal function/status; 5 = very abnormal/disrupted/unstable

Focus		1	2	3	4	5	Score
COGNITION	**ACUITY**	Normal	Interacts/responds in stable environment. Glasgow or MiniMental score confirms.	Some impairment; short term memory loss.	Moderate compromise in memory and reasoning.	Not able to interact appropriately understand, or express thoughts	
	INTENSITY	None	Occasional orienting needed	Frequent reorient needed; requires episodic monitoring	Requires frequent reorienting observation.	Cannot be left alone; high risk for injury to self/others.	
SELF CARE	**ACUITY**	Normal	Some deficits but compensates	Deficits require standby assistance from nursing staff	Requires mod. Assistance to complete self care; and is at some risk for injury to self.	Unable to perform any selfcare on own	
	INTENSITY	Completes all ADL/IADL independently	May need assistive device(s) but can do ADL and IADL.	Needs assistive device(s) as well as SBA to do ADL.	Unable to be alone for self care, needs mod. asst.	Totally dependent for ADL.	
EMOTIONAL/ SOCIAL	**ACUITY**	Affect appropriate; language skill intact.	Transient appropriate mood changes; language skills intact.	Periods of altered mood without; affect altered from typical inappropriate to event, context	Sustained periods of altered mood and affect; mood shifts; difficulty relating to others	Continuous unstable mood and affect; able to relate in meaningful manner episodically.	

	INTENSITY	No intervention	Occasional reflection, support and clarification required	Requires frequent checks, monitoring of interactions with other patients, staff.	Frequent checks and interventions to prevent episodes with patients/staff	Is unable to be left alone due to mood and affect; requires seclusion/time out and other interventions	
COMFORT	**ACUITY**	No expressed or observed discomfort	Episodic mild discomfort	Episodic moderate pain/discomfort	Very frequent serious pain/discomfort	Intense pain on nearly continuous basis with physical response (nausea)	
	INTENSITY	None	Oral meds and nursing measures effective.	Asst. and/or meds q 2 – 4 hrs plus nursing measures	Asst. and/or oral and IV/inj for pain; freq. nursing measures	Oral/IV/IM meds; nearly continuous nursing care	
FAMILY/SOCIAL SUPPORT	**ACUITY**	Intact, communicate with each other	Intact but scattered	Has emotional/ personal issues but is coping	Emotional and personal issues, cope with anger, hostility	Displays aggression, anger and anxiety toward each other and patient	
	INTENSITY	Listening	Listening, explaining, supporting	Listening, teaching, explaining, supporting and redirecting	Listening, monitoring, other CG (psych, CNS or NP, social worker) needed	Require intense work, staff violence prevention: precautions needed, high risk for violence, multiple other care givers needed	
INTERDISCIPLIN-ARY COORDINA-TION (IDSC)	**ACUITY**	Fully independent	Some self care deficits but with limited help, compensates.	Deficits are moderate and if not addressed, patient could harm self during LOS.	Deficits are significant, patient is unaware, and risk for injury is high	Fully dependent, lacks awareness or accurate cognition, risk for injury high.	
	INTENSITY	No IDSC needed during LOS	One IDSC during LOS	Two IDSC meetings needed during LOS	Three to four IDSC meetings needed to handle care during LOS	Daily and extensive IDSC meetings needed to handle care during LOS	

TRANSITIONS	**ACUITY**	Able to plan and participate in discharge or transfer	Partially able to consider and plan for discharge or transfer	Unable to plan or participate in discharge or transfer with significant coaching.			
	INTENSITY	Transition will be to home within days, will be independent	Transition will be to home, assistance will be needed but for short duration	Transition will be to subacute care for short while, then to home; assistance will be needed for up to 1, 1 ½ months	Transition to another facility, substantial rehabilitation needed before or if able to return to home environment	Transition to another facility in order to sustain life.	
TREATMENTS, TASKS, INTERVENTIONS	**INTENSITY**	Very few	Oral meds; simple dressings	Simple but frequent, or complex, infrequent	Complex medical and nursing interventions; technology required	Multiple, and/or continuous, complex medical and nursing interventions, technology required	