Nurse Staffing Plan

Facility: Samaritan North Lincoln Hospital
Received Date: May 21, 2024
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Hospitals are responsible for submitting plans that are approved, current, complete, and compliant. It is the hospital's responsibility to submit plans to OHA that comply with applicable laws including procedural requirements for adopting the plan and addressing all units requiring a staffing plan.

OHA does not rely on the posted plans in complaint investigations. Instead, during investigations, OHA requests and receives from hospitals plans and information about plan adoption. OHA reviews the procedure used to adopt a plan for a specific unit when it is necessary for the investigation of a valid complaint.

Approval of this posted plan may already have been investigated by OHA. To see if OHA has determined that the hospital failed to adopt a nurse staffing plan for a specific unit included in this plan packet, review the investigation reports available on OHA's website. You can check the report to determine the specific unit subject to investigation, OHA's determination, and the date of the alleged violation. Note that hospitals may submit updated plans to OHA after a finding of noncompliance so you may need to check directly with the hospital or nurse staffing committee to determine if a new plan has been adopted after a finding of noncompliance.

If you need this information in an alternate format,
please call our office at (971) 673-0540 or TTY 711

POLICY

Staffing Plan for Nursing Services Policy - SPCH

Applicable Departments: **Hospital Nursing Services departments/units included in the Hospital Nurse Staffing Plan include: Acute Care Unit, Intensive Care Unit, Labor and Delivery, Emergency Department, Surgical Services, Outpatient** Applicable Staff: **Infusion Center and Outpatient Wound Center**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**04/30/2024**	Reference Number	**1614**	Version:	**8**
Last Revision:	**04/09/2024**	Next Review Due:	**04/30/2026**		

PURPOSE

- This document defines the house wide SPCH nurse staffing as it applies to all hospital departments covered under the Oregon Hospital Staffing Law 441.763-441.768.
- In addition to this house wide nurse staffing plan, each nursing unit will develop and maintain a nurse staffing plan in accordance with the Oregon Hospital Staffing Law 441.763-441.768, hospital policies, and federal regulations.
- All nurse staffing plans (house wide and unit specific), will be monitored, evaluated, modified and implemented by the Nurse Staffing Committee.

DEFINITIONS

1. **Collective Bargaining Agreement (CBA):** Current union contract between SPCH and the respective union bodies depending on position (ONA or SEIU).
2. **JD:** Job Description
3. **ISO Audit:** International Organization for Standardization audit process is used to evaluate standards of quality and safety as applies to patient care.
4. **OAR:** Oregon Administrative Rules as adopted to carry out the Oregon Hospital Staffing Law (441.763-441.768)
5. **NSC:** Nurse Staffing Committee
6. **NSM**: Nurse Staff Member
7. **NSP:** Nurse Staffing Plan

IMPLEMENTATION

1. SPCH NSP AND UNIT BASED NSP IMPLEMENTATION

a. In addition to this document, each hospital nursing unit covered under this policy will have a unit specific NSP that further defines nurse staffing.
   i. Emergency Department Nurse Staffing Plan Policy - SPCH
   ii. Intensive Care Nurse Staffing Plan Policy - SPCH
   iii. Labor and Delivery Nurse Staffing Plan Policy - SPCH iv. Acute Care Nurse Staffing Plan Policy - SPCH
   v. Infusion Services Nurse Staffing Plan Policy - SPCH
   vi. Wound Care Nurse Staffing Plan Policy - SPCH
   vii. Surgical Services Nurse Staffing Plan Policy - SPCH

b. NSM Scheduling:
   i. Schedules are posted as per current Collective Bargaining Agreement (CBAs); NSMs are scheduled according to their FTEs.

ii. Scheduling requests are made via KRONOS scheduling system and approved according to the CBAs.
iii. When units have low census, it is an expectation that core staff of these units will float wherever needed.
iv. For unfilled shifts or staffing needs, nursing resources will be contacted as per the CBAs to meet patient care needs and unit activity per unit NSP.

c. The nursing supervisor/manager in collaboration with the direct care NSM:
   i. Routinely reviews nurse staffing in the units they oversee, applying NSPs and their respective staffing tools to ensure patient care needs are met. Tools may include unit-based patient acuity/intensity guidelines, shift reporting tools and unit activity (admissions, discharges and transfers).

d. Any staff member may initiate discussion regarding staffing or staffing concern, if they feel that their patient needs are not being met. In the case of a concern, staff members must report through the chain of command until resolution is reached: CNA > Primary RN > Charge RN (if utilized) > Nursing Supervisor and Nurse Manager > VP of Nursing or Administrator on call.

e. If needs exceed or are projected to exceed the staffing as defined by the unit specific NSP, then nursing supervisors/nurse manager will:
   i. Nursing Supervisors will float NSMs based on patient needs. Assignments in those units will be made in alignment with staff knowledge, skills, abilities, and competencies.
   ii. Work collaboratively with the staffing coordinator to identify nursing resources, including agency, to cover open shifts and additional needs.
   iii. If resources are unavailable and the staffing for a unit is projected to or falls outside of the unit specific NSP:
      1. This will be communicated immediately to the unit manager (if not already aware)
      2. The manager, charge RN (or in units without a charge RN, direct care staff) and supervisor will have a collaborative discussion regarding management of admissions and unit functioning.
      3. If all efforts fail, divert will be considered and senior leadership (VP of Patient Care or Administrator on call) will be consulted. **2. NURSING STAFF QUALIFICATIONS**

a. Regular Staff
   i. All staff are expected to maintain licensure, certifications and education listed in their respective job descriptions.
   ii. Certifications and required education and competencies are expected to be completed prior to expiration or by assigned due date. Staff failing to do so may be subject to corrective action as outlined in Professional

   Licensure Certification Registration and Required Advanced Clinical Training Policy - System (v3) iii. Certification and Educational Requirements are defined by unit specific Education Grids which can be found on the Learning & Development Intranet Site by searching by the “Employee Education Grid” and inputting the following criteria:
      1. Select Department
      2. Job Roles (as listed on the primary job description and any secondary job codes) b. Agency Travel Staff
   ii. Prior to being utilized in the department, the nurse manager or delegate screens the agency per diem/travel staff profile for:1 year or more of experience (preferred) within the unit to which they are being assigned.
      1. Certifications will be consistent with the JD they are fulfilling
      2. If a RN does not have all required certifications, the manager may make an exception. This will be communicated with the charge RN making the patient assignments.
   iii. Agency travel staff are expected to complete the following within 2 weeks of beginning their assignment:
      1. SHS Clinical Traveler Orientation packet
      2. Sign JD
      3. Complete unit based checklist

3. **NURSING STAFF MEMBER OVERTIME**
   a. As per the Oregon Hospital Staffing Law, SPCH will not require a NSM to work:

i. Beyond the agreed-upon and prearranged shift, regardless of the length of the shift (except for mandatory overtime below, as allowed by OAR 441.770)
ii. More than 48 hours in any hospital-defined work week;
iii. More than 12 hours in a 24-hour period; or iv. During the 10-hour period immediately following the 12th hour worked during a 24-hour period(4) SPCH may require an additional hour of work beyond the scheduled shift if:
1. A staff vacancy for the next shift becomes known at the end of the current shift; or
2. There is a potential harm to an assigned patient if the NSM member leaves the assignment or transfers care to another NSM.
v. Refer tome

b. Voluntary OT:
i. If a NSM agrees to work overtime, the NSM is accountable for the NSM's competency in practice and is responsible for notifying the NSM's supervisor when the NSM's ability to safely provide care is compromised.
ii. A NSM will not be called if they have already worked or are scheduled to work 108 hours in any two-week pay period. (On-call and education hours will not be counted toward this total).
iii. A NSM who works 10- or 12-hour shifts, will not be scheduled routinely for more than 4 shifts in a row. At the NSM's request, they may pick up additional shifts in addition to their regular schedule not to exceed 6 consecutive shifts.
iv. If extreme staffing circumstances exist, ii-iii above may be waived with express permission of the VP of Patient Care or the Administrator on call.

4. REST BREAKS AND MEAL BREAKS

a. Meals and breaks as described in the Meal Periods Rest Breaks and Work Schedules Policy -System (v12) will be coordinated with charge RN/delegate oversight to stay within the staffing parameters as defined in the unit NSP.
b. If needed, the nursing supervisor and/or manager will collaborate with the unit staff to facilitate coverage.
c. Staff will seek out and take advantage of meal/break opportunities. The NSM will report all potential missed breaks/meal to the charge RN and move up the chain of command (CNA > primary RN > charge RN> department manager or nursing supervisor) as appropriate in attempt to resolve prior to the end of the break window.
d. NSMs are required to complete documentation through the Kronos clock at the end of their shift regarding rest/meal breaks. Documentation in Kronos will be considered the primary source for break documentation. In addition, all rest and meal breaks will be documented on the unit Staff Break Documentation form. If any break or meal is missed, the NSM is responsible for documenting this and their attempts to resolve on the Staff Break Documentation form.

5. SPCH ADMISSION LIMITATION MANAGEMENT

a. Follow: Admission Limitation Management Procedure - SPCH (v1)

6. STAFFING CONCERNS

a. Staffing concerns should be addressed immediately with the chain of command in a timely manner for intervention.
b. When in the judgement of the direct care NSM, activity is such that patient care needs are not being met or patient safety is at risk, the NSM will immediately notify the chain of command to reach resolution.
i. If the NSM feels it is warranted (i.e., resolution is not achieved), they will submit an electronic Staffing Documentation Form outlining:
1. The current staffing concern
2. Current staffing
3. Possible mitigation of concerns
4. Staffing documentation forms will be reviewed by the manager when received and then will be reviewed at the next scheduled NSC. **7. RECORD RETENTION**

a. Applicable policies, procedures, work instructions, committee minutes, follow up investigations and actions taken will be maintained as required by Oregon Hospital Staffing Law 441.763-441.768:

REFERENCES/RELATED DOCUMENTS

1. Federal Regulation 485.635
2. OAR 441.763-441.768: Oregon Nurse Staffing Law
3. Oregon Secretary of State, Board of Nursing Chapter 851 (n.d.). Specifically:
   a. Division 45: Standards and scope of practice for the LPN and RN;
   b. Division 47: Standards for RN Delegation Process
   c. Division 63: Standards and Authorized Duties for the CNA and CMA
4. American Nurses Association (2015). Code of Ethics for Nurses. ISBN: 9781558105997
5. American Nurses Association (2015). Scope and Standards of Practice (3rd ed.). ISBN: 9781558102828 ·
6. Optum360 (2018). ICD-10-CM Professional for Physicians. Diagnoses based on ICD-10-CM diagnosis code assigned by physician.
7. SHS Policies/Documents:
   a. SPCH Hospital Nurse Staffing Committee Charter
   b. Admission Limitation Management Procedure - SPCH (v1)
   c. Mandatory Overtime Policy - System (v9)
   d. Professional Licensure Certification Registration and Required Advanced Clinical Training Policy - System (v3)
   e. Non COVID-19 High Consequence Infectious Diseases Policy - GSRMC, SAGH, SLCH, SNLH, SPCH (v25) f. Patient Surge Plan Policy - SPCH (v5)
   g. Scope of Service Policy - SPCH (v9)
   h. Procedural Sedation Care and Administration Policy - GSRMC, SAGH, SLCH, SNLH, SPCH (v12)
   i. Meal Periods Rest Breaks and Work Schedules Policy -System (v12)

POLICY

Acute Care Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Acute Care Unit**
Applicable Staff: **All Registered Nurses (RN) and Certified Nursing Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**04/10/2024**	Reference Number	**4693**	Version:	**4**
Last Revision:	**4/1/2024**	Next Review Due:	**04/10/2026**		

PURPOSE

The purpose of this policy is to define the staffing plan for the SPCH ACU in accordance with the Oregon Administrative Rules.

DEFINITIONS

1. Epic Nursing Assignment Wizard (NAW)- workflow tool within the Epic EMR that captures nurse assignments and assigned acuity/intensity.
2. Epic Acuity/Intensity Tool– EMR process that assigns acuity/intensity points to hospitalized patients within the ACU/ICU departments based on orders, documentations and patient transfers.
3. Unit activity – defined as all arrivals to and departures from the unit, including admissions, discharges, transfers, postoperative patients, and outpatients. This can also be affected by multiple staff changes within a shift or the presence of students, and orienting staff

IMPLEMENTATION

1. Nurse Staffing Ratios and Acuity/Intensity

a. Staffing is evaluated every 4 hours. Charge RNs and Nursing Supervisors utilize the Epic Nurse Assignment Wizard and shift documentation, unit activity and information specific to individual patient (such as close observation, 1:1 need, bariatric need) to tailor a plan for staffing for the current shift and project needs for the next shift.

b. Staffing is by ratio and acuity/intensity, where patients are assigned acuity/intensity points through the Epic EMR based on nursing care, interventions, provider orders and transitions of care (admission, discharge, and transfer). i. Ratios:

   a. RNs will typically be assigned in the ratio defined by care model in addendum B
   b. The RN: Patient ratio will not exceed 1:5.
   c. Outpatients, swing bed/transitional care or patients who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record, do not count in the staffing ratios and are assigned in accordance with their respective acuity/intensity

ii. Acuity ranges are defined in Epic as:

   a. 150-300 target acuity/intensity range (green)
   b. 300-375 warning acuity/intensity range – indicating additional resources may be needed to support (for example assistance with medication passes, nursing tasks taking longer periods of time) (yellow)
   c. 375-500 danger acuity/intensity range – additional nursing staff to be assigned to support the primary assignment (red)
   d. Actual Acuity/Intensity assignments may exceed the values outlined in the staffing model guidelines in these situations:

i. ADT – Admission, discharge and transfers may overlap current assignments for short periods of time (less than 4 hours). Assignments will be carefully evaluated by the charge RN (or delegate see addendum C) and the staff member to ensure the assignment is well supported.

ii. At the discretion of the charge RN (or delegate) and the staff member taking on the assignment. The reasoning behind such assignment will be documented in the staffing documentation.

c. At times of high acuity or critical patient needs; additional qualified staff or staff from other nursing units may float as per the Staffing Plan for Nursing Services Policy - SPCH

d. Charge RNs/Supervisors will utilize the Epic Nurse Assignment Wizard to assign patients to each RN while considering the model of care being utilized, the acuity/intensity target range guidelines for each model as described in addendum B and additional factors as described below.

e. Charge RN Assignments

i. Until 6/1/2024 to maintain operational consistency, charge RNs may be required to assume up to a partial patient load. This load, unless agreed to by the charge RN, should be at least one less patient than typical assignments as defined in addendum H.

ii. After 6/1/2024: Primary charge RNs (green level – see addendum C) and fill in charge RNs (Yellow) are not routinely assigned a patient load whenever possible to allow for completion of unit tasks, patient care oversight and patient flow. Known exceptions to this are:

a. Depending on the acuity/intensity/activity of the unit, the ACU Charge RN may be assigned one (1) patient at any time to improve unit flow as long as the 1:5 ratio is maintained. This is most likely to occur at census equaling 5, 9, 13 and 17, where an additional RN (given acuity/intensity/activity) may not be indicated or when a 5th patient cannot be added to an existing RN assignment.

b. Admissions to the unit towards the end of the shift where the charge RN can accept the patient without impacting other duties or RN ratios. This is in recognition that admission before shift change can improve the flow for the next shift, as well as reduce the burden of the admitting department.

c. Outpatient flow – outpatients are generally time limited and have limited impact to the other duties assigned to charge RNs.

d. Patients discharging from the unit with a set plan/time requiring minimal care/intervention. iii. When there is no primary or acting charge RN for the shift:

a. Off going charge RN or nursing supervisor will prepare staff assignments in NAW and make additional unit task assignments using the addendum D– Red Level RN Delegation of Charge RN Duties.

b. One RN will be designated as break/meal relief. This RN will also assume responsibilities for unit task assignments (addendum D). iv. When the charge RN is also the assigned preceptor for a new staff RN, the charge RN will delegate one RN on staff as break/meal relief. Plans for staffing will be made the day prior to the shift and handed off through the supervisor.

v. For consistency in leadership and unit processes the primary charge RNs will not be placed on call unless there is fill in charge (yellow) available to step into the role and this has been communicated to the yellow charge prior to charge RN shift start. The intent of this is to ensure patient safety and unit consistency.

2. CNA Staffing Ratios

a. CNAs are assigned patient care tasks in alignment with their certification level.

i. 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. These staff will not be given additional patient assignments. ii. CNAs may be regularly assigned in the following ratios:

a. Day shift: 1 CNA per 7 patients (not to exceed 7 assigned patients)
b. Night shift: 1 CNA per 8 patients (not to exceed 11 assigned patients)

iii. CNAs may also be assigned to task across the entire unit, in this role they would provide task assistance at the direction of the RN or charge RN for any patient care or unit task which falls within their scope of practice.

3. Meals and Breaks

a. In addition to language in the house wide SPCH NSP, on this unit meals and breaks for RNs will be assigned in blocks at the beginning of each shift.
   i. Charge RNs (or delegate) will assume patient care during break/mealtime. Staff are to report to the designated break relief RN at their assigned break time.
b. Meals and breaks for CNAs may overlap RN breaks. Staff remaining on the unit will assume full care responsibility for patients during meal/break times.

4. Addendums:

a. Addendum A: Other: Staffing Worksheet
b. Addendum B: Other: Models of Care
c. Addendum C: Other: Charge RN Assignment by Skill Level
d. Addendum D: Other: Red Level Charge RN Delegation of Essential Charge RN Duties

5. References/Related Documents

a. SHS Policies/Documents:
   i. Staffing Plan for Nursing Services Policy - SPCH
   ii. Adult Intensive Care, Progressive Care, Medical/Surgical, and Acute Care Standards of Care Policy - GSRMC, SAGH, SLCH, SPCH, SNLH iii. Adult Patient Placement and Monitoring Guidelines Procedure - GSRMC, SAGH, SLCH, SNLH, SPCH iv. Telemetry Procedure - SPCH
b. Academy of Medical Surgical Nursing Scope and Standards of Nursing Practice, 6th ed (2018)
c. AMSN Position Statement regarding Med/Surg Staffing (2020): https://www.amsn.org/about-amsn/amsn-positionsissues-nursing/staffing-standards-patient-care

Addendum A: Other: Staffing Worksheet

SPCH ACU PATIENT ASSIGNMENTS

Date: ____________ Day/Night

RN	ASSIGNMENT	0800/ 2000	1200/ 2400	1600/ 0400	CNA ASSIGNMENT
Charge RN/Delegate					

REV 3/2024

Addendum B: Other: Models of Care

ACU Nursing Care Models Worksheet

RN Models	Team Model	Total Care RN Model	Hybrid
Guideline	In the team model, each RN load will be assigned to fall within the **target range 150-300 acuity** points by the Epic Acuity/Intensity Tool. **Typical patient: nurse ratio 4:1**	In the total care model, each RN load will be assigned to fall within the **target range 150-225** acuity points by the Epic Acuity/Intensity Tool. **Typical patient: nurse ratio 3:1**	In the hybrid model, each RN load will be assigned to fall within the **target range 150-275** acuity points by the Epic Acuity/Intensity Tool. Hybrid assignments are flexible and can be made in the following combinations: 2 patients with CNA/1 Total Care 3 patients with CNA/1 Total Care 2 patients with CNA/2 Total Care 1 patient with CNA/3 Total Care* Assignments are adjusted/made with consideration of acuity/intensity and staff competency. *this assignment is more rare and would be made in specific situations where the acuity/intensity allows, for example on night shift in the second half of the shift after meal break and assignment intensity has decreased.
How do we describe the model? • What does it look like/consist of	Where a RN is paired with a CNA for their entire load of patients. The RN may be paired with one or more CNAs depending on acuity/intensity/geography.	The RN is assigned full (or total) nursing care of the patient. This includes all nursing care, including ADLs, call lights and full care documentation.	The RN is assigned patients paired with a CNA and patients that are total care.

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	In some circumstance, it may be appropriate to assign a RN to a CNA role for the shift to support overall staffing.		
When is it best utilized?	• High intensity patients (majority) • When CNA staffing is available	• ideally, Low to Moderate intensity patients or mix of patients (few high acuity/intensity) that allow for RNs to complete all cares in a patient assignment. • CNAs not available or inadequate number of CNAs to utilize team model	• When 1 CNA is present on the unit – caution need to ensure patient assignment considers acuity/intensity • Reduced staff experience/competency with total care • New staff or new agency staff
What are the pros/cons?	Pros: • Comfortable, what we know, is our current structure • Second eyes on our patients Cons: • Staffing adjustments (flexibility) is challenging	Pro: • Improved patient outcomes (literature) Cons: • Requires an additional skill set from RNs (clustering care, documentation, ADLs/hygiene) • Sense that there is less staff on the floor creating higher risk to patients (falls, call lights)	Pro: • Most flexible • Supports staff with less total care competency/experience Con: • Role and assignment confusion, especially with A/D/T • Staffs ability to adhere to assignment; staff requesting additional assistance on total care patients. • CNAs are assigned heaviest patients on unit making their overall acuity/intensity too high

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ACU Nursing Care Models Worksheet

How is it impacted by acuity/intensity?	Most resilient/flexible– can maintain full census of 14 pts with core staffing with fluctuations of acuity/intensity.	Intensity of patient is key driver – number of staff members and level of required assistance with ADLs/hygiene/mobility/frequent call lights	More Flexible than Total Care Model, however, independent total care patients discharged and replaced by higher acuity/intensity admissions/transfers. This may require reassignment of CNAs to new patients and shuffling of other patients to total care.

Addendum C: Other: Charge RN Assignment by Skill Level

Primary Charge RN Job Code	Training/Experiences Required: • Completed hiring process primary charge RN role • Orientation • Leadership Class/Training • Ongoing competency evaluated annually and demonstrated by fulfilling this role and participating to the highest level of these outlined responsibilities	Staff in this Category: Joelle Adams Tara Cox Willow Skye Ruth Moreland Katie McClenan Mindy Hagedon
Responsibilities:		
Communication	• Provide beginning of shift assignments/safety alerts ○ Off going charge RN – coordinate census sheet with brief report highlighting care required and any safety issues ○ Ongoing charge RN – round with staff regarding any safety issues and provide assignments • Check in with staff throughout regarding patient load/acuity/activity and provide resourcing	
Assignment Management	• Assignments made appropriate to the level of competency of the staff member, considering acuity/activity • Assign Follow-up phone calls • Assigns code responders as needed/requested • Maintains fiscal responsibility and the ACU staffing plan by: ○ Documents assignments, staffing decisions and patient census and acuities on ACU tools. ○ Collaborates with the nursing supervisor on staffing decisions for current and next shift utilizing the staffing plan	
Agency	• New Agency (not worked for ACU for last 6 months) provide basic unit orientation and current areas of focus • All agency staff: ○ Set expectation for charge RN oversight of activities ○ Delegate resource staff member ○ Provide feedback regarding patient care, organization, and overall performance to leadership	
Unit Rounding	• Ensure completion of: ○ ACU equipment check off and code cart checks ○ Resolution of Omnicell Discrepancies ○ End of shift narcotic count (touched bins only) ○ Pass through med box labeling/emptying on discharge • Unit Safety ○ Utility and medication area clean, organized and within safety requirements (i.e., equipment properly stowed, doors closed, etc.). ○ Keep hallways clear ○ F/U on defective equipment processes	

Oversight	• Maintain global awareness of ACU, SPCH, SHS and health care standard practice changes/expectations over long term (not just shift to shift) and use information to act as a resource to other staff • Provide oversight of and direction for patient care provided by nursing staff. • For each shift provide active oversight of the following processes/interventions for adherence to policy/procedure (including documentation): ○ Blood Product Transfusion ○ Telemetry Order Renewal ○ Quality Improvement and Occurrence Reporting ○ Follow up Phone Calls ○ Follow- up appointments ○ Infection Prevention Standards • Team Oversight: o Be a positive support for the unit, hospital and system changes and hold staff accountable to the same ○ Maintain ACU team agreements and redirect staff PRN o Give feedback directly to staff regarding performance/behavior and to leadership/manager as appropriate ○ Resolve both staff and patient concerns/issues at the lowest level of involvement possible • New Staff: o Assist in monitoring, giving feedback and formulating learning plans for/with new employees o Monitor orientation processes and allow time for preceptors to complete shift/rotation documentation of experiences prior to shift end o Provide feedback regarding new hire orientation for each rotation to the manager • Regular Staff: o Routinely monitor staff processes and organization ○ Routinely monitor staff documentation of events ○ Give routine feedback to staff regarding work related behaviors and unit norms ○ Communicate unit changes and completion of unit education with staff on shift o Monitor overdue Performance Manager tasks and help staff prioritize these within their work assignment
Leadership	• Attend and participate in Charge RN meetings • Assists with Quality Improvement and Patient Satisfaction Projects • Assists with revising Policies and Procedures • Assists with researching occurrences • Participates in problem solving
Acting Charge RN – Charge RN as Secondary job code	Training and Requirements: • Request secondary role approved by manager • Completion of Acting Charge RN orientation checklist with current Primary Charge RN during shifts where staff member assumes increasing charge RN role under the guidance of the Primary charge RN on regularly assigned shifts • Ongoing competency: is assigned in this role more than 4 shifts per year or completes annual completion of checklist **Responsibilities:** Staff in this Category: Jennifer Brandenburg Brook Clark
Communication	• Provide beginning of shift assignments/safety alerts o Off going charge RN – coordinate census sheet with brief report highlighting care required and any safety issues ○ Ongoing charge RN – round with staff regarding any safety issues and provide assignments • Check in with staff throughout regarding patient load/acuity/activity and provide resourcing
Assignment Management	• Assignments made appropriate to the level of competency of the staff member, considering acuity/activity • Assign Follow-up phone calls • Assigns code responders as needed/requested • Maintains fiscal responsibility and the ACU staffing plan by: o Documents assignments, staffing decisions and patient census and acuities on ACU tools.
Agency	• Collaborates with the nursing supervisor on staffing decisions for current and next shift utilizing the staffing plan • New Agency (not worked for ACU for last 6 months) provide basic unit orientation and current areas of focus • All agency staff: o Set expectation for charge RN oversight of activities o Delegate resource staff member o Provide feedback regarding patient care, organization, and overall performance to leadership Unit Rounding • Ensure completion of: o ACU equipment check off and code cart checks ○ Resolution of Omnicell Discrepancies ○ End of shift narcotic count (touched bins only) ○ Pass through med box labeling/emptying on discharge • Unit Safety ○ Utility and medication area clean, organized and within safety requirements (i.e., equipment properly stowed, doors closed, etc.). o Keep hallways clear

	• F/U on defective equipment processes
Oversight •	Maintain global awareness of ACU, SPCH, SHS and health care standard practice changes/expectations over long term (not just shift to shift) and use information to act as a resource to other staff • Provide oversight of and direction for patient care provided by nursing staff. • For each shift provide active oversight of the following processes/interventions for adherence to policy/procedure (including documentation): ○ Blood Product Transfusion ○ Telemetry Order Renewal ○ Quality Improvement and Occurrence Reporting ○ Follow up Phone Calls ○ Follow- up appointments ○ Infection Prevention Standards • Team Oversight: o Be a positive support for the unit, hospital and system changes and hold staff accountable to the same ○ Maintain ACU team agreements and redirect staff PRN o Give feedback directly to staff regarding performance/behavior and to leadership/manager as appropriate o Resolve both staff and patient concerns/issues at the lowest level of involvement possible Leadership • Participates in problem solving

Regular	staff RN tasking to complete charge RN requirements • General orientation	Training and Requirements: All other staff members	Staff in this Category:

Responsibilities	
Communication	• Communicates level of competency regarding this role clearly to the supervisor • The work team will clearly divide required tasks amongst the members to ensure completion. This will include: ○ Assignment Management ○ Agency Staff Support ○ Unit Rounding
Assignment them for Management	All decisions and assignments are made with the guidance and supervision of the Nursing Supervisor, please contact assistance whenever necessary.
	• A regular staff member will take on the role of maintaining the patient assignment documentation for the shift and oversee completion of Follow-up phone calls ○ Patient care assignments are made by collaboration within the work team utilizing the off going charge RN/nursing supervisor to ensure assignments are appropriate to the level of competency of the staff member and in consideration of acuity/activity and the ACU staffing plan. • Staffing decisions rest with the nursing supervisor and are done in collaboration with the work team.

Agency	• A regular staff member will take on the responsibility to be the point person for agency staff

Unit Rounding	A regular staff member will take on responsibility to ensure:
	• Ensure completion of:
	  ○ Code cart check
	  ○ Resolution of Omnicell Discrepancies
	  ○ End of shift narcotic count (touched bins only)
	  ○ Pass through med box labeling/emptying on discharge
	• Unit Safety
	  ○ Utility and medication area clean, organized and within safety requirements (equipment properly stowed, doors closed, etc.).
	  ○ Keep hallways clear

Oversight	• As time allows, staff members will cross check each other's work for adherence to policy/procedure (including documentation):
	  ○ Blood Product Transfusion
	  ○ Infection Prevention Standards

Addendum D – Other: Red Level Charge RN Delegation of Essential Charge RN Duties

No Primary (Green) or Fill-in (Yellow) charge RN on shift?

As per the ACU staffing plan, all staff operate by collaboration using the RED charge RN level and this worksheet as a guide. Assign a RN to each of the requirements below:

Requirement	Point Person Assigned	Completed?	RN Initials
Assignments: • Acts as point person for the supervisor on admission/discharge/transfer coordination • Collaborates with the team/supervisor on assignments – if uncomfortable with making assignments, then assignment tasks fall to the supervisor • Maintains the assignments in the Epic Nurse Assignment Wizard (assist by supervisor), assignment sheet(s) and this form		Yes No	
Breaks: • Maintains and ensures completion of break documentation. • Acts as point person that a staff can report if not getting a break – resolves this collaborative with team or supervisor/manager		Yes No	
Agency/NEW Agency Orientation • Provides oversight and resourcing for any agency staff • Provides basic orientation to any new agency staff assigned to the unit (the new agency person will have their check off sheet.)		Yes No	
Unit Rounding • Completes unit equipment checklist (including Code cart check off) • Resolves Omnicell Discrepancies • Completes end of shift narcotic count (touched bins only) • Ensures pass through med box are labeled and are emptied at discharge		Yes No	

POLICY

Emergency Department Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Emergency Department (ED)**
Applicable Staff: **Registered Nurses (RN) and Certified Nursing Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**04/10/2024**	Reference Number	**4698**	Version:	**4**
Last Revision:	**04/09/2024**	Next Review Due:	**04/10/2026**		

PURPOSE

The purpose of this policy is to define the staffing plan for the SPCH ED in accordance with the Oregon Administrative Rules.

DEFINITIONS

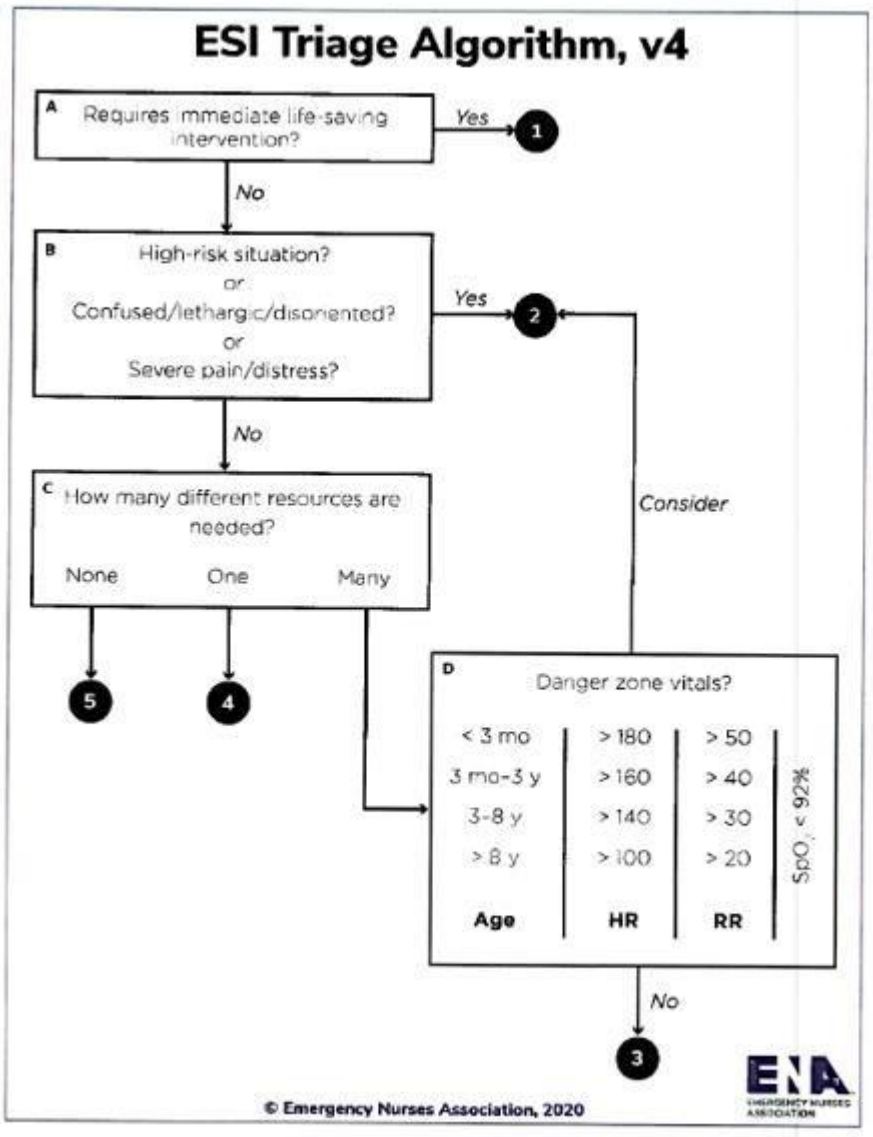
1. None

IMPLEMENTATION

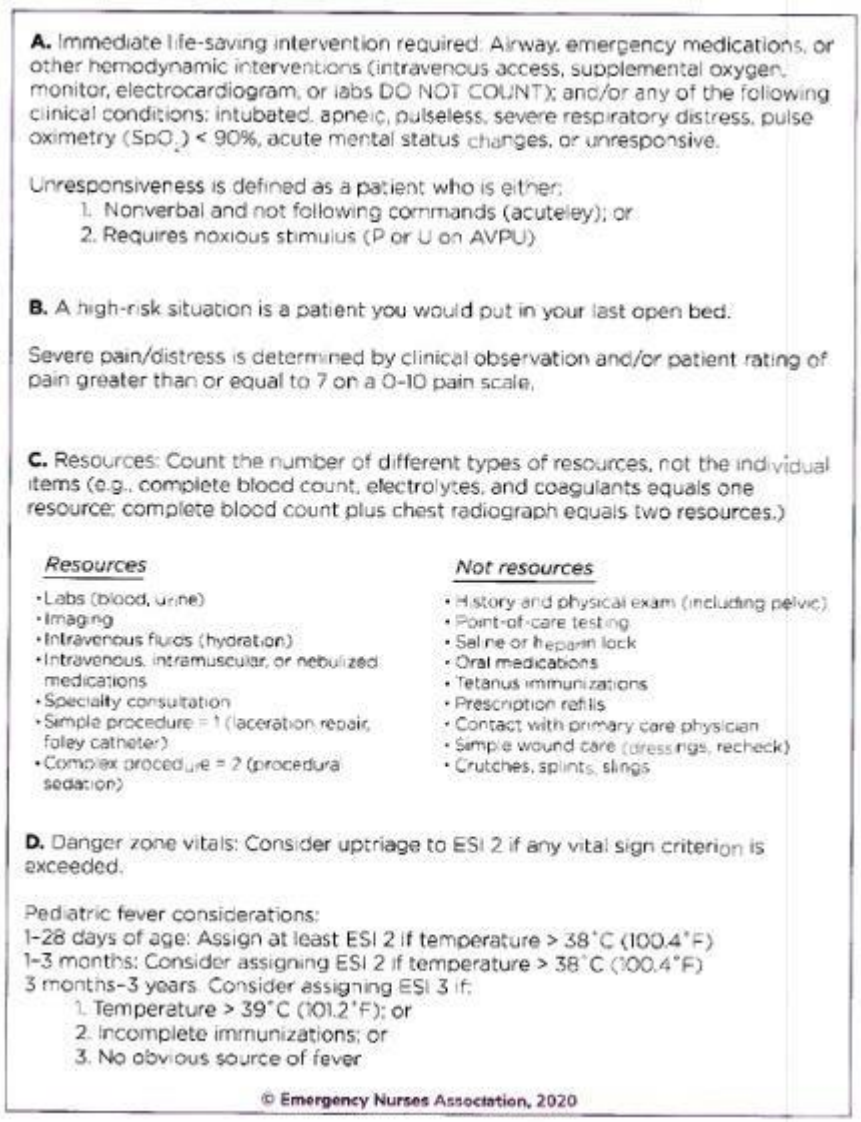
1. **Nurse Staffing for Acuity and Intensity**
   a. The Emergency Department utilizes the emergency severity Index (ESI) 5 level triage system for establishing initial triage acuity. They include 5 levels: resuscitation (1), emergent (2), urgent (3), semi-urgent (4), and non-urgent (5). There is also an intensity guideline (Addendum A)
   b. Initial RN ratio is determined by ESI and Intensity tool in accordance with the Emergency Nurses Association Guidelines and Oregon Hospital Staffing Law:
      i. ESI 1 (unstable) or ESI 2 high intensity - 1:1 or 2:1 ii. ESI 2 low intensity- 1:2 or 1:3 iii. ESI 3, 4, & 5 - 1:4
   c. Patient acuity is reevaluated upon assigned RN's reassessments, with any acute patient changes.
   d. Assignments are adjusted by the charge nurse throughout both day shift and night shift as patient census, ESI or Intensity changes and staff availability/ skill mix change
   e. A charge nurse may:
      i. Take patient assignments, including patient assignments taken for the purpose of covering staff who are on meal breaks or rest breaks.
      ii. Be taken into account in determining the direct care registered nurse-to-patient ratio during periods when the charge nurse is taking patient assignments.
   f. Patients, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record; do not count in the staffing ratios and reassigned as necessary in accordance with ESI level
   5.
2. **CNA Staffing Ratios**
   a. CNA's are assigned patient care task in alignment with their certification level. In this department, CNA's are only utilized in tasking and sitting.
3. **Addendums:**
   a. Unit specific Acuity/Intensity Tool
   b. Other: Staffing Worksheet
4. **References/Related Documents**
   a. SHS Policies and Procedures:
      i. Staffing Plan for Nursing Services Policy - SPCH

b. Emergency Severity Index (Copyright Notice). Content last reviewed May 2020. Agency for Healthcare Research and Quality, Rockville, MD.
c. ENA's Staffing and Productivity in the Emergency Department, Position Statement, 2018.
d. Emergency Nurses Association (2020) Position Statement. Retrieved from: https://www.ena.org/ · Emergency Nurses Association (2020). ENA Practice Resources. Retrieved from: https://www.ena.org/docs/default-source/educationdocument-library/esi-implementation-handbook-2020.pdf?sfvrsn=fdc327df_

Addendum A: Unit Specific Acuity/Intensity Tool



Addendum A continued: Unit Specific Acuity/Intensity Tool



A. Immediate life-saving intervention required. Airway, emergency medications, or other hemodynamic interventions (intravenous access, supplemental oxygen, monitor, electrocardiogram, or labs DO NOT COUNT); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, pulse oximetry (SpO_2) < 90%, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient who is either:

1. Nonverbal and not following commands (acuteley); or
2. Requires noxious stimulus (P or U on AVPU)

B. A high-risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of pain greater than or equal to 7 on a 0-10 pain scale.

C. Resources: Count the number of different types of resources, not the individual items (e.g., complete blood count, electrolytes, and coagulants equals one resource; complete blood count plus chest radiograph equals two resources.)

Resources	*Not resources*
• Labs (blood, urine)	• History and physical exam (including pelvic)
• Imaging	• Point-of-care testing
• Intravenous fluids (hydration)	• Saline or heparin lock
• Intravenous, intramuscular, or nebulized medications	• Oral medications
• Specialty consultation	• Tetanus immunizations
• Simple procedure = 1 (laceration repair, foley catheter)	• Prescription refills
• Complex procedure = 2 (procedural sedation)	• Contact with primary care physician
	• Simple wound care (dressings, recheck)
	• Crutches, splints, slings

D. Danger zone vitals: Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric fever considerations:
1-28 days of age: Assign at least ESI 2 if temperature > 38°C (100.4°F)
1-3 months: Consider assigning ESI 2 if temperature > 38°C (100.4°F)
3 months-3 years: Consider assigning ESI 3 if:

1. Temperature > 39°C (101.2°F); or
2. Incomplete immunizations; or
3. No obvious source of fever

Addendum A continued: Intensity Tool

Intensity Points	Condition/Interventions
<1	<u>No resources or interventions needed</u> Example: • fast track patients, acuity of 5 • patients requiring no interventions
1	<u>Non-urgent Patients</u> Example: • minimal assistance, no IV or saline lock placed • no further interventions or work up completed/pending results • low acuity (4 & 5) and stable mental health
2	<u>Urgent Patients</u> Example: • Emergent/urgent, moderate hygiene or mobility assistance • Wound care and dressing changes/splinting and crutch teaching • Medications and IV push meds • Simple procedures requiring RN assistance
3	<u>Critical Patients</u> Example: • Maximum assist • Altered Mental Status with agitation (including restraints and seclusion) • Complex wound care/splinting/debridement • Bladder irrigation/complex catheter or ostomy care • Modified Trauma, critical patients (can include cardioversion with IV medication and procedural sedation, infusions requiring titration and monitoring, blood administration, sepsis workup, NSTEMI, patients on Bi-pap/C-pap, DKA)
4	<u>Emergent/Actively Decompensating patients</u> Example: • 1:1, Acute stroke/STEMI/ cardiac or respiratory arrest of any age • Trauma/Sedations • Traction/pelvic sling/ MTP • Pediatric/neonatal critical care, laboring mother, unstable patient of any age

Nurses with 1:1 or 2:1 ratio will have their patient assignment reduced or will be assisted by having additional resources provided to them (RN, ED tech, other).
This intensity tool in conjunction with the Emergency Severity Index (ESI 5 level triage system) will act as guidelines for charge RN to create nurse assignments.
All patient assignments are subject to change with any acute patient changes, or with RN reassessment. The table below will act as a guideline for this:

Addendum D: Other: Staffing Worksheet

CHARGE NURSE ASSIGNMENT/DAILY CHECK-OFF LIST

DATE: _____

DAYS:

Room/Duty Assignments:

Charge _____
Triage: _____
FT (1-4) _____
Rm 5-8: _____
Rm 10-13 _____
Rm 14-17: _____
Float: _____
Tech: _____
Desk: _____
RR Nurse: _____

Trauma Room	
Break Sheet	
Cultures	
Code Carts	
Eye Wash/Decon Shower (Mondays)	
RRT Bag	
Carts & Linens	
Rapid Response RN	
Collect Voceras	

Shift Notes:

_____
_____
_____

NIGHTS:

Room/Duty Assignments:

Charge _____
Triage: _____
FT (1-4) _____
Rm 5-8: _____
Rm 10-13 _____
Rm 14-17: _____
Float: _____
Tech: _____
Desk: _____
RR Nurse: _____

Trauma Room	
Break Sheet	
Cultures	
Code Carts	
RRT Bag	
Carts & Linens	
Rapid Response RN	
QC's	
Collect Voceras	

Shift Notes:

_____
_____
_____

POLICY

Infusion Services Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Outpatient Infusion**
Applicable Staff: **Registered Nurses (RN) and Certified Nursing Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**04/10/2024**	Reference Number	**4695**	Version:	**4**
Last Revision:	**4/1/2024**	Next Review Due:	**04/10/2026**		

PURPOSE

The purpose of this policy is to define the staffing plan for the SPCH Infusion Department in accordance with the Oregon Administrative Rules.

DEFINITIONS

1. Unit Activity – Unit activity includes all arrivals to and departures from unit. This includes transfers to ED, preparation for direct admissions and adding patients for treatments. This can also be affected by multiple staff changes within a shift or the presence of students or new staff orienting to the department.

IMPLEMENTATION

1. Nurse Staffing for Acuity, Intensity and Ratios

a. Care is allocated by hospital and unit needs primarily determined by the unit census. Census and assignments are reviewed by the charge RN at two-hour intervals, and with any acute change in patient condition or schedule change.
b. The RN to pt ratio at any one time is 1:4.
c. Infusion RNs are assigned by length of infusion, treatment cycle, and number of medications being administered. RN acuity shall be no more than a score of twenty (20) in a ten (10) hour shift.
d. Charge nurses are assigned a partial assignment with lowest possible acuity to allow time for assisting staff and facilitating clinic flow.
e. Best practice and care guidelines adhere to: Oncology Nurses Society (ONS), Infusion Nurses Society (INS), Samaritan Hospital Systems Policy and Procedures

2. CNA Staffing Ratios

a. CNA's are assigned patient care task in alignment with their certification level. In this department, CNA's are only utilized in tasking.

3. Addendums

a. Addendum A: Unit Specific Acuity/Intensity Tool
b. Addendum B: Other: Infusion Daily Staffing Sheet

4. REFERENCES/RELATED DOCUMENTS

a. SHS Policies:
i. Staffing Plan for Nursing Services Policy - SPCH ii. Infusion Per Diem Staff Expectation Policy - SPCH **Addendum A: Acuity & Intensity Scale** Acuity Scale for SPCH Ambulatory Infusion

Non-ambulatory patients (bump up one level)

LEVEL	NONCHEMOTHERAPY RELATED ACTIVITIES	IV AND SUBCUTANEOUS CHEMOTHERAPY
Level I: Less than 30 minutes **Nursing time:** 20 minutes	• Port Lab Draws/Flushes • PICC Lab Draw • Dressing Change • Pump Removal • CADD Tubing Change Only • Any SQ IM non-Chemo • SQ Mab (not cancer related examples: Xolair, Stelara, Nucala, Prolia, Xgeva) • ***If doing two items level Is bump up to level II***	• Chemo Hormonals (Lupron, Faslodex, Zoladex, Octreotide)
Level II: 30-90 minutes **Nursing time:** 45 minutes	• Central Line Troubleshoot/TPA • Hydration • Single IV Infusion/Push (Iron, ABX) • Phlebotomy	• SQ Chemo non-Hormonal • Subsequent Infusions of Single Agent Chemo/Mab
Level III 1-2 hours **Nursing time:** 60 minutes	• Pediatric IV/Hydration • Elastomeric teach • ACTH Stim Test • Iron Dextran • IVIG • Single Unit of Blood Products • CADD/TPN Teach • Enteral Feeding Teaching • Second Dose Darzalex	• First Infusion of Any Single Drug /Mab regimen • BCG instillation • 2 Chemo Drug Regimens • Chemo Teach • Peripheral Therapeutic Phlebotomy • Subsequent dose Rituxan • 3rd dose on of Darzalex
Level IV 2-4 hours **Nursing time:** 90 minutes	• Multiple Units of Blood products • Phlebotomy from central line • Iron Dextran (if > 3 hours)	• 3-4 Chemo Drug Regimen • Subsequent dose of Platinol • Subsequent dose of Gazyva (>4 hours) • FOLFOX • FOLFIRI • PAC-paclitaxel, doxorubicin, and cyclophosphamide
Level V More than 4 hours **Nursing time:** 180 minutes		• First Dose Gazyva • First Dose Rituxan • RCHOP

P:\staffing committee work\Acuity Scale for SPCH Ambulatory Infusion 2024.docx **Addendum B: Infusion Daily Staffing Sheet**
P:\staffing committee work\Daily Staffing Sheets blank infusion feb 2024.docx

Infusion Daily Staffing Sheet

Date_____

Scheduled Patients:	RN Hours Scheduled:
Patients Added On:	RN Hours Worked:
Patients Cancelled:	CNA Hours Scheduled:
Total Patients Seen:	CNA Hours Worked:
Transfers:	Mandatory Absence:
Discharges:	Voluntary OT:
New Admits:	Mandatory OT:

Acuity

	Camie	Lynn	Sonja	Steve	Kim	Barb	Jessica	Jenni	Kay	Beth	Anja	Leann
0800 & 0900												
1000 & 1100												
1200 & 1300												
1400 & 1500												
1600 & 1700												
TOTALS												

Meals & Breaks

	Camie	Lynn	Sonja	Steve	Kim	Barb	Jess	Jenni	Kay	Beth	Tammi	Anja	Pamala
Break 1													
Covered													
Meal													
Covered													
Break 2													
Covered													
Comments													

Length of work	2 hours or less	2 Hrs 1 min - 5Hrs 59 mins	6 Hrs	6 Hrs 1min – 10 Hrs	10 Hrs 1 min -13 hrs 59 min
Number Rest Breaks	0	1	1	2	3
Number Meal Breaks	0	0	1	1	1

Revised 09/10/22

POLICY

Intensive Care Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Intensive Care Unit (ICU)**
Applicable Staff: **Registered Nurses (RN) and Certified Nursing Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**05/01/2024**	Reference Number	**4694**	Version:	**4**
Last Revision:	**04/26/2024**	Next Review Due:	**05/01/2026**		

PURPOSE

The purpose of this policy is to define the staffing plan for the SPCH ICU in accordance with the Oregon Administrative Rules.

DEFINITIONS

1. **Epic Nursing Assignment Wizard** - workflow tool within the Epic EMR that captures nurse assignments and assigned acuity/intensity.
2. **Epic Acuity/Intensity Tool**-EMR process that assigns acuity/intensity points to hospitalized patients within the ACU/ICU departments based on orders, documentation and patient transfers.
3. **SPCH ICU Staffing Rubric**-Guideline for minimum ratio staffing based on patient level of care (ICU/Med Surg) and unit acuity/intensity as determined by total department score in Epic Nursing Assignment Wizard.
4. **Unit activity** – defined as all arrivals to and departures from the unit, including admissions, discharges, transfers, postoperative patients, and outpatients. This can also be affected by multiple staff changes within a shift or the presence of students, and orienting staff. Additional ICU activity includes telemetry monitoring of ICU/ACU patients, assisting with PACU/phase 1 patients recovering after hours in ICU, procedural sedation and close observation needs.

IMPLEMENTATION

1. Nurse Staffing for Acuity, Intensity and Ratios

a. Care is provided to patients following the American Association of Critical Care Nurses (AACN) and American Nurses Association (ANA) standards of care and ethics. The AACN optimal standard for ICU level patients is a nurse-to-patient ratio of 1:2. Med Surg level patients may also be cared for in the ICU.

b. Staffing is evaluated every 4-hours. Charge RNs (or delegate) and Nursing Supervisors collaborate using the SPCH ICU Staffing Rubric (addendum B), Nursing Assignment Wizard, unit activity, and information specific to individual patients to tailor a plan for staffing for the current shift, and project needs for the next shift. This is tracked in Epic and documented on the SPCH ICU Staffing Worksheet (addendum A)

c. Nurse to patient ratios are determined by SPCH ICU Staffing Rubric while considering acuity/intensity scores, where patients are assigned acuity/intensity points through Epic Acuity/Intensity tool, on nursing care provided, interventions, provider orders and transitions of care. Nurse to patient ratios may increase or decrease based by the patient's acuity and intensity and assessment of unit needs.

   i. ICU status patients with acuity points greater than or equal to 150 points for **each patient**: 1:2 ratio

   ii. ICU status patients with acuity points up to 149 points for **each patient**: 1:3 ratio

iii. Med-Surg patients are assigned in a 1:4 ratio (or be differentiated in the EMR as a Med/Surg status patient)

d. Target assignment ranges for each RN (based on the Epic Nurse Assignment Wizard): :
    i. 150-300 target acuity/intensity range (green)
    ii. 300-375 warning acuity/intensity range – indicating additional resources may be needed to support (for example assistance with medication passes, nursing tasks taking longer periods of time) (yellow)
    iii. 375-500 danger acuity/intensity range – additional nursing staff to be assigned to support the primary assignment (red)
e. In times of high acuity or critical patient needs; additional qualified staff or staff from other nursing units may float as per the Staffing Plan for Nursing Services Policy - SPCH

2. CNA Staffing Ratios

a. CNAs are assigned patient care tasks in alignment with their certification level.
b. 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. These staff will not be given additional patient assignments.
c. Close observation care staff may be assigned up to a regular assignment.
d. CNAs may be regularly assigned in the following ratios:
    a. Day shift: 1 CNA per 7 patients (not to exceed 7 assigned patients)
    b. Night shift: 1 CNA per 8 patients (not to exceed 11 assigned patients)

3. Addendums

a. Addendum A: SPCH ICU Staffing Worksheet
b. Addendum B: SPCH ICU Staffing Rubric

3) Adult Intensive Care, Progressive Care, Medical/Surgical, and Acute Care Standards of Care Policy - GSRMC, SAGH, SLCH, SNLH, SPCH

excellence/aacn-standards
American Association of Critical Care Nurses (n. d.). Essentials of Critical Care Orientation (ECCO). Retrieved from https://www.aacn.org/education/online-courses/essentials-of-critical-care-orientation

References/Related Documents:

A. SHS Policies and Procedures:
   1) Staffing Plan for Nursing Services Policy - SPCH v.7 (policytech.com)
   2) Procedural Sedation Care and Administration Policy - GSRMC, SAGH, SLCH, SNLH, SPCH

   SPCH, SNLH
   4) Adult Patient Placement and Monitoring Guidelines Procedure - GSRMC, SAGH, SLCH, SNLH, SPCH 5) Telemetry Procedure - SPCH
B. American Association of Critical Care Nurses (n. d.). AACN standards. Retrieved from https://www.aacn.org/nursing-

C.

Addendum A: SPCH ICU Staffing Worksheet

ICU 24hr Patient Census Acuity Tracking Tool:

Date: __________

Teles? How many @ 0800: ______ 1200: ______ 1600: ______ 2000: ______ 0000: ______ 0400: ______

Patient Sticker **Room #**	**RN** (AM/PM printed initials)	**Acuity** (at 4H intervals, and with any change in patient condition; change time if needed). ***A= acuity, 1:1 = sitter (non- RN)***							
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
	/	Time: 0800 A: 1:1 ☐	Time: 1200 A: 1:1 ☐	Time: 1600 A: 1:1 ☐	Time: 2000 A: 1:1 ☐	Time: 0000 A: 1:1 ☐	Time: 0400 A: 1:1 ☐	**Admit Time:** **A:** 1:1 ☐	**DC Time:** Transfer Home
Total Unit Acuity Scores in 4 H intervals (found in the Epic Nursing Assignment Wizard)		Time: 0800	Time: 1200	Time: 1600	Time: 2000	Time: 0000	Time: 0400		

***Please note events requiring additional staffing during shift on the back of this form** (i.e. ACU IV starts, 1:1's, trauma response, codes, rapid response, emergent admissions, etc.)* ICU 3/24 PD

Addendum B: SPCH ICU Staffing Rubric

ICU Staffing Rubric

ICU Pt's	Med Surg Pt's	#RN's	Break RN if Assign. Wizard for Unit > 300	Additional RN if Assign. Wizard for Unit > 600	Total RN's	CNA
0	0	1	-	-	1	0
1	0	2	-	-	2	0
2	0	2	1	1	2 + 1 for breaks or 3	1
3	0	2	1	1	2 + 1 for breaks or 3	1
4	0	2	1	1	2 + 1 for breaks or 3	1
5	0	3	-	-	3	1
6	0	3	-	-	3	1
0	1	1	1	-	1 + 1 for breaks	1
1	1	2	1	1	2 + 1 for breaks or 3	1
2	1	2	1	1	2 + 1 for breaks or 3	1
3	1	2	1	1	2 + 1 for breaks or 3	1
4	1	3	-	-	3	1
5	1	3	-	-	3	1
0	2	1	1	-	1 + 1 for breaks	1
1	2	2	1	1	2 + 1 for breaks or 3	1
2	2	2	1	1	2 + 1 for breaks or 3	1
3	2	3	-	-	3	1
4	2	3	-	-	3	1
0	3	1	1	1	1 + 1 for breaks or 3	1
1	3	2	1	1	2 + 1 for breaks or 3	1
2	3	3	-	-	3	1
3	3	3	-	-	3	1
0	4	2	1	1	2 + 1 for breaks or 3	1
1	4	3	-	-	3	1
2	4	3	-	-	3	1
0	5	2	1	1	2 + 1 for breaks or 3	1
1	5	3	-	-	3	1
0	6	2	1	1	2 + 1 for breaks or 3	1

POLICY

Labor and Delivery Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Labor, Delivery, Recovery and Postpartum Unit (LDRP)**
Applicable Staff: **Registered Nurses (RN) and Certified Nursing Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**04/30/2024**	Reference Number	**4696**	Version:	**4**
Last Revision:	**4/1/2024**	Next Review Due:	**04/30/2026**		

PURPOSE

The purpose of this policy is to define the staffing plan for the SPCH LDRP in accordance with the Oregon Administrative Rules.

DEFINITIONS

1. MSE – Medical Screening Exam
2. NSM – Nurse Staffing Member

IMPLEMENTATION

1. Nurse Staffing for Acuity and Intensity

a. Staffing requirements are based on Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) staffing guidelines (2022) and adapted acuity tool, not to exceed ratios defined by OAR 441.765.
b. Acuity point values equate to 1.0 points equal 1 LDRP qualified RN. In the cases of decimals, the RN target will be rounded up to the whole number.
c. Ratios:
   i. Labor and Delivery – active labor or complications 1:1 ii. Labor and Delivery – no active labor or complications 1:2
   iii. Labor and Delivery – postpartum, antepartum, and well-baby nursery 1:6 iv. Mother baby – 1:8
d. Staffing is evaluated every 4-hours and with changes in patient condition. Assignments may consist of a variety of patient types. NSM and Nursing Supervisor collaborate using the acuity tool, unit activity, and information specific to individual patients to tailor a plan for staffing the current shift and project needs for the next shift.
e. In times of high acuity or critical patient needs; additional qualified staff or staff from other nursing units may float as per the Staffing Plan for Nursing Services Policy - SPCH

2. CNA Staffing Ratios

a. CNA's are assigned patient care task in alignment with their certification level. In this department, CNA's are only utilized in tasking.

3. Addendums

a. Addendum A: Unit specific Acuity/Intensity Tool

4. References/Related Documents

a. SHS Policies and Procedures:
   i. Staffing Plan for Nursing Services Policy - SPCH

ii. Obstetric Service Divert Due to Staffing Deficit Procedure - SNLH, SPCH

b. American Academy of Pediatrics Committee on Fetus and Newborn and American College of Obstetricians and Gynecologists (2017). Guidelines for Perinatal Care Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: The American College of Obstetricians and Gynecologists.

c. Association of Women's Health, Obstetric and Neonatal Nurses. (2022). Guidelines for Professional Registered Nurse Staffing for Perinatal Units. Washington, DC: Author.

Addendum A: Unit Specific Acuity/Intensity Tool

LDRP Staffing Acuity

DATE:_____

Acuity	Patient Type/Clinical Situation	0700	1100	1500	1900	2300	0300
Antepartum							
0.5	NST						
1.0	Initial triage 20-30m or Unstable						
0.5	Triage - stable						
0.3	Antepartum - stable						
1.0	Antepartum - unstable						
Intrapartum							
0.5	Cervical Ripening						
1.0	Labor with medical/OB complications (diabetes, morbid obesity, PreE, HTN, twins, demise, cat 2 or 3 FHR)						
1.0	Labor with Oxytocin						
1.0	Labor with min to no pain relief or medical interventions						
1.0	Labor with intermittent auscultation						
1.0	Labor with magnesium sulfate admin						
1.0	Labor with epidural						
1.0	Labor in 2nd stage						
0.5	Labor with NO complications						
2.0	Birth until critical elements met: 1) initial assessment 2) repair complete 3) hemodynamically stable 4) Infant ID bands on 5) SBAR handoff						
2.0	Urgent/Emergent C/S						
Postpartum and Newborn Care							
0.25	Couplet after 2-hour recovery period; *Mom&Baby*						
0.5	Women immediate postoperative day; *MOM Only*						
0.2	Women postpartum w/o complications; *MOM only*						
0.3	Womens postaprtum w/ complications (Established Mag Sulfate, PPH, Unstable HTN); *MOM only*						
0.2	Healthy newborns requiring routine care; *BABY only*						
0.3	Level 2 newborn						
0.5	Level 3 newborn						
1.0	Level 4 newborn						
Maternal and Newborn Follow Up							
0.5	NBFU						
0.5	Maternal Follow Up						
	Total RN Target						
	RN Staffed						

A minimum of 2 nurses in the hospital as minimum staffing, even when there are no perinatal patients. Another labor nurse should be called in to be available to care for any other pregnant women who may present for care while the first 2 nurses are caring for the woman undergoing birth. At least 1 registered nurse physically present at all times in the nursery when babies are physically present.

Maximum Ratios:
Labor and Delivery – active labor or w/ complications 1:1
Labor and Delivery – no active labor or complications 1:2
Labor and Delivery – PP, antepartum, and well-baby nursery 1:6
Mother baby – 1:8

Meals & Breaks may be accomplished with 1 RN and 1 NSM only IF Total RN Targed ≤ 1.0

updated 12/18/2023

POLICY

Surgical Services Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Surgical Services Department**
Applicable Staff: **Registered Nurses (RN) and Certified Nursing Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**05/01/2024**	Reference Number	**4699**	Version:	**4**
Last Revision:	**4/1/2024**	Next Review Due:	**05/01/2026**		

PURPOSE

To define the staffing plan for the SPCH Surgical Services Department in accordance with the Oregon Administrative Rules.

DEFINITIONS

1. CBA – Collective Bargaining Agreement

IMPLEMENTATION

1. Nurse Staffing for Acuity and Intensity

a. Surgical Services nurse staffing requirement and care is based on acuity and intensity factors as defined by the American Society of Peri-anesthesia Nurses (ASPAN) and Association of Peri-operative Registered Nurses (AORN). The unique nature of a surgery department depends on a flexible staffing plan to provide safe care for day-to-day changes in patient acuity.

b. To project daily staffing and with any patient condition change the unit utilizes the acuity/intensity tool see Addendum A

c. As defined in the acuity/intensity the total nurse equivalent hours for the preoperative/postoperative areas are divided by the total number of staff RNs to determine the actual number of staff required. In the cases of decimals, the RN target will be rounded up to the whole number.

d. Operating Room (OR):

   i. Minimum per scheduled surgery: 1 RN per patient, per OR, in the role of the circulating nurse and 1 scrub person (RN or tech) per patient, per OR.

   ii. The charge nurse assigns staffing to each case, taking into consideration the acuity and intensity of care required. These assignments are posted on the daily schedule.

e. Patients, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record; do not count in the staffing ratios and reassigned as necessary in accordance with acuity/intensity.

f. Scheduled on call is required and addressed in the CBA.

g. Charge RNs (pre/post and OR) are not routinely assigned to patient care.

2. CNA Staffing Ratios

a. CNA's are assigned patient care task in alignment with their certification level. In this department, CNA's are only utilized in tasking.

3. Addendums

a. Addendum A: Unit specific Acuity/Intensity Tool

b. Addendum B: Other: Staffing Worksheet

4. References/Related Documents:

a. SHS Policies and Procedures:

i. Staffing Plan for Nursing Services Policy - SPCH

b. Peri-anesthesia Nursing Standards, Practice Recommendations, and Interpretive Statements. New Jersey, ASPAN. Conner, R. (Ed.). (2017).

c. Guidelines for Perioperative Practice (2017 ed.). Denver, CO: AORN Publications.

Addendum A: Unit Specific Acuity/Intensity Tool

SPCH Peri-Op
Staffing Worksheet 2022

PHASE	Identification of Acuity	Number of Patients per Acuity	Formula	Total Nurse Equivalent Hours
PREOP	Variable nurse start-times and surgery start-times			
1	**PATIENT REQUIRING UP TO OR LESS THAN 40 MINUTES:** Screening procedures, non-invasive or minimally invasive, Monitored Anesthesia Care or no anesthesia.		N x .75	
2	**PATIENT REQUIRING UP TO OR LESS THAN 60 MINUTES: (EX: Colectomy, ORIF, Total Joint Replacement)** General Anesthesia and/or Regional Block.		N x 1.00	
PHASE I	Staffing needs guided by the 2015-2017 ASPAN Practice Recommendations	Number of Patients per Acuity	Formula	Total Nurse Equivalent Hours
1	**PATIENT: INCLUDING FOLLOWING CRITERIA, BUT NOT LIMITED TO:** 2 conscious patients, stable and free from complications, but not yet meeting Phase I discharge criteria. One unconscious patient, hemodynamically stable, stable airway, over age 16 and one conscious patient, stable and free from complications.	(Optimal 1:2)	N x .5	
	Conscious patient, stable, 16 years of age and under (r/t emergence delirium in pediatric post-op patients) with family or competent support staff present, but not yet meeting Phase I discharge criteria	(Optimal 2:1)	N x 2	
2	**PATIENT: (1-3 hours recovery time) INCLUDING FOLLOWING CRITERIA, BUT NOT LIMITED TO:** Ongoing airway and/or hemodynamic instability.	(1:1)	N x 1	
3	**PATIENT: INCLUDING FOLLOWING CRITERIA, BUT NOT LIMITED TO:** One critically ill, unstable patient.	(2:1)	N x 2	
PHASE II	Staffing guided by the 2015-2017 ASPAN Practice Recommendations.	Number of patients per Acuity	Formula	Nurse Equivalent Hours
1	**PATIENT REQUIRING UP TO OR LESS THAN 30 MINUTES, BUT NOT LIMITED TO:** Screening procedure, Monitored Anesthesia Care or no anesthesia, over 16 years of age or 16 years of age and under with family present.	(1:3 - use .5 r/t 30 min. ea.)	N x .5	
2	**PATIENT REQUIRING UP TO OR LESS THAN 60 MINUTES, BUT NOT LIMITED TO:** Screening procedure, non-invasive or minimally invasive, Monitored Anesthesia Care or no anesthesia, *when patient has delayed sedation emergence*, 16 years of age and under with family present.	(1:2)	N x .5	
3	**PATIENT REQUIRING UP TO OR LESS THAN 4 HOURS, BUT NOT LIMITED TO: (EX:** Hernia/Lap Appy/ORIF/ LAP Chole/Hernia Repair/General Anesthesia and/or Regional Block. 16 years of age and under without family or support	(1:2)	N x .5	
4	**ANY UNSTABLE PATIENT REQUIRING A TRANSFER TO HIGHER LEVEL OF CARE.**	1:1	N x 1	
Visit Nurse	PREOP: Average time visit (by phone and/or in person): Up to or less than 45 minutes		N x .75	
	POSTOP: Average time per post-op visit (by phone): Up to or less than 15 minutes		N x .25	
Relief Nurse	**1 Lunch/Break Nurse per day**	N/A		8
Charge Nurse	**1 Charge Nurse per day**	N/A		8
CNA2	**1 CNA2 per day**	N/A		8
			Daily Totals	
			Daily Totals ÷8	Total Nurses needed

Addendum B: Other: Staffing Worksheet

FRIDAY AUGUST 25, 2023

	PATIENT	Expected Time	Check in Time	BED		PACU	P II	POST/ROUNDS

POLICY

Wound Care Nurse Staffing Plan Policy - SPCH

Applicable Departments: **Outpatient Wound Center (OWC)**
Applicable Staff: **Registered Nurses (RN), Licensed Practical Nurse (LPN) and Certified Nurses Assistants (CNA)**

Owner:	**Janette Armstrong (Clinical Policy-Process Spec)**				
Approved by:	**SPCH Nurse Staffing Committee**				
Approved:	**04/30/2024**	Reference Number	**4822**	Version:	**3**
Last Revision:	**4/1/2024**	Next Review Due:	**04/30/2026**		

PURPOSE

To define a staffing plan for the SPCH Outpatient Wound Center in accordance with the Oregon Administrative Rules.

DEFINITIONS

1. None

IMPLEMENTATION

1. **Nurse Staffing for Acuity and Intensity**
   - A. Unit census and acuity will determine the staffing within the Outpatient Wound Center.
   - B. In the Outpatient Wound Care appointments are scheduled every 15, 30, or 60 minutes depending on the patient's acuity/intensity and visit type (nurse vs. clinician visit).
     1) Nurse visit ratio: one to one care for assessment and treatment
     2) Clinician visit ratio: one to one care, and one nursing staff member assigned to Case Management
   - C. Patients range from independent to bedridden. The chronically wounded patient is often comorbid with diseases including but not limited to congestive heart failure, vascular disease, chronic renal failure, dialysis, poorly controlled diabetes, cancer, and a variety of autoimmune diseases.
   - D. Nursing staff will work collaboratively with the clinical leadership to address patient care assignments that are outside of the ratios in 1.B.
   - E. Best practice and care guidelines adhere to: Wound Ostomy Continence Nursing (WOCN), Wound Care Certification (WCC), NAWCO (National Alliance of Wound Care and Ostomy), Samaritan Hospital System Policy and Procedures.
2. **CNA Staffing Ratios**
   - A. CNA's are assigned patient care task in alignment with their certification level. In this department, CNA's are only utilized in tasking.

REFERENCES

• SHS Policies: ○ Staffing Plan for Nursing Services Policy - SPCH v.8 (policytech.com) ○ Wound Care Per Diem Staff Expectations Policy - SPCH

• Wound, Ostomy, and Continence Nursing (2018). Scope and Standards of WOC Practice (2 ed.). *An Executive Summary. Journal of Wound, Ostomy & Continence Nursing* : July/Aug 2018- Volume45-Issue 4- p369-387.

Samaritan Health Services Building healthier communities together	Approved:	PROCEDURE
	Version #:	
	Document Owner:	

APPLICATION

Nursing Services departments/units included in the Hospital Nurse Staffing Plan, as voted on by the Hospital Nurse Staffing Committee include:

1. Med-Surg
2. Intensive Care Unit
3. Family Birthing Center
4. Emergency Department
5. Surgical Services
6. Wound Care Clinic
7. Ambulatory Infusion

POLICY

Hospital nursing departments/units covered under this policy will maintain staffing appropriate for patient care requirements, taking into consideration:

1. Patient Diagnoses
2. Staff competencies
3. Unit activity
4. Breaks/lunches
5. Unit specific guidelines, in accordance with hospital policies, OAR 333-510 and in compliance with ORS 444.152-444.117, and federal regulations.

DEFINITIONS

1. OAR: Oregon Administrative Rules
2. ORS: Oregon revised statues
3. RN: registered nurse
4. CNA: Certified Nursing Assistant
5. SNLH: Samaritan North Lincoln Hospital

IMPLEMENTATION

Nurse Staffing Plan

1. Each Hospital Nursing department/unit covered under this policy will have a specific plan for staffing based on patient population, national specialty organization recommendations, evidence-based practice and in compliance with HB2697

2. Minimum staffing for a department/unit, when a patient is present:

A. -Surg Unit (MS): two (2) RNs or one (1) RN and one (1) CNA with one staff member on-call-based on the acuity of the patients.

B. Intensive Care Unit (ICU): two (2) RNs or one (1) RN and one (1) CNA depending on acuity of patients (i.e. Med-Surg Overflow, stable Med-Surg pediatric patient, Critical Care level patient).

C. Family Birthing Center (FBC): - two (2) labor trained RNs with one or more patients; (AWHONN Minimum staffing standards). If no patients: two (2) labor RNs to be in house.
D. Emergency Department (ED): two (2) RNs and one (1) ED Technician.
E. Surgical Services (SS): two (2) RNs
F. Ambulatory Infusion: one (1) RN and (1) CNA, or (2) RNs with chemotherapy infusion
G. Wound Clinic: one (1) RN and (1) CNA

3. Creation of the staffing plans:
   A. Each Unit is responsible for the creation of a unit-based staffing plan consistent with patient population served and skill mix of the Unit.
   B. Clinical competency and Scope of service are foundational to the development of the Unit staffing plan.
   C. Staffing plans include unit-based guidelines and methods for determining the acuity and intensity of the patients.
4. The House Supervisor in collaboration with the charge nurse, direct care nursing staff and Nurse Manager:
   A. Reviews Unit based patient acuity/intensity guidelines and shift reporting tools, assessing the admission, discharge and transfer activity on the unit, time required for direct care, non-direct care, and relevant diagnoses.
   B. Reviews the patient care needs and nursing staff scheduled, reallocating resources across the hospital setting as needed to meet projected patient acuity and care requirements each shift, for each Unit and as needed, based on Unit activity (admission, discharge, transfer, special care needs).
   C. Floats nursing staff to nursing units based on patient needs, staff knowledge, skills, abilities and competencies.
   D. When units are closed, it is an expectation that core staff of these units will float or provide helping hands wherever needed.
   E. Work collaboratively with the Staffing Coordinator to identify nursing resources, that are needed when shifts need to be covered or there is an increase in census beyond SNLH nursing staff scheduled
      i. The House Supervisor or Nurse Manager will ensure that Agency or contract staff who agree to work at SNLH will be required to have the same license and credentials as nurses who regularly work in the unit to which they will be assigned. In addition, they will have completed the HR required Agency orientation to SNLH and any department specific orientation
   F. Nursing staff are scheduled according to their FTEs and department hours of operation.
5. Requests for PTO, Education, to cover empty shifts, or to trade shifts are made via KRONOS scheduling system and approved according to the time off and staffing policies/agreements for that department/unit.
6. Schedules are based upon agreed upon rotations, which are not altered without prior agreement by the staff member. Schedules are posted at least four (4) weeks in advance of the first working day of the schedule.

Vacant/Unfilled Shifts

1. Staffing Coordinator/House Supervisor/Nurse Manager will call, email, or text (based on nursing staff member's preferences) the following supplemental nursing staff resources to identify availability to meet patient care needs and Unit activity:
    A. Per Diem
    B. Part time
    C. Full time
    D. Samaritan Health Services Inter facility float program (IFF)
    E. Staffing agencies
    F. Consider utilizing the House Supervisor or manager to fill the staffing need
    G. Employees may request to cover extra shifts that have not been filled once the schedule is posted, these extra shifts are paid at an incentive rate.
    H. Incentive pay will also be paid to those employees who voluntarily agree to pick up a shift as outlined in the Premium Shift Program Policy - SNLH .

Nursing Staff Qualifications

1. Staffing is based on specialized qualifications and competencies for the unit assigned.
2. Unit based qualifications and competencies are consistent with nationally recognized, evidence-based standards and guidelines.
3. A list of on-call, standby, per diem, IFF, and nurse staffing agencies is maintained in the staffing office, as resources to support additional staffing needs.
4. The use of Agency (outside) nursing staff will comply with HR policies to ensure they are adequately licensed, oriented, and their clinical knowledge and skills are evaluated.

Nursing Staff Member Overtime

SNLH will not require a nursing staff member to work beyond the agreed-upon and prearranged shift, regardless of the length of the shift (except for mandatory overtime below, as allowed by OARs)

Mandatory Overtime (Mandatory Overtime Policy - System)

1. SNLH may require an additional hour of work beyond the hours authorized if
    A. A staff vacancy for the next shift may require an additional hour of work beyond the hours authorized.
    B. There is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another nursing staff member.
    C. Mandatory overtime, when required, is documented in Kronos.
    D. Time spent by the nursing staff member in required meetings or receiving education or training will be included as hours worked
    E. Time spent on call or on standby when the nursing staff member is required to be at the hospital will be included as hours worked.

F. The plan does not apply to nursing staff needs:
   1) In the event of a national or state emergency or circumstances requiring the implementation of a facility disaster plan.
   2) In Emergency circumstances that may include
      a. Sudden and unforeseen adverse weather conditions
      b. A worldwide pandemic
      c. An infectious disease epidemic suffered by hospital staff
      d. Any unforeseen event preventing replacement staff from approaching or entering the premises

2. A registered nurse at a hospital may not place a patient at risk of harm by leaving a patient care assignment during an agreed upon scheduled shift or an agreed-upon extended shift without authorization from the appropriate supervisory personnel as required by the Oregon State Board of Nursing OAR, chapter 851.
3. For OR/PACU On-call Program Regarding the work rule of working more than 12 hours in a 24-hour period:

   A. After business hours the surgery department will have scheduled on-call shifts.
   B. When OR/PACU staffs have worked call-back hours the OR Team Facilitator will query staff's ability and desire to safely continue to work the next scheduled shift or any portion thereof.
   C. Staffing adjustments to cover the 10-hour rest periods or lesser number of rest period hours as requested by the staff member will be made in collaboration with the surgery facilitator, House Supervisor, and manager or designee.

Rest Breaks and Meal Breaks

Meals and breaks as described in the Meal Periods Rest Breaks and Work Schedules Policy -System will be agreed upon and covered by each department/unit per each unit's specific staffing plan. The House Supervisor and management will collaborate with the unit staff to facilitate coverage as needed.

SNLH Admission Limitation Management

Follow: Admission Limitation Management Procedure - SNLH

Monitoring, Evaluation and Modification of Staffing Plans

The Hospital Nurse Staffing Committee charter outlines the duties and responsibilities of the committee representatives.

Staffing Concerns and Deviations

1. Staffing concerns are addressed in real time as reported to House Supervisors, Nurse Manager or VP of Patient Care Services, for timely interventions.

2. Staffing concerns are to be submitted in RL Datix under "Nurse Staffing Concerns" within 72 hours. The manager and staffing office will complete their documentation and each concern is reviewed quarterly at the Hospital Nurse Staffing Committee meeting.
3. Each hospital unit may deviate from a nurse staffing plan, except with respect to meal breaks and rest breaks, including the applicable registered nurse-to-patient ratios, within a period of 12 consecutive hours, no more than six times during a rolling 30-day period, without being in violation of the nurse staffing plan. The unit manager must notify the hospital nurse staffing committee no later than 10 days after each deviation. RL Datix will be used to submit and track deviations. RL Datix will then send notification to the nurse staffing committee via committee shared email. Each subsequent deviation during the 30-day period constitutes a separate incident.

Record Retention

Applicable policies, procedures, work instructions, committee minutes, follow up investigations and actions taken will be maintained for a period of 3 years, as required by OAR 333 and the Hospital Nurse Staffing Committee law.

See the following are unit specific staffing plans:

SNLH Med/Surg Unit:

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with OARs**
Narrative	**Medical Surgical Unit Staffing Plan**
333-510-0110 2 (a) **Patient Population**	The Medical Surgical Unit provides 24/7 care for patients requiring acute medical or surgical needs ages 18 to end of life. Patients over the age of 14, who meet the weight-based requirement of adult ACLS, are considered on a case-by-case basis. The Medical Surgical Unit has the unit capacity of ten (10) beds with ability to have telemetry monitoring in all ten (10) beds; four (4) observation rooms and six (6) inpatient rooms. The unit can monitor five (5) rooms with AvaSys video monitoring, utilized for patient safety. The unit operates twenty-four-hours a day, seven days a week. All patients have access to Case Management and Chaplain services as needed.
Description of individual and aggregate patient needs	The Medical Surgical Unit assesses, intervenes, refers, transfers, consults, coordinates, and provides inpatient care needs. The Medical Surgical patient needs include but are not limited to patient and family education and teaching, medication administration and reconciliation, telemetry monitoring, referrals and consults for additional nursing services (nutrition, respiratory, wound care), monitoring chronic and acute health conditions, coordination of care, and psychosocial care and support.
Staff qualifications and competencies	**All staff must have**: • Basic Life Support (BLS) • Orientation Assessment Tool (OAT)

	Registered Nurses must have: • Advanced Cardiac Life Support (ACLS) • National Institute of Health Stroke Scale (NIHSS) • Charge RN- Progressive Care Unit (PCU) OAT competency • RNs- Medical Surgical competencies per the education grid (Education Grid Manager (samhealth.net) • Assignments will be made and adjusted as needed based on identified patient care needs and staff competencies. • The scope of practice for all licensed nurses as defined by the Oregon State Board of nursing: OAR 851-045-0040 (3) Standards related to the licensed nurses' responsibilities for ethics, including professional accountability and competence. (d) Accepts only nursing assignments for which one is educationally prepared and has the current knowledge, skills, and ability to safely perform. • Per House Bill ORS 441.151 Section 8: Charge RN's may cover meal breaks while remaining under the ratio of that unit. ICU RN's will be assigned no more than 2 patients. PCU RN's will be assigned no more than 3 patients. Medical Surgical RN's will be assigned no more than 5 patients. • 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. No additional patients may be assigned. **Certified Nursing Assistant (CNA) 1-2** Are assigned patient care in alignment with their certification level • Per House Bill ORS 441.151 Section 8: CNAs will not be assigned more than seven patients at a time during a day or evening shift, or to more than eleven patients at a time during a night shift. • 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. No additional patients may be assigned. • The scope of practice for all licensed staff as defined by the Oregon State Board of nursing: OAR 851-063-0030 (Oregon Laws) authorized duties and standards for Certified Nursing Assistants. **Tele Techs** • Basic ECG class completion within 1-2 months of hire
Average daily census	**2023** 8.3
Average monthly Census	**2023** 252.8
333-510-0110 2 (b) **Unit Acuity**	Nursing care and acuity is aligned with the Academy of Medical-Surgical Nurses (AMSN) which takes in to account the patients individualized need and the assigned nurse's ability to meet the needs of the patient Safe Staffing (amsn.org). Estimated time needed to complete the following tasks: • Admission 1 hour • Patient transfer 45 minutes • Surgical prep 45 minutes

- Specific diagnosis and medication education: 1.5 hours
- Discharge education: 2 hours
- Complete discharge: 1 hours

Charge RNs/Supervisors will utilize the Epic Nurse Assignment Wizard to evaluate acuity/ intensity and assign patients to each RN. This will be in consideration of the model of care being utilized, the target range guidelines for each model as described in ADDENDUM A, and additional factors as described below:

1) When there is no primary or acting charge RN for the shift:
   a. Off going charge RN or nursing supervisor will prepare staff assignments in Nurse Assignment Wizard and make additional unit task assignments and delegation of Charge RN Duties.
2) CNAs are assigned patient care in alignment with their certification level:
   a. 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. These staff will not be given additional patient assignments.
3) In times of high acuity or critical patient needs, additional qualified staff, or staff from other nursing units float to care for patients within their realm of competency.
4) Actual Acuity/Intensity assignments may exceed the values outlined in the staffing model guidelines in these situations of ADDENDUM C:
   a. ADT– Admission, discharge, and transfers may overlap current assignments for short periods of time (less than 4 hours) ADDENDUM C. Assignments will be carefully evaluated by the charge RN and the staff member to ensure the assignment is well supported.
   b. At the discretion of the charge RN (or delegate) and the staff member taking on the assignment. The reasoning behind such assignment will be documented in the staffing documentation.

Staffing is evaluated every 4 hours and documented on the "Med Surg/ICU Daily Meal and Break" form ADDENDUM B. Charge RNs and Nursing Supervisors utilize the Epic Nurse Assignment Wizard and Charge RN shift documentation to capture, unit activity and information specific to individual patient (such as close observation, 1:1 need, bariatric need) to tailor a plan for staffing for the current shift and project needs for the next shift.

5) Unit activity includes all arrivals to and departures from unit. This includes admission, discharge, transfer, postoperative patients, and outpatients. This can also be affected by multiple staff changes within a shift or the presence of students or orientee staff.
6) All instances of staffing outside of expected guidelines will be communicated to the unit manager.
7) If acuity/activity exceeds or are projected to require staff resources outside of those scheduled, the charge RN will notify the nursing supervisor or manager and request additional staff resource. If requested resources are unavailable, the manager, charge RN and supervisor will have a collaborative discussion regarding management of admissions and unit functioning.
8) If all efforts fail, the unit will be closed to admissions until acuity/activity falls or staffing

	issues are resolved. This will be communicated to senior leadership (Vice Present (VP) of Nursing. Telemetry Monitoring: The ICU has the capability of remote cardiac telemetry monitoring for up to ten (10) patients and/or continuous SpO2 via telemetry monitoring. There patients are cared for through the collaborative efforts of the ICU RN and Medical Surgical RN. The ICU RN is responsible for monitoring, interpreting, documenting findings (uploading rhythm strips into the Electronic Medical Records) and notifying the care team as appropriate. The Medical Surgical RN is responsible for direct and immediate patient care, monitoring (within scope), actioning emergent alarms, and all other equipment related alarms (i.e., poor SpO2 signal/pleth, low battery, lead disconnect) and ensuring patient is admitted to the central and equipment is on and functional. If the patient requires any alarm parameter adjustments, the Medical Surgical RN and ICU RN collaborate and are responsible for addressing this with the provider and obtaining an order so adjustments can be made by the ICU RN or telemetry tech at the central station.
333-510-0110 2 (c) **Total Diagnosis/Scope of Care**	Sepsis unspecified and specified Acute kidney failure Hypertensive heart disease with and without heart failure Cerebral infarction Pneumonia/Pneumonitis with and without hypoxia Chronic obstructive pulmonary disease Congestive heart failure Fracture/orthopedic procedures Acute respiratory failure Cellulitis Alcohol withdrawal Altered mental status Electrolyte imbalance Failure to thrive/comfort care Pre/post operative care Extended recovery Gastrointestinal bleed, illness, obstruction Generalized weakness/fall Gynecology overflow Hospice respite care Swing bed program participants After hour and weekend ambulatory care patients or nursing service needs

333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	Care is provided to patients following the Academy of Medical Surgical Nurses (AMSN) and American Nurses Association (ANA- https://www.researchgate.net/publication/5403378_Nursing_Scope_of_Practice_Descriptions_and_Challenges) standards of care and ethics. Staffing is by acuity/intensity, where patients are assigned acuity/intensity points through the Epic EMR based on nursing care, interventions, provider orders, and transitions of care (admission, discharge, and transfer) Academy of Medical-Surgical Nurses (AMSN) Guidelines (Safe Staffing (amsn.org).
333-510-0110 2 (e) **Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff**	A. Care is provided to patients following the academy Medical Surgical (AMSN) and America Nursing Association (ANA) standards of care and ethics. Staffing is by acuity/ intensity, where patients are assigned acuity/intensity points through the Epic EMR based on nursing care (ADDENDUM E), interventions, provider orders, and transitions of care (admissions, discharge, and transfer). Target assignment ranges for RNs: 1). 150-300 target acuity/intensity range 2). 300-375 warning target acuity/intensity range- indicating additional resources may be needed to support (for example assistance with medication passes, nursing tasks taking longer periods of time) 3). 375-500 danger target acuity/intensity range- additional nursing staff to be assigned to support the primary assignment B. Charge RNs/Supervisors will utilize the Epic Nurse Assignment Wizard to assign patients to each RN while considering the model of care being utilized, the target range guidelines for each model as described in ADDENDUM A
Nursing intensity: the level of patient needs for nursing care as determined by nursing assessment	The following are examples of issues that increase the intensity of patients in the Medical Surgical Unit: • Mobility needs • Bariatric patients • Interpretive Services/communication barriers • Altered mental status/dementia • Alcohol withdrawal • Family dynamics • Isolation patients

	• Secondary diagnosis of behavioral health • Telehealth • Out of facility transfer
333-510-0110 2 (f) **Unit Matrix including the minimum number of nursing staff needed at any given time. May not be solely on national benchmarks (i)**	Minimum unit staffing: 1 RN assigned to 5 or fewer patients. 1 CNA to 7 or fewer patients. Variations may be dependent on the nursing model in use (ADDENDUM A). In addition, there must be a charge RN. If there is one (1) or more patients being telemetry monitored, an ICU RN is required to be on staff. One ICU RN will be responsible for no more than the monitoring of six (6) patients on telemetry/cardiac monitoring. Should the need exceed six (6) patients, a second ICU RN must be present. See ADDENDUM D
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	The unit manager, assistant manager, house supervisor, or combination thereof, will collaborate with the charge RN to evaluate discharge possibilities, transfers to other facilities and staffing ratios. Refer to Admission Limitation Management Procedure - SNLH v.2 (policytech.com)
333-510-0110 2 (g) **Meal and Break Coverage**	Meals and breaks as described in the SHS Meal Periods Rest Breaks and Work Schedules Policy -System v.12 (policytech.com) will be agreed upon and covered by each department/unit. The Charge RN will collaborate with the unit staff to facilitate coverage as needed. When meal breaks cannot be accommodated, this is recorded by the House Supervisor on the daily staffing sheets and on a Kronos Exception Form (KEF). On Inpatient units, the charge RN will provide meal/break coverage. In the event the Charge RN has a patient assignment, the unit manager, assistant manager, and or house supervisor will assist in break/meal coverage. In addition, meal/breaks are recorded on the Daily Meal and Break Schedule sheet ADDENDUM B. Charge RN will provide break relief to the ICU. With one (1) ICU level patient on the unit, the Charge RN will provide patient care, and serve as the second RN on the ICU unit and will perform ICU level patient care at the direction of the remaining ICU RN. If the ICU unit has PCU or Medical Surgical level patients, the Charge RN will serve as the second nurse on the unit.
333-510-0140 **Emergency staffing plan exceptions in the event of**	In the event of a State, Federal, or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee.

national/state emergency	Emergency staffing needs or census management is managed between the nursing supervisor, charge RN(s) of affected units and manager or designee, if needed. B. The Patient Surge Plan Policy - SNLH v.2 (policytech.com)will be utilized as indicated. In addition to surge staffing, there is a plan in place for times when there is limited bed availability for Medical Surgical patients who require admission Boarding Patients in the Emergency Department - Patients Requiring Admission - Practice Recommendations Guidelines - GSRMC, SAGH, SLCH, SNLH, SPCH v.1 (policytech.com)
Environmental Factors	The focus to provide in-room care including procedures, medication administration, documentation, care conference, family participation and shift report. B. All patient care rooms are equipped with all necessary medical equipment (air, oxygen, suction). Each room has a bathroom, communication board, and nurse call light system. Beds are configured by: 1) Six (6) inpatient rooms 2) Four (4) observation rooms, no shower in room. 3) Two (2) inpatient rooms can be flexed as Labor, Delivery, Recovery and Postpartum (LDRP) flex beds C. Special features may include: 1) Ceiling lift tracks in every room 2) Sit to Stand Lift/hover mat/ hover jack 3) One negative pressure airflow isolation room 4) PPE door hangers 5) Patient call system 6) Automated medication dispensing cabinet 7) Adult code cart 8) Blanket warmer 9) Bladder scanner 10) DME and equipment room 11) Supply room 12) Dirty utility room 13) Nourishment center 14) AvaSys available for 5 rooms 15) Telemetry monitoring
Standards and Quality	Standards and Quality (333-510-0110 2d E636) A. AMSN and ANA standards of practice and ethics apply. B. Quality Metrics shall be measured, such as, but not limited to: 1) Blood product transfusion

	2) Patient Safety– Fall Reduction 3) Readmission reduction 4) Infection control 5) Pain management 6) Patient satisfaction measure
Addendum List:	ADDENDUM A: Patient Care Models ADDENDUM B: Daily Meal and Break Schedule ADDENDUM C: Assignment and Acuity Sheet ADDENDUM D: Minimum Staffing Grid

References	American Nurses Association: White, Debbie & Oelke, Nelly & Besner, Jeanne & Doran, Diane & McGillis Hall, Linda & Giovannetti, Phyllis. (2008). Nursing Scope of Practice: Descriptions and Challenges. Nursing leadership (Toronto, Ont.). 21. 44-57. 10.12927/cjnl.2008.19690. Admission Limitation Management Procedure - SNLH v.2 (policytech.com) Adult Intensive Care, Progressive Care, Medical/Surgical, and Acute Care Standards of Care Policy - GSRMC, SAGH, SLCH, SPCH, SNLH v.4 (policytech.com) Boarding Patients in the Emergency Department - Patients Requiring Admission - Practice Recommendations Guidelines - GSRMC, SAGH, SLCH, SNLH, SPCH v.1 (policytech.com) Delgado, DNP, RN, ACNP, S. (2023, September 12). Nurse Staffing: Ratios, Reimbursement and the Work Environment. *American Association of Critical-Care Nurses*. Education Grid Manager (samhealth.net) https://www.aacn.org/blog/nurse-staffing-ratios-reimbursement-and-the-work-environment Meal Periods Rest Breaks and Work Schedules Policy -System v.12 (policytech.com Patient Surge Plan Policy - SNLH v.2 (policytech.com) OAR 851-045-0040 – Scope of Practice Standards for All Licensed Nurses (public.law) Wells, Celia & Zhang, Ziya & Spano-Szekely, Lauraine & Siller, Jennifer & Brannon, Helen & Schulz, Kathleen & Scott, Christine & Dolphy, Melody & Hughes, Ellen & Kohli-Seth, Roopa. (2021). Tiered Model of Nurse Staffing for Critical Care and Emergency Departments in the Wake of a Pandemic. The Journal of nursing administration. 51. E1-E5. 10.1097/NNA.0000000000000979. Tiered Model of Nurse Staffing for Critical Care and Emergency Departments in the Wake of a Pandemic (researchgate.net) 82nd Oregon Legislative Assembly 2023 Regular Session. House Bill 2697

ADDENDUM A

Patient Care Models

RN Models	Team Model	Total Care RN Model	Hybrid	Tiered Model
Guideline	In the team model, each RN load will be assigned to fall within the **goal range of 150-300** acuity points by the Epic acuity/intensity tool.	In the Total Care RN Model, each RN load will be assigned to fall within the **goal range of 150-300** acuity points by the Epic acuity/intensity tool. See Section: 333-510-0110 2 (e) Patient acuity: Complexity of patient care needs requiring the skill/care of nursing staff	In the Hybrid Model, each RN load will be assigned to fall within the **goal range of 150-300** acuity points by the Epic acuity/intensity tool. Assignments can be made in any combination provided maximum ratios are followed: • Medical Surgical RN 5:1 • PCU RN 3:1 • ICU RN 2:1 • CNA 7:1 days/evenings • CNA 11:1 nights	In the Tiered Model, one ICU RN will be assigned to all 4 ICU patients, however, a PCU RN will be paired with the ICU RN and provide care under the direction of the ICU RN (Wells et al, 2021).
Model Description	RN is paired with a CNA for their entire load of patients. CNA may be paired with one or more RNs, depending on acuity/intensity, or geography. At times, it may be appropriate to assign a RN to a CNA role for the shift to	RN is assigned full (or total) nursing care of the patient. This includes all nursing care, including ADLs, call lights, and full care documentation.	The RN's assignment consists of total care of some patients and some patient cares assigned to CNA.	Charge RN will provide break relief to the ICU. With one (1) ICU level patient on the unit, the Charge RN will provide patient care, and serve as the second RN on the ICU unit and will perform patient care at the direction of the remaining ICU RN. If the ICU unit has PCU or Medical Surgical level patients, the Charge RN

	support overall staffing.			will serve as the second nurse on the unit.
Census Impact	Flexible and resilient- supports full 10 pts census with core staffing and allows for fluctuations of acuity/intensity	Supports full 10 patient census with core staffing. Can be limiting with a patient census that has impulsivity and high patient intensity.	Best utilized with planned/known discharges. May require reassignment of CNA's throughout the shift.	Supports the department for timely break/meal relief and high census that results in ED boarding
Best Utilized	• When CNA staffing is available • High intensity patients	• Low intensity patients • CNA's not available or inadequate number of CNA's to utilize the Team Model.	• Limited CNA staff • Lower acuity patients to be assigned as total care patients.	• Breaks/meals • Critical staffing shortage • ED Boarding Boarding Patients in the Emergency Department - Patients Requiring Admission - Practice Recommendations Guidelines - GSRMC, SAGH, SLCH, SNLH, SPCH v.1 (policytech.com)

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	Version #:	
	Document Owner:	

ADDENDUM B

Med-Surg/ICU Daily Meal & Break Schedule DATE_____

DAY	Start Time	Covered By	NIGHT	Start Time	Covered By
NURSE 1			NURSE 1		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
NURSE 2			NURSE 2		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
NURSE 3			NURSE 3		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
CNA 1			CNA		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
CNA 2			UNIT CLERK		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		

ADDENDUM C

Med Surg DAY SHIFT

DATE:

CNA:

RN		RN		RN	
Assignment/Acuity		Assignment/Acuity		Assignment/Acuity	
800		800		800	
1200		1200		1200	
1600		1600		1600	
Y N		Y N		Y N	
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

SHIFT NOTES:

Med Surg NIGHT Shift

CNA:

RN		RN		RN	
Assignment/Acuity		Assignment/Acuity		Assignment/Acuity	
2000		2000		2000	
0		0		0	
400		400		400	
Y N		Y N		Y N	
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

SHIFT NOTES:

ICU DAY Shift

RN		RN		SHIFT NOTES:	
Assignment/Acuity		Assignment/Acuity			
800		800			
1200		1200			
1600		1600			
Y N		Y N			
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

ICU NIGHT Shift

RN		RN		SHIFT NOTES:	
Assignment/Acuity		Assignment/Acuity			
2000		2000			
0		0			
400		400			
Y N		Y N			
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

ADDENDUM D

Med-Surg Staffing Guide				ICU Staffing Guide	
Patient's	**RN's**	**CNA's**	**Charge RN**	**Pt Status**	**Ratio**
7-10	2	2*	1	ICU	1:2
6	2	1	1	PCU	1:3
1-5	1	1	1	MS	1:3

Pt acuity to be discussed with Charge RN and HS.
If >6 pt's on cardiac monitoring/telemetry, 2 ICU RN's are required.
*Applications open

ADDENDUM E

Statement from Epic: Nursing workload scoring systems help nursing departments make more informed, efficient staffing decisions based on data already available in the system. Nursing workload scores indicate how much effort is associated with a patient during a shift, based on work done in previous shifts, such as medication administrations and assessments, and data in his hospital chart, such as a new order or upcoming discharge. Charge nurses can use nursing workload scores to identify patients who require extra attention and make sure to distribute work evenly among nurses to help ensure both safe, attentive care and nurse happiness. In addition, staffing by workload is a requirement of credentialing agencies such as CMS and The Joint Commission.

Intensive Care Unit Staffing Plan

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with OARs**
Narrative	**Intensive Care Unit Staffing Plan**
333-510-0110 2 (a) **Patient Population**	The Intensive Care Unit (ICU) provides 24/7 care for patients requiring critical medical or surgical interventions ages 18 to end of life. Patients over the age of 14, who meet the weight-based requirement of adult ACLS, are considered on a case-by-case basis. ICU staff also provides care and monitoring to Progressive Care Unit (PCU) level patients, as well as Medical Surgical level patients. The ICU has the unit capacity of four (4) beds with ability to have cardiac monitoring. The unit has AvaSys video monitoring capabilities. ICU supports the care of invasive and non-invasive ventilated patients as well as patients requiring titratable drips, pressure line monitoring, end tidal CO2 monitoring, and additional interventions specific to critical care patient populations. All patients have access to Case Management and Chaplain services as needed.
Description of individual and aggregate patient needs	The ICU staff assesses, intervenes, refers, transfers, consults, coordinates, and provides inpatient care needs. The ICU patient needs include, but are not limited to, patient and family education and teaching, medication administration and reconciliation, cardiac monitoring, cardioversion, arterial blood pressure monitoring, ventilation, non-invasive positive pressure ventilation, airway management, vasopressors, antiarrhythmics, referrals and consults for additional nursing services (nutrition, respiratory, wound care), monitoring chronic and acute health conditions, coordination of care, and psychosocial care and support. Additional needs identified

	in Adult Intensive Care, Progressive Care, Medical/Surgical, and Acute Care Standards of Care Policy - GSRMC, SAGH, SLCH, SPCH, SNLH v.4 (policytech.com)
Staff qualifications and competencies	**All staff must have**: • Basic Life Support (BLS) • Orientation Assessment Tool (OAT) **Registered Nurses must have:** • Advanced Cardiac Life Support (ACLS) • National Institute of Health Stroke Scale (NIHSS) • Essentials of Critical Care Orientation (ECCO) training modules • ICU/CCU competencies per the education grid (Education Grid Manager (samhealth.net) • Assignments will be made and adjusted as needed based on identified patient care needs and staff competencies. • The scope of practice for all licensed nurses as defined by the Oregon State Board of nursing: OAR 851-045-0040 (3) Standards related to the licensed nurses' responsibilities for ethics, including professional accountability and competence. (d) Accepts only nursing assignments for which one is educationally prepared and has the current knowledge, skills, and ability to safely perform. • Per House Bill ORS 441.151 Section 8: Charge RN's may cover meal breaks while remaining under the ratio of that unit. ICU RN's will be assigned no more than 2 patients. PCU RN's will be assigned no more than 3 patients. Medical Surgical RN's will be assigned no more than 5 patients. • 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. No additional patients may be assigned. **Certified Nursing Assistant (CNA) 1-2** Are assigned patient care in alignment with their certification level • Per House Bill ORS 441.151 Section 8: CNAs will not be assigned more than seven patients at a time during a day or evening shift, or to more than eleven patients at a time during a night shift. • 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. No additional patients may be assigned. • The scope of practice for all licensed staff as defined by the Oregon State Board of nursing: OAR 851-063-0030 (Oregon Laws) authorized duties and standards for Certified Nursing Assistants **Tele Techs** • Basic ECG class completion within 1-2 months of hire
Average daily census	**2023** 3.2

Average monthly Census	**2023** 37.9
333-510-0110 2 (b) **Unit Acuity**	Nursing care and acuity is aligned with the American Association of Critical-Care Nurses (AACN) which considers the patient's individualized needs and the assigned nurse's ability to meet the needs of the patient (Delgado, 2023). Per OR Estimated time needed to complete the following tasks: • Admission 1 hour • Patient transfer 45 minutes • Surgical prep 45 minutes • Specific diagnosis and medication education: 1.5 hours • Discharge education: 2 hours • Complete discharge: 1 hours Charge RNs/Supervisors will utilize the Epic Nurse Assignment Wizard to evaluate acuity/ intensity and assign patients to each RN. This will be in consideration of the model of care being utilized, the target range guidelines for each model as described in ADDENDUM A, and additional factors as described below: 1) When there is no acting charge RN for the shift: a. Off going charge RN or nursing supervisor will prepare staff assignments in Nurse Assignment Wizard and make additional unit task assignments and delegation of Charge RN Duties. 2) CNAs are assigned patient care in alignment with their certification level: a. 1:1 care staff provides total care for the assigned patient, completing all tasks within their scope and competency. These staff will not be given additional patient assignments. 3) In times of high acuity or critical patient needs, additional qualified staff, or staff from other nursing units float to care for patients within their realm of competency. 4) Actual Acuity/Intensity assignments may exceed the values outlined in the staffing model guidelines in these situations of ADDENDUM C: c. ADT– Admission, discharge, and transfers may overlap current assignments for short periods of time (less than 4 hours) ADDENDUM C. Assignments will be carefully evaluated by the charge RN and the staff member to ensure the assignment is well supported.

	d. At the discretion of the charge RN (or delegate) and the staff member taking on the assignment. The reasoning behind such assignment will be documented in the staffing documentation. Staffing is evaluated every 4 hours and documented on the "Med Surg/ICU Daily Meal and Break" form ADDENDUM B. Charge RNs and Nursing Supervisors utilize the Epic Nurse Assignment Wizard and Charge RN shift documentation to capture unit activity and information specific to individual patient (such as close observation, 1:1 need, bariatric need) to tailor a plan for staffing for the current shift and project needs for the next shift. 5) Unit activity includes all arrivals to and departures from unit. This includes admission, discharge, transfer, postoperative patients, and outpatients. This can also be affected by multiple staff changes within a shift or the presence of students or orientee staff. 6) All instances of staffing outside of expected guidelines will be communicated to the unit manager. 7) If acuity/activity exceeds or are projected to require staff resources outside of those scheduled, the charge RN will notify the nursing supervisor or manager and request additional staff resource. If requested resources are unavailable, the manager, charge RN and supervisor will have a collaborative discussion regarding management of admissions and unit functioning. 8) If all efforts fail, the unit will be closed to admissions until acuity/activity falls or staffing issues are resolved. This will be communicated to senior leadership Vice Present (VP) of nursing. Telemetry Monitoring: The ICU has the capability of remote cardiac telemetry monitoring for up to ten (10) patients and/or continuous SpO2 via telemetry monitoring. There patients are cared for through the collaborative efforts of the ICU RN and Medical Surgical RN. The ICU RN is responsible for monitoring, interpreting, documenting findings (uploading rhythm strips into the Electronic Medical Records) and notifying the care team as appropriate. The Medical Surgical RN is responsible for direct and immediate patient care, monitoring (within scope), actioning emergent alarms, and all other equipment related alarms (i.e., poor SpO2 signal/pleth, low battery, lead disconnect) and ensuring patient is admitted to the central and equipment is on and functional. If the patient requires any alarm parameter adjustments; the Medical Surgical RN and ICU RN collaborate and are

	responsible for addressing this with the provider and obtaining an order so adjustments can be made by the ICU RN or telemetry tech at the central station.
333-510-0110 2 (c) **Total Diagnosis/Scope of Care**	Sepsis Hypertensive heart disease with heart failure Chronic obstructive pulmonary disease with (acute) exacerbation Acute kidney failure specified and unspecified Cerebral infarction, unspecified Hypo-osmolality and hyponatremia Acute respiratory failure with hypoxia Hypertensive heart and chronic kidney disease with heart failure Paroxysmal atrial fibrillation Pneumonia, unspecified Pulmonary embolism Acute Pneumothorax/Hemothorax Gastrointestinal, neurologic, urinary, and metabolic illness of a critical nature Critical electrolyte balance Alcohol or other substance abuse overdose or withdrawal Critically ill or unstable post operative patients Critically ill post-partum patients Rule out myocardial infarction Overflow of medical surgical patients
333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	Care is provided to patients following the AACN and American Nurses Association (ANA-https://www.researchgate.net/publication/5403378_Nursing_Scope_of_Practice_Descriptions_and_Challenges) standards of care and ethics. Staffing is by acuity/intensity, where patients are assigned acuity/intensity points through the Epic EMR based on nursing care, interventions, provider orders, and transitions of care (admission, discharge, and transfer) AACN Guidelines (Delgado, 2023).

333-510-0110 2 (e) **Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff**	A. Care is provided to patients following the AACN and American Nurses Association (ANA- https://www.researchgate.net/publication/5403378_Nursing_Scope_of_Practice_Descriptions_and_Challenges) standards of care and ethics. Staffing is by acuity/intensity, where patients are assigned acuity/intensity points through the Epic EMR based on nursing care (ADDENDUM E), interventions, provider orders, and transitions of care (admission, discharge, and transfer) AACN Guidelines (Delgado, 2023). Target assignment ranges for RNs: 1). 150-300 target acuity/intensity range 2). 300-375 warning target acuity/intensity range- indicating additional resources may be needed to support (for example assistance with medication passes, nursing tasks taking longer periods of time) 3). 375-500 danger target acuity/intensity range- additional nursing staff to be assigned to support the primary assignment C. Charge RNs/Supervisors will utilize the Epic Nurse Assignment Wizard to assign patients to each RN while considering the model of care being utilized, the target range guidelines for each model as described in ADDENDUM A
Nursing intensity: the level of patient needs for nursing care as determined by nursing assessment	The following are examples of issues that increase the intensity of patients in the ICU: • Mobility needs • Bariatric patients • Interpretive Services/communication barriers • Altered mental status/dementia • Alcohol withdrawal • Family dynamics • Isolation patients • Secondary diagnosis of behavioral health • Telehealth • Out of facility transfer • Restraints • Concurrent monitoring of telemetry • Needs specific to invasive and non-invasive ventilated patient populations • Increased frequency of vital sign/cardiac monitoring • Assisting with bedside procedures

333-510-0110 2 (f) **Unit Matrix including the minimum number of nursing staff needed at any given time. May not be solely on national benchmarks (i)**	Minimum unit staffing: If one (1) ICU patient is present on the unit, two (2) ICU RNs are required. 1 CNA to 7 or fewer patients. Variations may be dependent on the nursing model in use (ADDENDUM A). In addition, there must be a charge RN. If there is one (1) or more patients being telemetry monitored, an ICU RN is required to be on staff. One (1) ICU RN will be responsible for no more than the monitoring of six (6) patients on telemetry/cardiac monitoring. Should the need exceed six (6) patients, a second ICU RN must be present. See ADDENDUM D
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	The unit manager, assistant manager, house supervisor, or combination thereof, will collaborate with the charge RN to evaluate discharge possibilities, transfers to other facilities and staffing ratios. Refer to Admission Limitation Management Procedure - SNLH v.2 (policytech.com)
333-510-0110 2 (g) **Meal and Break Coverage**	Meals and breaks as described in the SHS Meal Periods Rest Breaks and Work Schedules Policy -System v.12 (policytech.com) will be agreed upon and covered by each department/unit. The Charge RN will collaborate with the unit staff to facilitate coverage as needed. When meal breaks cannot be accommodated, this is recorded by the House Supervisor on the daily staffing sheets and on a Kronos Exception Form (KEF). On Inpatient units, the charge RN will provide meal/break coverage. In the event the Charge RN has a patient assignment, the unit manager, assistant manager, and or house supervisor will assist in break/meal coverage. In addition, meal/breaks are recorded on the Daily Meal and Break Schedule sheet ADDENDUM B. Charge RN will provide break relief to the ICU. With one (1) ICU level patient on the unit, the Charge RN will provide patient care, and serve as the second RN on the ICU unit and will perform ICU level patient care at the direction of the remaining ICU RN. If the ICU unit has PCU or Medical Surgical level patients, the Charge RN will serve as the second nurse on the unit.
333-510-0140 **Emergency staffing plan exceptions in the event of national/state emergency**	In the event of a State, Federal, or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee. Emergency staffing needs or census management is managed between the nursing supervisor, charge RN(s) of affected units and manager or designee, if needed. B. The Patient Surge Plan Policy - SNLH v.2 (policytech.com)will be utilized as indicated. In addition to surge staffing, there is a plan in place for times when there is limited bed availability for ICU patients who require admission Boarding Patients in the

	Emergency Department - Patients Requiring Admission - Practice Recommendations Guidelines - GSRMC, SAGH, SLCH, SNLH, SPCH v.1 (policytech.com)
Environmental Factors	The focus to provide in-room care including procedures, medication administration, documentation, care conference, family participation and shift report. B. All patient care rooms are equipped with all necessary medical equipment (air, oxygen, suction). Each room has a bathroom, communication board, and nurse call light system. Beds are configured by: 1) Four (4) inpatient rooms C. Special features may include: 1) Ceiling lift tracks in every room 2) Sit to Stand Lift/hover mat/ hover jack 3) One negative pressure airflow isolation room 4) PPE door hangers 5) Patient call system 6) Automated medication dispensing cabinet 7) Adult and pediatric code cart 8) Blanket warmer 9) H track ceiling lift 10) DME and equipment room 11) Supply room 12) Dirty utility room 13) Nourishment center 14) AvaSys available for 4 rooms 15) Telemetry/cardiac monitoring
Standards and Quality	Standards and Quality (333-510-0110 2d E636) A. AACN and ANA standards of practice and ethics apply. B. Quality Metrics shall be measured, such as, but not limited to: 1) Blood product transfusion 2) Patient Safety– Fall Reduction 3) Readmission reduction 4) Infection control 5) Pain management 6) Patient satisfaction measure
Addendum List:	ADDENDUM A: Patient Care Models ADDENDUM B: Daily Meal and Break Schedule ADDENDUM C: Assignment and Acuity Sheet

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	ADDENDUM D: Minimum Staffing Grid

References

American Nurses Association: White, Debbie & Oelke, Nelly & Besner, Jeanne & Doran, Diane & McGillis Hall,
Linda & Giovannetti, Phyllis. (2008). Nursing Scope of Practice: Descriptions and Challenges. Nursing leadership (Toronto, Ont.). 21. 44-57. 10.12927/cjnl.2008.19690.

Admission Limitation Management Procedure - SNLH v.2 (policytech.com)

Adult Intensive Care, Progressive Care, Medical/Surgical, and Acute Care Standards of Care Policy - GSRMC, SAGH, SLCH, SPCH, SNLH v.4 (policytech.com)

Boarding Patients in the Emergency Department - Patients Requiring Admission - Practice Recommendations Guidelines - GSRMC, SAGH, SLCH, SNLH, SPCH v.1 (policytech.com)

Delgado, DNP, RN, ACNP, S. (2023, September 12). Nurse Staffing: Ratios, Reimbursement and the Work Environment. *American Association of Critical-Care Nurses*.

Education Grid Manager (samhealth.net)

https://www.aacn.org/blog/nurse-staffing-ratios-reimbursement-and-the-work-environment

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Patient Surge Plan Policy - SNLH v.2 (policytech.com)

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Wells, Celia & Zhang, Ziya & Spano-Szekely, Lauraine & Siller, Jennifer & Brannon, Helen & Schulz, Kathleen & Scott, Christine & Dolphy, Melody & Hughes, Ellen & Kohli-Seth, Roopa. (2021). Tiered Model of Nurse Staffing for Critical Care and Emergency Departments in the Wake of a Pandemic. The Journal of nursing administration. 51. E1-E5. 10.1097/NNA.0000000000000979.

Tiered Model of Nurse Staffing for Critical Care and Emergency Departments in the Wake of a Pandemic (researchgate.net)

82nd Oregon Legislative Assembly 2023 Regular Session. House Bill 2697

ADDENDUM A

Patient Care Models

RN Models	Team Model	Total Care RN Model	Hybrid	Tiered Model
Guideline	In the team model, each RN load will be assigned to fall within the **goal range of 150-300** acuity points by the Epic acuity/intensity tool.	In the Total Care RN Model, each RN load will be assigned to fall within the **goal range of 150-300** acuity points by the Epic acuity/intensity tool. See Section: 333-510-0110 2 (e) Patient acuity: Complexity of patient care needs requiring the skill/care of nursing staff	In the Hybrid Model, each RN load will be assigned to fall within the **goal range of 150-300** acuity points by the Epic acuity/intensity tool. Assignments can be made in any combination provided maximum ratios are followed: • Medical Surgical RN 5:1 • PCU RN 3:1 • ICU RN 2:1 • CNA 7:1 days/evenings • CNA 11:1 nights	In the Tiered Model, one ICU RN will be assigned to all 4 ICU patients, however, a PCU competent RN will be paired with the ICU RN and provide care under the direction of the ICU RN (Wells et al, 2021).
Model Description	RN is paired with a CNA for their entire load of patients. CNA may be paired with one or more RNs, depending on acuity/intensity, or geography. At times, it may be appropriate to assign a RN to a CNA role for the shift to	RN is assigned full (or total) nursing care of the patient. This includes all nursing care, including ADLs, call lights, and full care documentation.	The RN's assignment consists of total care of some patients and some patient cares assigned to CNA.	Charge RN will provide break relief to the ICU. With one (1) ICU level patient on the unit, the Charge RN will provide patient care, and serve as the second RN on the ICU unit and will perform patient care at the direction of the remaining ICU RN. If the ICU unit has PCU or Medical Surgical level patients, the Charge RN

	support overall staffing.			will serve as the second nurse on the unit.
Census Impact	Flexible and resilient- supports full 4 patient census with core staffing and allows for fluctuations of acuity/intensity	Supports full 4 patient census with core staffing. Can be limiting with a patient census that has impulsivity and high patient intensity.	Best utilized with planned/known discharges. May require reassignment of CNA's throughout the shift.	Supports the department for timely break/meal relief.
Best Utilized	• When CNA staffing is available • High intensity patients	• Low intensity patients • CNA's not available or inadequate number of CNA's to utilize the Team Model.	• Limited CNA staff • Lower acuity patients to be assigned as total care patients.	• Breaks/meals • Critical staffing shortage • ED Boarding Boarding Patients in the Emergency Department - Patients Requiring Admission - Practice Recommendations Guidelines - GSRMC, SAGH, SLCH, SNLH, SPCH v.1 (policytech.com)

ADDENDUM B

Med-Surg/ICU Daily Meal & Break Schedule DATE_____

DAY	Start Time	Covered By	NIGHT	Start Time	Covered By
NURSE 1			NURSE 1		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
NURSE 2			NURSE 2		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
NURSE 3			NURSE 3		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
CNA 1			CNA		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		
CNA 2			UNIT CLERK		
Break 1			Break 1		
Meal			Meal		
Break 2			Break 2		
Break 3			Break 3		

ADDENDUM C

Med Surg DAY SHIFT

DATE:

CNA:

RN		RN		RN	
Assignment/Acuity		Assignment/Acuity		Assignment/Acuity	
800		800		800	
1200		1200		1200	
1600		1600		1600	
Y N		Y N		Y N	
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

SHIFT NOTES:

Med Surg NIGHT Shift

CNA:

RN		RN		RN	
Assignment/Acuity		Assignment/Acuity		Assignment/Acuity	
2000		2000		2000	
0		0		0	
400		400		400	
Y N		Y N		Y N	
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

SHIFT NOTES:

ICU DAY Shift

RN		RN		SHIFT NOTES:	
Assignment/Acuity		Assignment/Acuity			
800		800			
1200		1200			
1600		1600			
Y N		Y N			
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

ICU NIGHT Shift

RN		RN		SHIFT NOTES:	
Assignment/Acuity		Assignment/Acuity			
2000		2000			
0		0			
400		400			
Y N		Y N			
PT Count Start		Acuity Start			
Admits		Discharges		Transfers	
PT Count End		Acuity End			

ADDENDUM D

Med-Surg Staffing Guide				ICU Staffing Guide	
Patient's	**RN's**	**CNA's**	**Charge RN**	**Pt Status**	**Ratio**
7-10	2	2*	1	ICU	1:2
6	2	1	1	PCU	1:3
1-5	1	1	1	MS	1:3

Pt acuity to be discussed with Charge RN and HS.
If >6 pt's on cardiac monitoring/telemetry, 2 ICU RN's are required.
*Applications open

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ADDENDUM E

Statement from Epic: Nursing workload scoring systems help nursing departments make more informed, efficient staffing decisions based on data already available in the system. Nursing workload scores indicate how much effort is associated with a patient during a shift, based on work done in previous shifts, such as medication administrations and assessments, and data in his hospital chart, such as a new order or upcoming discharge. Charge nurses can use nursing workload scores to identify patients who require extra attention and make sure to distribute work evenly among nurses to help ensure both safe, attentive care and nurse happiness. In addition, staffing by workload is a requirement of credentialing agencies such as CMS and The Joint Commission.

Family Birthing Center Staffing Plan

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with OARs**
Narrative	**Family Birthing Center Staffing Plan**
333-510-0110 2 (a) **Patient Population**	The Family Birthing Center (FBC) provides 24/7 care for pregnant persons, 20 weeks gestation and above. We also care for neonates from birth to 28 days. We are a level 1 critical access. We keep pregnant persons 36 weeks and above, complex patients or preterm persons are transferred to tertiary hospitals for care. Nursery care is for well babies, 36 weeks and above. Neonates that are unstable or needing higher level of care are transferred out to appropriate care facilities.
Description of individual and aggregate patient needs	Family Birthing Center assesses, stabilizes, resuscitates, intervenes, refers, transfers consults and coordinates patient care needs. The primary care pregnant persons need include but are not limited to: patient and family education and teaching, medication administration and reconciliation, monitoring chronic and acute health conditions during pregnancy, coordination of care for community resources and lactation support. The primary care neonates need include but are not limited to: resuscitation, stabilization, education of primary care givers, medication administration, assessing and monitoring for acute health conditions as they present, coordination of care for community resources, and outpatient follow ups.
Staff qualifications and competencies	**All staff in FBC must have**: • Cardiopulmonary Resuscitation Basic Life Support (CPR BLS) • Neonatal Resuscitation Program (NRP) **Registered Nurses**: • Basic Fetal Monitoring at hire • Intermediate Fetal Monitoring by 1 year • Advanced Cardiac Life Support (ACLS) within 6 months of hire

	• STABLE course required within 1 year of hire. • New to specialty RNs must complete Perinatal Orientation Education Program (POEP) and Neonatal Orientation Education Program (NOEP) in their orientation period. Along with completion of LDRP Orientation Assessment Tool (OAT) • Annual assigned department competencies and education per the education grid. • The scope of practice for all licensed nurses as defined by the Oregon State Board of nursing: OAR 851-045-0040 (3) Standards related to the licensed nurses' responsibilities for ethics, including professional accountability and competence. (d) Accepts only nursing assignments for which one is educationally prepared and has the current knowledge, skills and ability to safely perform. **OB Tech** • CNA2 • Complete OAT during orientation period. • Annual assigned department competencies and education per the education grid **Additional resources and support staff based on acuity/intensity and census**: • RNs and CNAs coming in to FBC as helping hands will be delegated tasks that are in their scope of practice and competency levels.
Average Census 2023	Daily Average: 1.8 Deliveries 106 Total visits: 644 which includes triages, NSTs, lactation support and outpatient follow ups.
333-510-0110 2 (b) **Unit Acuity**	Nursing care time studies identified the following, which are included as part of the determination for staffing and the NSP: • Time to complete admission 1 hour • Time to complete transfer 45 minutes • Time to prep for OR Scheduled: 2 hours • Time for lactation education: 1.5 hours • Time for post-partum maternal and newborn care discharge education: 2 hours Time to complete discharge (excluding education): 1.5 hours

333-510-0110 2 (c) **Total Diagnosis/Scope of Care**	The FBC provides 24/7 care in the following manner, but not limited to: • Outpatient testing/Triage • Newborns < 28 days • Inpatient labor 36.0 weeks and above • Antepartum inpatient/outpatient/observation & stabilization for transport • Postpartum couplet care • Well newborns, twins • Stabilize and transport premature neonates • Phototherapy for hyperbilirubinemia • Scheduled cesarean sections and Emergency cesarean sections • Outpatient newborn follow ups, weight checks, bilirubin checks, outpatient circumcision • Lactation consultation and support • Gyn surgical recoveries Below are examples of the most common diagnoses for patients in the FBC: • Term gestation, labor • Term gestation, cesarean, repeat or primary • Anemia • Gestational Hypertension • Pre-eclampsia without severe features • Gestational Diabetes, diet controlled and/or insulin dependent • Hyperbilirubinemia requiring phototherapy • Preterm labor or PPROM requiring transport
333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	Family Birthing Center follows: Association of Women's Health and Neonatal Nurses (AWHONN) Staffing Standards 2023 House Bill 2697-B Nurse to patient ratios. American Society of Peri Anesthesia Nurses (ASPAN) Nursing Standards and Recommendations 2023-2024 Adequate staffing is critical to providing safe, high-quality nursing care for all those who give birth and their babies. Staffing needs in perinatal units are dynamic, consistent with the various types of patients and clinical situations encountered in a perinatal service. Clinical consideration must be given to the fetus, during labor, and the newborn patient, that nurses are responsible, that historically have not been accounted for, as interventions and a significant portion of time is spent in interventions and cares. (AWHONN 2023).

333-510-0110 2 (e) **Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff**	FBC will utilize the OB Acuity/Intensity and assignment form (see attached) every 4 hours and will adjust as needed in collaboration with the house supervisor and/or department manager. **Antepartum 1:1** – • Initial OB Triage • Unstable antepartum complications i.e.: Preterm labor, bleeding, hypertension • IV Magnesium drip for first hour **Antepartum 1:2-3** • Scheduled NSTs • OB Triage, after initial assessment and stable condition • Stable antepartum patients **Intrapartum 1:1** • Medical or obstetric complications during labor (diabetes, morbid obesity, preeclampsia, hypertensive crisis, multiple gestation, fetal demise, abnormal fetal heart rate patterns • Labor patients on oxytocin • Natural labor, no pain relief or medical interventions, intermittent auscultation • First hour of Magnesium Sulfate initiation • First 30 minutes of regional anesthesia • Active pushing stage of labor **Intrapartum 1:2** • Persons in labor without complications **Intrapartum 2:1** • Birth: one RN responsible for birthing person, one RN solely responsible for baby **Postpartum/Newborn/Couplet care 1:1** • Immediate postop/postpartum recovery – first 2 hours • Newborn undergoing a circumcision, during procedure and first post procedure check. • Newborns needing stabilization **Postpartum/Newborn/Couplet care 1:2** • First day postop section **Postpartum/Newborn/Couplet care 1:3** • Mother/baby couplets after 2 hr. recovery period with consideration for acuity mix for first day postop patients
Nursing intensity: the level of patient needs for nursing care as determined by	The following are examples of issues that increase the intensity of patients in the FBC: • Complex family dynamics • DHS involvement • Social Determinates of Health

nursing assessment	• Need for interpretive services • Bariatric patients • Persons with disabilities • Persons in isolation • NICU Telehealth • Blood administration • Postpartum Hemorrhage • Eclampsia • Hypertensive crisis. • OB related emergencies
333-510-0110 2 (f) **Unit Matrix including the number of nursing staff needed at any given time. May not be solely on national benchmarks (i)**	Minimum staffing: Family Birthing Center is always staffed with 2 labor ready RNs, 24/7. OB Tech is scheduled Monday through Friday and as needed per acuity and intensity. Nursing staff will assess staffing needs per unit acuity and communicate with House Supervisor if need for increased staffing. House Supervisor and/or staffing office will call for supplemental staffing, per the Staffing Plan for Nursing Services- Vacant shift.
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	Follow procedures in Policy Tech: Admission Limitation Management Procedure-SNLH Obstetric Service Divert Due to Staffing Deficit Procedure-SNLH, SPCH
333-510-0110 2 (g) **Meal and Break Coverage**	• RNs will get 30-minute lunch and three 15-minute rest breaks per 12-hour shift, according to SHS policy. • OB Techs will get a 30-minute lunch and two 15-minute rest breaks per 8-hour shift, according to SHS policy. **Coverage for breaks and meals will be given with assistance by:** • **Weekdays**: Nurse manager to cover meals/breaks. • If manager unable to cover, and monitored patient is present, a labor trained RN will be called in to assist with meals/breaks. If unmonitored patients present, will be assisted by NRP certified personnel. • **Nights and weekends**: if unmonitored patient(s) present, will be assisted by NRP certified personnel.

	• If monitored patient(s) present, a labor trained RN will be called in to cover lunches/breaks. • Documentation of meal and rest breaks will be on the FBC Break document, indicating who will be caring for patients when the assigned nurse is on break, nurse will sign that they received meal/breaks on form. If unable to take meal/break the missed meal/break will be crossed out and a Kronos exception form will be filled out and signed by the staff member and house supervisor.
333-510-0140 **Emergency staffing plan exceptions in the event of national/state emergency**	In the event of a State, Federal or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee.
Environmental Factors	The focus to provide at the bedside care including procedures, medication administration, documentation and family participation. FBC has: • 2 full labor suites with all the medically necessary equipment (i.e. labor beds, fetal monitors with vitals, IV pumps, epidural pumps, neonatal warmers with resuscitation capabilities) • A 2 bed, semi-private triage room that is fully capable of converting to a labor room as needed. • Nursery for stabilization with full emergency and resuscitation equipment, bubble c-pap, tele-doc NICU, cardiac monitors, etc. Nursery can flex into a labor triage space, with roving fetal monitor. • Infant security system (Totguard) • Ability to flex into 2 rooms shared with the Med/Surg floor. Each of those rooms can convert to labor rooms. • Store room • Medication and Nourishment room
Standards and Quality	OSBN and AWHONN standards of practice and ethics apply and can be measured. • Adverse events • Postpartum and newborn infection rates • Patient/newborn falls • Patient satisfaction • Nursing satisfaction
Addendum List:	FBC Labor and Delivery Acuity Sheet

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References	Standards for Professional Registered Nurse Staffing for Perinatal Units- AWHONN 2023 American Society of Peri Anesthesia Nurses (ASPAN) Nursing Standards and Recommendations 2023-2024

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	TRIAGE	LDRP 1	LDRP 2	MS 14	MS 15	NURSERY	Quarter of Shi
3	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	
	= Routine NB	= Routine NB	= Routine NB	= Routine NB	= Routine NB	= Routine NB	
5	= AP, stable	= AP, stable	= AP, stable	= AP, stable	= AP, stable	= AP, stable	**7:00**
	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	
	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	Acuity Total:
	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	_____
#	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	
	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	Circle:
	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	0-15 = 1 nurse
	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	16-30 = 2 nurses
15	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	31-45 = 3 nurses
	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	46-60 = 4 nurses
	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	
	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hours	
	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	Assignments:
	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive care	
	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	
30	= Delivery	= Delivery	= Delivery	= Delivery	= Delivery	= Delivery	
	= Cesarean	= Cesarean	= Cesarean	= Cesarean	= Cesarean	= Cesarean	
	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	
3	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	
	= Routine NB	= Routine NB	= Routine NB	= Routine NB	= Routine NB	= Routine NB	
5	= AP, stable	= AP, stable	= AP, stable	= AP, stable	= AP, stable	= AP, stable	**11:00**
	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	
	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	Acuity Total:
	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	_____
#	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	
	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	Circle:
	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	0-15 = 1 nurse
	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	16-30 = 2 nurses
15	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	31-45 = 3 nurses
	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	46-60 = 4 nurses
	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	
	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hours	
	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	Assignments:
	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive care	
	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	
30	= Delivery	= Delivery	= Delivery	= Delivery	= Delivery	= Delivery	
	= Cesarean	= Cesarean	= Cesarean	= Cesarean	= Cesarean	= Cesarean	
	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	
3	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	= PP woman no complications	
	= Routine NB	= Routine NB	= Routine NB	= Routine NB	= Routine NB	= Routine NB	
5	= AP, stable	= AP, stable	= AP, stable	= AP, stable	= AP, stable	= AP, stable	**15:00**
	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	= PP woman complications	
	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	= NB convalescence care	Acuity Total:
	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	= Couplet out of recovery	_____
#	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	= NST = Labor uncompl.	
	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	= Triage p assess = C/S POD1	Circle:
	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	= Cervical ripen = NB intermed. ca	0-15 = 1 nurse
	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	= Mag. maintenance	16-30 = 2 nurses
15	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	= Triage initial = Intermittent ausc	31-45 = 3 nurses
	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	= AP, unstable = Epidural initiation	46-60 = 4 nurses
	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	= Labor pushing = Mag, 1st hour	
	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hour	= Labor complicat = Recovery 2 hours	
	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	= Labor oxytocin = NB procedure	Assignments:
	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive car	= Labor s pain relie = NB intensive care	
	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	= Labor magnesium	
30	= Delivery	= Delivery	= Delivery	= Delivery	= Delivery	= Delivery	
	= Cesarean	= Cesarean	= Cesarean	= Cesarean	= Cesarean	= Cesarean	
	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	= NB unstable critical	

Minimum of 2 LDRP trained nurses in the hospital at all times, despite patient census.

Nurse to Patient Ratio

1 to 5 Postpartum women without complications, stable (women only [not couplets], no more than 3 of which are immedidate postoperative day cesarean)
Newborns without complications, routine care (newborns only [not couplets])

1 to 3 Antepartum complications, stable
Postpartum women with complications, stable (women only [not couplets])
Couplets after 2 hour recovery period (1:3 meaning considering mixing acuity rather than all recent postcesarean)
Newborn requiring continuing care (convalescing; newborns only [not couplets])

1 to 2 Nonstress test
Triage, stable and after initial assessment
Cervical ripening
Magnesium infusion, maintenance dose and/or postpartum (1:2 meaning one additional woman or one couplet)
Labor without complications
Cesarean birth immediate postoperative day
Newborn requiring intermediate care (sick, 6-12 hrs/day of nursing care; newborn only [not couplets])

1 to 1 Initial triage
Antepartum complications, unstable
Magnesium infusion, first hour (administered for any reason: preterm labor prophylaxis, preeclampsia)
Labor with complications (diabetes, pulmonary or cardiac disease, morbid obesity, preeclampsia or hypertensive crisis, multiple gestation, fetal demise, any abnormal or indeterminate FHR pattern, TOLAC)
Labor with oxytocin administration
Labor with minimal or no pain relief/interventions
Labor with Magnesium infusion
Labor in active pushing phase
Fetal monitoring with intermittent ausculation
Regional anesthesia initiation and until patient stable (at least 30 mins after initial dose)
Recovery for minimum 2 hours
Circumcision and other newborn surgical procedures (preoperative, intraoperative, postoperative)
Newborn requiring intensive care (severely ill, constant nursing care, continuous cardiopulm or other support; newborn only [not couplets])

2 to 1 Vaginal Birth
Cesarean
Unstable newborn requiring complex critical care

Standards for Professional Registered Nurse Staffing for Perinatal Units, AWHONN, 2022

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Emergency Department Staffing Plan:

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with OARs**
Narrative	Emergency Department Staffing Plan The emergency Department has the unit capacity of seven (7) beds with ability to have telemetry monitoring in all seven (7) beds. The unit can monitor two (2) rooms with video monitoring capabilities that are used as secure rooms with roll down locked doors. Four (4) rooms are used as flex rooms shared with outpatient service. The unit operates twenty-four-hour, seven day a week. Five (5) of the rooms have overhead ceiling lifts used for patient transfer. All patients have access to Case Management and Chaplain services as needed.
333-510-0110 2 (a) **Patient Population**	The Emergency Department provides 24/7 care for patients of all age groups. Care includes all patient populations. Emergency Department Patients are classified according to the ESI 5 Level Triage System. Emergency Severity Index Copyright Notice. Content last reviewed May 2020. Agency for Healthcare Research and Quality, Rockville, MD. (Addendum A) Types include Resuscitation (Level 1), Emergent (Level 2), Urgent (Level 3), Semi-Urgent (Level 4), Non-Urgent (Level 5). (See addendum A: ESI Triage Acuity Tool and Algorithm)
Description of individual and aggregate patient needs	The Emergency Department stabilizes, resuscitates, assesses, intervenes, refers, transfers, consults, and coordinates patient care needs. The primary care emergency patient needs include but are not limited to: Patient and family education and teaching, medication administration and reconciliation, monitoring chronic and acute health conditions, coordinate care, acute psychiatric care, psychosocial care and support, wound care, and Injury Care.
Staff qualifications and competencies	The Emergency Department is staffed with RNs and ED Techs who are licensed/certified through the Oregon State Board. Certifications and Competencies are expected to be completed by due date or staff may be subject to corrective action. **All Staff:** • Cardiopulmonary Resuscitation Basic Life Support (CPR – BLS Healthcare Provider) • Completion of Orientation (OATS) • Annual Emergency Department education as outlines in the department education grid. • Violent and non-violent restraints • *ACIT training*

Registered Nurses (RNs):

- RN should possess at least one year of emergency department experience or completion of the core competency modules specified by the Emergency Nurses Association (ENA).
- Advanced Cardiac Life Support (ACLS)
- Pediatric Advanced Life Support (PALS)
- Trauma Nursing Core Curriculum (TNCC)
- Neonatal Resuscitation program (NRP)
- ESI triage
- TPA administration
- Stroke Education, including Code Stroke

Registered Nurses (RNs) under a temporary travel contract:

- Current Unencumbered Oregon RN License
- Cardiopulmonary Resuscitation Basic Life Support (CPR – BLS Healthcare Provider)
- Advanced Cardiac Life Support (ACLS)
- Pediatric Advanced Life Support (PALS)
- Trauma Nursing Core Curriculum (TNCC)
- Department Competencies per Skills Checklist

Charge Nurse require the above competencies and additionally are responsible for the evaluation of shift specific demands.

- Unit Census
- Patient Acuity
- Anticipated activity (procedures, admissions, discharges)
- Number of staff scheduled and potential for additional staff (floats, agency)
- Staff skill mix/ competency level

Nurses floating into the department as an emergency nurse will be cross trained to the environment, fulfilling all competencies and qualifications prior to taking an assignment.

Nurses floating to the emergency department to care for boarding patients, such as medical or critical care patients boarding in the emergency department will be allowed to care for patients if their scope of practice, competency and qualifications are equivalent to level of care of the admitted patient that is waiting for a bed in the facility.

For the Registered Nurse and Charge Nurse:

The scope of Practice for All Licensed Nurses as defined by the Oregon State Board of Nursing: OAR 851-045-0040 (3) Standards related to the licensed nurses' responsibilities for ethics, including professional accountability and competence. (d) Accepts only nursing assignments for

	which one is educationally prepared and has the current knowledge, skills, and ability to safely perform. (h) Retains Samaritan North Lincoln Hospital Unit Staffing Plans/Scope of Service professional accountability when accepting, assigning, or supervising nursing care and interventions. **ED Tech I** • One required: CNA2/EMT/AEMT/EMT-I **ED Tech II** • Both required: CNA2 & EMT or AEMT or EMT-I **ED Tech III** • EMT-P • Advanced Cardiac Life Support (ACLS) • Pediatric Advanced Life Support (PALS)
Average daily census	Q1: Q2: Q3: Q4:
333-510-0110 2 (b) **Unit Acuity**	Average length of stay for emergency department Patients: Approximate time required to complete ADT: Admissions • To ED Average – Ten (10) minutes • Into Hospital Average – Sixty (60) minutes Discharge • Home, uncomplicated Average – Ten (10) minutes Transfer • Another facility, uncomplicated Average – Sixty (60) minutes
333-510-0110 2 (c) **Total Diagnosis/Scope of Care**	The Emergency Department provides twenty-four-hour, seven day a week care for patients across the entire age spectrum. Each patient coming to the Emergency Department is evaluated by an Emergency Room Physician and given a diagnosis prior to admission, discharge, or transfer. Below are examples of the top diagnoses of patients seen in the Emergency Department: •Chest Pain •Anxiety •Stroke

	•Cardiac/STEMI •Atrial Fibrillation •Nausea/Vomiting/Diarrhea •COPD •Procedures, I & D's, Wound Irrigation, Suture Removal •Trauma •Asthma •Abdominal Pain •Depression •Fractures •Burns •Suicidal/Homicidal
333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	Evidence based findings and guidelines from the Emergency Nurses Association guide decision making about the clinical, educational, and staffing needs in the Emergency Department. The Charge Nurses collaborate with staff nurses, emergency department Manager and Hospital Supervisors to ensure that staffing levels have flexibility and can be adjusted to maintain the appropriate staffing levels based on patient care needs and nursing skill mix. Evaluation of staffing and productivity is based on patient census and acuity, direct and indirect time for care delivery, and the experience and skill mix of the emergency department staff. Such evaluation also includes the impact on patient and emergency nurse safety and satisfaction and the recruitment and retention of qualified emergency nurses. Emergency nurses support further research regarding emergency department staffing models and their impact on patients, nurses, and healthcare systems. **Staffing and Productivity in the Emergency Department. ENA.org. https://www.ena.org/. Accessed July 12, 2021.**

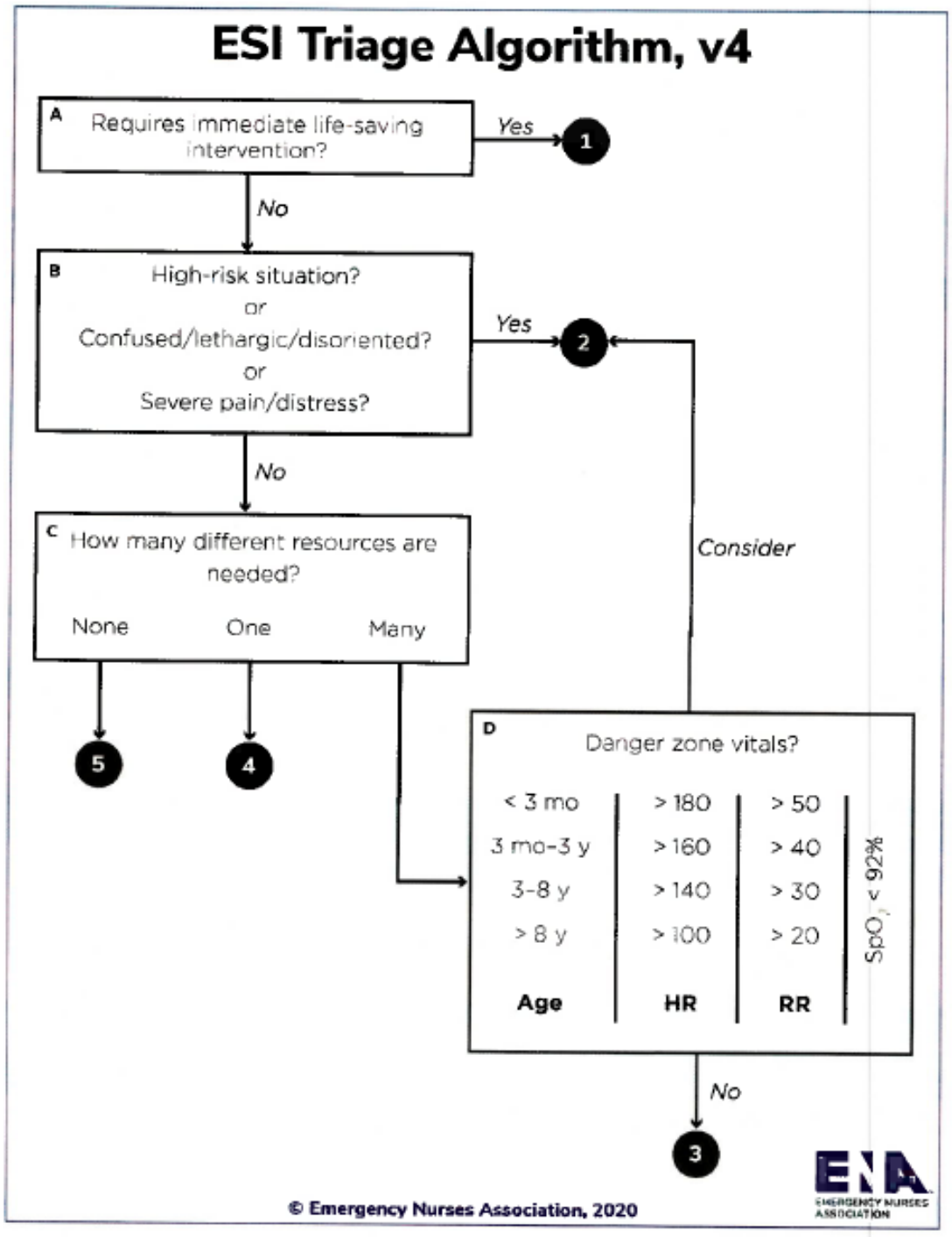
333-510-0110 2 (e) **Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff**	RN ratio is based off Emergency Nurses Association Guidelines: • Trauma 1:1 or 2:1 • Forensic/Sane 1:1 • Critical/Resuscitation 1:1 or 2:1 • Emergent/ Urgent 1:3 • Medical Acute/ Non-Urgent/ Stable Mental Health 1:4 • Low Acuity (ESI 4 & 5) non-urgent 1:4 (Fast Track) Boarding patients waiting for ICU admit to NLH 1:2 Boarding patients waiting for MS admit to NLH 1:4 **Staffing Determination:** Patients that are considered high intensity and/or high ESI acuity (1-2) with continuous assessment of the unit can necessitate modifications to the RN ratios to promote safe patient care. **Note:** The emergency department utilizes the emergency severity Index (ESI) 5 level triage system for establishing initial triage acuity. They include 5 levels: resuscitation (1), emergent (2), urgent (3), semi-urgent (4), and non-urgent (5). Patient Acuity is reevaluated upon assigned RN's reassessments, with any acute patient changes. If any change in ESI score is warranted, this will be updated in EPIC.
Nursing intensity: the level of patient needs for nursing care as determined by nursing assessment	Assessments and reassessments of patients are determined by the acuity of the patient, medication given, or care provided. The following procedures can affect the intensity of nursing care: • Blood administration • Procedural Sedation • Restraints or Seclusion • Infusions requiring titration and monitoring. • Splint Care • Chest Tube Placement • IV Placement • OR Prep • ADL Requirements • Stroke Care • Trauma Care • Sepsis Workup/Care • Suicidal Care/Monitoring • Overdose • Cardiac Arrest • Bladder Irrigation

	•Assignments are adjusted throughout both day shift and night shift as patient census, acuity/Intensity level and staff availability/ skill mix change. Acuity is determined using the evidence-based process of Emergency Severity Index (ESI). Intensity level is determined by assessment of the patient's nursing needs. The charge nurse also assesses once at the beginning of the shift and continuously throughout each shift, both day shift and night shift, whether patient care needs are being met or if patient safety is at risk and adjustments are made accordingly. This may include staffing up or down depending on needs of the department.
333-510-0110 2 (f) **Unit Matrix including the minimum number of nursing staff needed at any given time. May not be solely on national benchmarks (i)**	**Core Staffing guideline per number of patients as follows:** • This can be flexed up/down based on skills mix, volume, acuity and/or intensity of patients. Core staff for the ED is 2 RNs and 1 Tech. **Nurse Manager:** Variable Hours **Trauma Nurse Coordinator:** Variable Hours **Charge Nurse:** 1 RN 0600-1830, 1 RN 1800-0630 **Staff nurse:** All Shifts: 2 RN 0600-1830, 1 RN 1200-0030, 2 RN 1800-0630 **ED Tech:** 12 hours shifts: 1 ED tech 0600-1830, 1 ED Tech 1830-0630 **Unit Clerk:** Additional staff may be scheduled for holidays, community events, and seasonal to accommodate a potential increase in census. **Charge RN:** Responsible for managing the flow of the department as acuity and intensity of care both increases and decreases within the department, The Charge RN is not considered a Primary RN, however, is expected to assist in patient care or take a modified patient assignment to meet the needs and flow of the department. Charge RN, or delegate are responsible for monitoring: • Department Census • Patient Acuity • Anticipated Activity (Procedures, Admissions, Discharges, Transfers) • Number of staff scheduled (assess need for additional staff and MA staff when census is low) • Staff Skill Mix, Competency Level **Staff RN:** Emergency Department RN employed by SHS, have ACLS/BLS/TNCC/NIH/PALS/NRP, at least 1 year of ED nursing experience, have completed all professional ED assigned CBLs, ESI Triage competency checked off and be able to function independently in the Emergency Department.

	Traveler/Agency RN: Experienced ED RN that has a contract to work in the Emergency Department that have completed EPIC ASAP training, have ACLS/BLS/TNCC/PALS/NIH and completed department orientation. **Trauma Nurse Coordinator:** Coordinates trauma care, data collection, education, and requirements to meet State regulations. Experienced ED RN meeting primary RN requirements. **ED Tech:** Assist nursing staff with patient care as per their job description. **Per-Diem:** Expected to work in their home department if shifts are available before being eligible to work in other NLH departments or Inter-Facility Float (IFF) scheduling. Per-diem staff is expected to request open shifts in Kronos. Per-diem employees are expected to stay current in unit, hospital, individual education, and system matters required for employment.
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	The Charge RN is responsible for managing the flow of the department and as the acuity or intensity of care increases within the department. Less acute patients are held in the waiting room, nurse protocols are started and monitored by the Charge RN, Triage RN, or delegate. Each RN is responsible for alerting the Charge RN when the intensity of their assignment has increased so that their patient assignment can be adjusted accordingly. Diversion Statement: • The Charge RN has the responsibility to bring up concerns, following the chain of command (ED Provider, Nursing Supervisor, ED Manager) to evaluate all resources are being used appropriately and possible need for ambulance diversion and/or transfers. In the event the decision is made to put the department on divert, the VP of Patient Care Services will need to be consulted for final approval.
333-510-0110 2 (g) **Meal and Break Coverage**	Meals and breaks are assigned at the beginning of the shift by the Charge RN and will be accomplished by staying within the staffing parameters. If in the staff members judgement, they are not able to provide coverage, they will report to the leadership and move up the chain of command as appropriate in attempt to resolve. (See Addendum B) Leadership is provided by the Department Manager, Nursing Supervisor and Charge Nurse
333-510-0140 **Emergency staffing plan exceptions in the event of national/state emergency**	**Surge Plan:** In times of high acuity or critical patient needs; additional qualified staff or staff from other nursing units may float. CNAs may also float to the emergency department. When in the judgment of the direct care registered nurse, activity is such that patient care needs are not being met or patient safety is at risk, the direct care nurse will follow the chain of command. Leadership is provided by the Department Manager, Nursing Supervisor and Charge Nurse. In the event of a State, Federal or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee
Environmental Factors	The focus to provide in-room care including procedures, medication administration, documentation, and family participation. There are seven (7) beds with all necessary medical equipment (i.e., cardiac monitoring, air, oxygen, suction) and one (1) Triage Room. There are an

	additional four (4) flex rooms shared between the emergency department and outpatient. Two patient bathrooms In room central cardiac and vital sign monitoring for all seven (7) ED rooms. Special features may include: • Patient Ceiling Lifts in Rooms 1-3, 6-7 • (1) Trauma Bay • (2) Licensed Psychiatric Safe Rooms with Video Monitoring • Patient Call System • Automated Medication Dispensing Cabinet (Omnicell) • (2) Adult Code Carts & (1) Pediatric Code Cart • Tele-Medicine for Neuro • Blanket Warmer • Difficult Airway Cart • Glide Scope • EKG Machine • DME (1) Supply Rooms
Standards and Quality	ENA and OSBN standards of practice and ethics apply and can be measured. Quality Metrics shall be measured, such as, but not limited to: • ED Throughput • Trauma Care • Restraint application and documentation • Procedural Sedation
Addendum List:	Addendum A: ESI Triage Acuity Tool and Algorithm Addendum B: Emergency Break/Lunch sheet Addendum C: ED Capacity Assessment Tool

Addendum A ESI Triage acuity Tool


ESI Triage Algorithm, v4
A
Requires immediate life-saving intervention?
Yes
1
No
B
High-risk situation?
or
Confused/lethargic/disoriented?
or
Severe pain/distress?
Yes
2
No
C
How many different resources are needed?
None
One
Many
5
4
Consider
D
Danger zone vitals?
< 3 mo
3 mo-3 y
3-8 y
> 8 y
Age
> 180
> 160
> 140
> 100
HR
> 50
> 40
> 30
> 20
RR
SpO2 < 92%
No
3
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ENA
EMERGENCY NURSES ASSOCIATION

A. Immediate life-saving intervention required: Airway, emergency medications, or other hemodynamic interventions (intravenous access, supplemental oxygen, monitor, electrocardiogram, or labs DO NOT COUNT); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, pulse oximetry (SpO_2) < 90%, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient who is either:

1. Nonverbal and not following commands (acuteley); or
2. Requires noxious stimulus (P or U on AVPU)

B. A high-risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of pain greater than or equal to 7 on a 0–10 pain scale.

C. Resources: Count the number of different types of resources, not the individual items (e.g., complete blood count, electrolytes, and coagulants equals one resource; complete blood count plus chest radiograph equals two resources.)

Resources	*Not resources*
• Labs (blood, urine) • Imaging • Intravenous fluids (hydration) • Intravenous, intramuscular, or nebulized medications • Specialty consultation • Simple procedure = 1 (laceration repair, foley catheter) • Complex procedure = 2 (procedural sedation)	• History and physical exam (including pelvic) • Point-of-care testing • Saline or heparin lock • Oral medications • Tetanus immunizations • Prescription refills • Contact with primary care physician • Simple wound care (dressings, recheck) • Crutches, splints, slings

D. Danger zone vitals: Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric fever considerations:
1–28 days of age: Assign at least ESI 2 if temperature > 38°C (100.4°F)
1–3 months: Consider assigning ESI 2 if temperature > 38°C (100.4°F)
3 months–3 years. Consider assigning ESI 3 if:

1. Temperature > 39°C (101.2°F); or
2. Incomplete immunizations; or
3. No obvious source of fever

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Acuity re-evaluation tool:

Any patient that becomes Hemodynamically unstable, unable to maintain own airway/Intubated, found to have injuries that are a threat to life or limb, or becomes unconscious will automatically be re-assigned an ESI Score of 1	**ESI Score 1**
Patients previously scored an ESI score of 3-5 who: Shows signs of progressing sepsis Vital Signs enter Danger Zone as per ESI Guidelines Ill but stable child/infant with high fever or degradation of presentation even if still stable Pt becomes a conscious sedation by nurse Any patient becomes, confused/disoriented/or lethargic Any patient becomes or reveals they are Suicidal or Mentally unstable Active Seizure Patient condition becomes high risk for any reason	**ESI Score 2**
Patients previously scored an ESI 4-5 who: Have acute changes that may require multiple resources Upon assessment show signs of severe Pain or Distress A Pre-op/ Ambulatory infusion/ Wound Care Referral patient becomes an emergency room patient Any patient who shows signs of worsening disease process that although stable show worsening vital signs. Simple wound or Laceration cleanings or repairs become more complicated	**ESI Score 3**
Patients previously scored an ESI 5 who: Have a need for at least 1-resource or show a need for more intensive care than would possibly be handled by Urgent Care/Fast Track. There is a concern that they could not wait in lobby for extended amount of time.	**ESI Score 4**
Most patients would not be downgraded from higher level to lower level of care, but if they are originally given a score of 4 and show no resource needs or: Medication refill: Well baby check, can be diverted to Fast Track, or can wait in the lobby for an extended amount of time safely.	**ESI Score 5**

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Addendum B: Emergency Break/Lunch sheet

Emergency Department Break Schedule

Date: _____

Length of Work	Number of Rest Breaks Required	Number of Meal Breaks Required
2hrs 1min-5hrs 59min	1	0
6hrs	1	1
6hrs 1min-10hrs	2	1
10hrs 1min-13hrs 59min	3	1
14hrs	3	2

Nurses

Shift	RN	RN handoff	Break 1	Break 2	Break 3	Lunch
0600						
0600						
0600						
11						
12						
1800						
1800						
1800						

EDT/Sitter/Unit Clerk

Shift	EDT/Sitter/UC	Handoff	Break 1	Break 2	Break 3	Lunch
0600						
0600						
1100						
1200						
1800						
1800						

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Staff are to initial you received each of your scheduled breaks and lunch, if you could not take one, draw a line through he missed time and fill out a Kronos exception form indicating why you missed it and the charge nurse sign it as well.

Addendum C: ED Capacity Assessment Tool

ED – Capacity Assessment Tool

SNLH – Emergency Department Capacity Assessment Tool – ECAT

Purpose:

During high capacity or acuity events, the Capacity Assessment Tool can be initiated by the ED CN. This tool is to help evaluate the ED capacity, give situational awareness and help provide guidance and consideration for requesting additional help.

Instructions:

1. Prior to notification of house supervisor regarding a high capacity or high acuity situation, complete the assessment tool.
2. Form to be completed by CN or their Designee (unit clerk etc.)
3. Review the assessment and identify interventions.
4. Assess plan and implement interventions identified.
5. If capacity event is not addressed or relieved, consult with ED MD for recommendations then contact the ED manager.

ED CAPACITY ASSESSMENT TOOL

Date:	Time of Event:

*****Is the ED at 125% of capacity (14 patients) and meet two of the following? If yes, continue filling out form and contact ED Manager or ADM, and Nursing Supervisor*****

1.	15% of ED filled with critical patients (2 patients)	Yes	No
2.	Transfers delayed greater than 2 hours	Yes	No
3.	Admit delay greater than 3 hours	Yes	No
4.	Hospital on Divert	Yes	No

ED SNAPSHOT

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1.	Number of ED patients in the department	# pts:	
2.	Number of patients in ED waiting transfer and/or admit	# pts:	
3.	Triage/ waiting room Census	# pts:	
4.	Approximate Lobby waiting time	Time:	
5.	Approximate ED length of stay	Time:	
6.	Number of RN's and CNAs staffed	# RN's:	#Techs's:
7.	Is an ED physician available to be called in?	Yes	No
7.	Number of ED MD's and mid-level providers	#MD:	#ML:
8.	Number of ED pts waiting >2hr for ICU bed	# pts:	
9.	Number of pts waiting >3hrs for admit	# pts:	
	Number of pts waiting > 2 hours for acceptance and/or transport		
10.	Number of pts left without being seen.	# pts:	
11.	Number of psychiatric pts	# pts	
13.	Number of patients with Escalations Status:		
	Traumas:_____ Codes: _____ STEMI's _____Critical pts: _____ Strokes_____	Other:	

ASSESSMENT AND INTERVENTION

1.	ICU/PCU beds available?	Yes	No
3.	Med/Surg beds available?	Yes	No
5.	EMS waiting for ED rooms	Yes	No
6.	Alternative measures exhausted i.e., hall beds, level 4 &5 treated in the lobby?	Yes	No
9.	House supervisor contact hospitalists to notify of backup in ED.	Yes	No

ED CRITICAL CAPACITY IMPLEMENTATION

1.	**Nursing Supervisor Approval:**	**Yes**	**No**
2.	**ED Management Approval:**	**Yes**	**No**
3.	**ED MD Approval:**	**Yes**	**No**
4.	**Administrator Approval:**	**Yes**	**No**

Name of ED Charge Nurse:

_____

Signature:

_____

Start Time:	End Time:

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Alternative Solutions Checklist

SUBMIT COMPLETED FOR TO ED MANAGER and HOUSE SUPERVISOR

- ☐ Admitted patients transferred upstairs to their room quickly (ED and floor CNAs to get pt.'s up to floor)
- ☐ Hospitalists to see admitted patients upstairs if bed is ready
- ☐ Floor nurse sent down to take care of admitted patients when room is delayed
- ☐ Float CNA's down to help admitted pt.'s with toileting, vitals, and other ADL's
- ☐ Discuss with Hospitalists and Surgery teams about expediting DC
- ☐ Talk with case management about arranging transportation for potential DC patients
- ☐ When hospital is at 100% of capacity, staffing office places calls for additional staff house wide.
- ☐ ED discharges sent to waiting room when waiting for ride when appropriate
- ☐ Midlevel to see pt.'s in triage when ED rooms full
- ☐ Place Midlevel in triage to assess and place orders, treat, and discharge for all pts possible.
- ☐ Triage RN to enter triage protocol orders in ASAP to initiate diagnostics if midlevel is not available.
- ☐ Lab to draw patients in lobby (appropriate area provided)
- ☐ Call to all ED RNs to request additional staff (ED secretary, Staffing or unit manager)
- ☐ Cross trained staff to ED and hospital finds coverage for them on the floor
- ☐ Calling in additional ED MD's

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NOTES:_____
_____
_____
_____
_____
_____

References	
	1. Emergency Nurses Association (2020) Position Statement. Retrieved from: https://www.ena.org/ 2. Emergency Nurses Association (2020). *ENA Practice Resources.* Retrieved from: https://www.ena.org/docs/default-source/education-document-library/esi-implementation-handbook-2020.pdf?sfvrsn=fdc327df_ 3. Oregon Secretary of State, Board of Nursing Chapter 851 (n.d.). *Division 45: Standards and scope of practice for the LPN and RN*. Retrieved from: https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3929

Surgical Services Staffing Plan:

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with OARs**
Narrative	**Surgical Services Staffing Plan**
333-510-0110 2 (a) **Patient Population**	• Pediatric patients above the age of two (2) years through geriatric.
Description of individual and aggregate patient needs	Surgical Services provides elective and emergency surgical and procedural care to all patients, pediatric the age of two through geriatric. It additionally provides anesthesia services hospital wide as requested and appropriate for all patients. The Surgical Services Department provides Perioperative care (Pre-op, Intraoperative, Phase I and II) to our surgical and procedural patients. Aggregate patient needs include but are not limited to: • Endoscopy • ENT

	• General Surgery • Gynecology • Urology • Obstetrics • Orthopedics • Ophthalmology • Podiatry • Plastics • Screenings • Small Bowel/Bowel Obstruction • Cataracts • Acute blood loss • Ortho fractures
Staff qualifications and competencies	PACU, OR, Ambulatory trained RNs that have completed department specific orientation and competencies. These nurses are required to hold education/license/certifications for the following, per their job description: • Graduate of an Accredited School of Nursing • Registered Nurse with an unencumbered Oregon license to practice • BLS (required at hire) for all • ACLS (required within 3 months of hire) for **PACU, Amb RN only** • PALS or ENPC (required within 6 months of hire) for **PACU, Amb RN only** • All licensure and certifications are maintained as per specific job description and educational grids found on Learning and Development Intranet site Required competencies for Surgical Technologists (scrub techs): • Graduate from accredited Surgical Technologist Program and CEUs to maintain certification • BLS or American Heart Association Certified Basic Life Support. Peri-anesthesia Competencies include, but are not limited to the following: • Knowledge of patient rights and advance directives • Knowledge of specific diagnostic testing guidelines • Cardiac rhythm recognition • Preoperative teaching • Pre-anesthesia nursing history and assessments • Medications and associated interactions and risks • Day of surgery/procedure preparation • Physiological systems review and assessment • Intravenous access • Sedation/analgesia: assessment, administration, and monitoring • Pulse oximetry interpretation • Thermoregulation • Anesthetic agents and adjuncts • Postoperative nausea and vomiting: assessment, reassessment, intervention and monitoring • Pain assessment, reassessment, intervention and monitoring • Comfort assessment • Age-specific care • Safety assessment • Infection prevention and control measures • Regulatory guidelines for pre-operative/pre-procedure verification • Cultural sensitivity • Critical thinking, reasoning and analysis

	• Malignant hyperthermia • Local anesthetic system toxicity Phase I Post Anesthesia Competencies: (all activities listed above, plus:) • Airway management • Respiratory and ventilatory management including non-invasive positive pressure ventilation in concert with respiratory therapy staff • Pharmacology • Thermoregulation • Hemodynamic monitoring and assessment Peri-anesthesia fluid management and resuscitation • Acid/base balance evaluation and arterial blood gas interpretation in concert with the CRNA staff • Safety measures • Physiological monitor alarm recognition and response Phase II Post Anesthesia Competencies (all activities listed above, plus:) • Surgery/procedure-specific post-operative/post-procedure care including assessments, potential complications and discharge teaching. Extended Care (all activities listed above)
Average daily census	Average daily census/patient activity in the Unit: 4 per day Based on nursing care time studies: • The average admission time for one RN is 30 minutes • The average admission time for one RN with the Pre-Surgical Screening Coordinator call completed is 30 minutes • Transfer/Discharge – 20 minutes The department of Surgery functions as a procedural area so the surgery schedule determines the patient census per day. The Pre-Surgical Screening Coordinator calls the scheduled surgery patients prior to the surgical procedure. Patients are admitted into the Ambulatory Surgery Department (Pre-op) prior to their procedure and taken to PACU postoperatively. Extended recovery and/or inpatients are transferred to a nursing unit following the completion of Phase I and/or Phase II post anesthesia care for continued post-operative care.
Average monthly Census	2023: Monthly Average: 115 Total Surgical Cases in 2023: 1383
333-510-0110 2 (b) **Unit Acuity**	Pre-anesthesia phase: • One nurse is assigned to one patient until the admission is complete. As second nurse may assist with the process when acuity dictates. Post-anesthesia phase: • PACU RN staffing follows the ASPAN guidelines for Phase I care: o Two nurses, one of whom is an RN competent in Phase I post-anesthesia nursing care, are in the same room/unit where the patient is receiving Phase I care. In general, a 1:2 nurse ratio in Phase I allows for appropriate care. Care in Phase I may last for 30 minutes to 1-2 hours for most patients. • Class1:2 - One nurse to two patients o One unconscious patient, hemodynamically stable with a stable artificial airway and over the age of eight (8) years of age, and one conscious, stable and free of complications. o Two conscious patients, stable and free of complications o Two conscious patients, stable, eight (8) years of age or under with family or competent support staff available

	• Class 1:1 – One nurse to one patient
	  o At the time of admission, until the critical elements are met
	  o Unstable airway (patients requiring active interventions to maintain patency – jaw thrust, chin lift or oral airway, evidence of obstruction, gasping, choking, wheezing, symptoms of respiratory distress – dyspnea, tachypnea, panic, agitation, cyanosis
	  o Any unconscious patient eight (8) years of age or under
	  o A second nurse must be available to assist as necessary
	• Class 2:1 – Two nurses to one patient
	  o One critically ill, unstable, complicated patient
	Phase II Level of Care:
	• Peri-anesthesia nursing roles during this phase focus on preparing the patient/family/significant other for care in the home or as extended level of care.
	• Two competent personnel, one of whom is an RN competent in Phase II post-anesthesia nursing, are in the same room/unit where the patient is receiving Phase II level of care. An RN must be in the Phase II PACU at all times while a patient is present. Care in Phase II generally lasts for 15 min to 2 hours depending on patient response.
	  o Class 1:3 – One nurse to three patients: Over 8 years of age, 8 years of age or under with family present
	  o Class 1:2 – One nurse to two patients: 8 years of age and under without family or support staff present, initial admission of patient post procedure
	  o Class 1:1 – Unstable patient of any age requiring transfer
	Extended Care:
	• A part of Phase II care where the nursing role is to provide ongoing care for patients requiring extended observation/intervention after transfer from Phase I level of care.
	• Two competent personnel, one of whom is an RN possessing competence appropriate to the patient population, are in the same room/unit where the patient is receiving "extended" level of care. The need for additional RNs is dependent on the patient's acuity, complexity of care, census, and the physical environment. Patients may be transferred for extended care to any clinical patient care department, to meet the needs of the patient, department or staffing.
	  o Class 1:3-5 – One nurse for three to five patients
	• Examples of patients that may be cared for in this phase include but are not limited to: Patients waiting for transportation home, patients with no caregiver, patients who have had procedures requiring extended observation/interventions (potential risk for bleeding, pain management, Post-operative nausea and vomiting), patients being held for inpatient beds.

333-510-0110 2 (c) **Total Diagnosis/Scope of Care**	• Surgical Services provides 24/7 care in the following manner, but not limited to: • Outpatient and inpatient general surgery, urology, gynecology, podiatry, orthopedics, cesarean section delivery, Plastics and PICC (peripherally inserted central catheter) • Endoscopy: esophagogastroduodenoscopy, colonoscopy, sigmoidoscopy • Phase I and Phase II Recovery • Post Radiological Procedure Recovery • Preop admissions • Anesthesia services

	• Sterile Processing needs for hospital and clinics
333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	• Ambulatory surgery and PACU is staffed according to the 2024 ASPAN staffing recommendations listed. The Nurse in charge and manager compares the required staffing with the patient census throughout the day and adjust as needed. • The Operating Room is staffed according to 2024 AORN staffing recommendations: The Nurse in charge and manager compares required staffing with the patient census throughout the day and adjust as needed. • Per Diem staffing is utilized to fill vacancies in staffing schedules based on planned PTO or FMLA. Per Diem staff may also be utilized to meet daily staffing needs in the event of unplanned absence of scheduled staff. Per Diem employees are expected to stay current in unit, hospital and system matters and stay current with required education.

333-510-0110 2 (e)
 	
Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff
	Post-anesthesia phase:
	• PACU RN staffing follows the ASPAN guidelines for Phase I care:
	  o Two nurses, one of whom is an RN competent in Phase I post-anesthesia nursing care, are in the same room/unit where the patient is receiving Phase I care. In general, a 1:2 nurse ratio in Phase I allows for appropriate care. Care in Phase I may last for 30 minutes to 1-2 hours for most patients.
	• Class1:2 - One nurse to two patients
	  o One unconscious patient, hemodynamically stable with a stable artificial airway and over the age of eight (8) years of age, and one conscious, stable and free of complications.
	  o Two conscious patients, stable and free of complications
	  o Two conscious patients, stable, eight (8) years of age or under with family or competent support staff available
	• Class 1:1 – One nurse to one patient
	  o At the time of admission, until the critical elements are met
	  o Unstable airway (patients requiring active interventions to maintain patency – jaw thrust, chin lift or oral airway, evidence of obstruction, gasping, choking, wheezing, symptoms of respiratory distress – dyspnea, tachypnea, panic, agitation, cyanosis
	  o Any unconscious patient eight (8) years of age or under
	  o A second nurse must be available to assist as necessary
	• Class 2:1 – Two nurses to one patient
	  o One critically ill, unstable, complicated patient
	Phase II Level of Care:

	• Peri-anesthesia nursing roles during this phase focus on preparing the patient/family/significant other for care in the home or as extended level of care. • Two competent personnel, one of whom is an RN competent in Phase II post-anesthesia nursing, are in the same room/unit where the patient is receiving Phase II level of care. An RN must be in the Phase II PACU at all times while a patient is present. Care in Phase II generally lasts for 15 min to 2 hours depending on patient response. o Class 1:3 – One nurse to three patients: Over 8 years of age, 8 years of age or under with family present o Class 1:2 – One nurse to two patients: 8 years of age and under without family or support staff present, initial admission of patient post procedure o Class 1:1 – Unstable patient of any age requiring transfer Extended Care: • A part of Phase II care where the nursing role is to provide ongoing care for patients requiring extended observation/intervention after transfer from Phase I level of care. • Two competent personnel, one of whom is an RN possessing competence appropriate to the patient population, are in the same room/unit where the patient is receiving "extended" level of care. The need for additional RNs is dependent on the patient's acuity, complexity of care, census, and the physical environment. Patients may be transferred for extended care to any clinical patient care department, to meet the needs of the patient, department or staffing. o Class 1:3-5 – One nurse for three to five patients Examples of patients that may be cared for in this phase include, but are not limited to: Patients waiting for transportation home, patients with no caregiver, patients who have had procedures requiring extended observation/interventions (potential risk for bleeding, pain management, Post-operative nausea and vomiting), patients being held for inpatient beds
Nursing intensity: the level of patient needs for nursing care as determined by nursing assessment	The following are examples of issues that increase the intensity of patients in Surgical Services: • ASA category • Age • Family dynamics • Mobility • Interpretive services • Bariatric patients • Disabilities • Isolation patients • Sensory deficits • Complex Surgical Cases • Quick Procedures ie Cataract • Mentation • Blood/blood product infusion • Continuous intravenous medication infusions • Multiple medication administration: intravenous, intra-muscular, sub-cutaneous and/or by mouth • Education: pre-procedure and post-procedure • Difficult intravenous catheter starts • Assist CRNA with blocks • Consultations and coordination of care • Complicated procedures ex: airway maintenance with chin lift, frequent suctioning, nebulizer treatment, tracheotomy care, ostomy care
333-510-0110 2 (f) **Unit Matrix including the**	Minimum staffing: a. Minimum staffing for Ambulatory (Preop) when a patient is present: Two RNs b. Minimum staffing for PACU when a patient is present: Two RNs c. Minimum staffing for OR when a patient is present: One RN circulator and One ST or RN ST

minimum number of nursing staff needed at any given time. May not be solely on national benchmarks (i)	• Charge nurse assigns staffing to each case on the snap board in Epic, taking into consideration acuity and intensity of care required. These assignments are posted on the daily white board schedule. • Scheduled staffing: a. 0700-1530 Surgery Scheduler b. 0630-1500 Ambulatory Surgery: 1 Charge RN, RNs based on schedule and acuity c. 0700-1530 OR: 1 Charge RN, RN's, STs based on schedule and acuity d. 0800-1630 PACU-RNs based on schedule and acuity • On-Call Staffing: After-hours on-call staff consists of one (1) OR RN, one (1) CST or another RN (to scrub) and one (1) PACU RN. At completion of the case, the OR RN becomes the second nurse in PACU during recovery of the patient. The OR/PACU on-call schedule is Monday through Friday, 15:00 – 07:00 and 24 hours (07:00 – 07:00) on Saturday, Sunday, Legal Holidays or weekdays with no cases scheduled.
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	Perioperative patient flow is evaluated continuously throughout the day by the OR manager and the RNs in charge. The RNs will collaborate with the house supervisor to assess available staff as determined by acuity/intensity/surge. The RNs will work collaboratively with the house supervisor to utilize the SNLH Admission Limitation Management Policy, with direct care nursing staff initiating the review as needed. Interdepartmental Communication: Huddles are performed once daily at 10 am between members of leadership as available: unit manager, charge RN, Materials buyer/stock and as needed throughout shift.
333-510-0110 2 (g) **Meal and Break Coverage**	RNs will get 30-minute lunch and two 15-minute rest breaks per 8-hour shift, according to SHS policy. Length of period worked / Number of rest breaks / Meal breaks 2 hours or less: 0 / 0 2 hours, 1 min – 5 hours, 59 min: 1 / 0 6 hours: 1 / 0 6 hours, I min – 10 hours: 2 / 1 10 hours, 1 min – 13 hours, 59 min: 3 / 1 14 hours: 3 / 2 • Coverage for breaks and meals will be provided with assistance of an OR Charge RN, PACU Charge RN, Nurse Manager or House Supervisor when manager not available. • NSC is submitting variance request for approval of missed meal/breaks during call back surgical cases. Requested: Waiver for missed meals/breaks for surgical call back as emergency procedures cannot be halted during call back hours as staff in hours is limited to the team called in for the procedure. • If patient census/activity makes it difficult for the NSM to plan for allotted breaks, the NSM will take action to report prior to the end of the defined break window. The NSM will report all potential missed breaks to the charge RN and move up the chain of command (primary RN > charge RN> department manager or nursing supervisor) as appropriate in attempt to resolve. NSMs are required to complete documentation through the Kronos clock at the end of their shift regarding rest/meal breaks. If any

	break or meal is missed, the NSM is responsible for documenting this and their attempts to resolve on the Nurse Staffing Concerns template in RLDatix. Staff are responsible for additional duties: • Checking emergency equipment • Pick up patient from admitting & escort to pre-operative unit • Omnicell counts • Room inventory • Room stocking • Checking for outdates • Precepting, orienting and training new employees and nursing students • Answering phones and transmits messages to appropriate party • Clean and re-set pre-op/PACU area between patients: bathroom, stretcher, monitoring equipment • Glucometer Quality Control • Answer door • Greet family members &/or locate family to speak with MD • Set out clothes for out-patients • Escort patients to ride home and/or wait with patient until ride arrives • Call patients post-operatively or pre-operatively if PSSC unavailable • Transport specimens to the lab
333-510-0140 **Emergency staffing plan exceptions in the event of national/state emergency**	In the event of a State, Federal or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee. Emergency staffing needs, or census management is managed between the nursing supervisor, charge RN(s) of affected units and manager or designee, if needed.
Environmental Factors	Surgical Services has: • 6 Preop Private Rooms with two shared patient bathrooms. • 2 PACU bays, 1 PACU private neg pressure room • 2 Main ORs with room 2 being designated as ortho room and emergency c-section entrance. • 1 Endoscopy suite which includes a separate scope cleaning room and scope storage • Sterile Processing Unit: 1 Decontamination room, 1 Clean Assembly room • Medication and Nourishment room • Store room
Standards and Quality	AORN and ASPAN standards of practice and ethics apply and can be measured. • Adverse events • Patient Satisfaction • Nursing Satisfaction • Surgical Site infections • Correct Patient, Correct Procedure, Correct Site • IUSS rates
Addendum List:	None

References	American Operating Room Nurse (AORN) Nursing Standards and Recommendations 2023-2024

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	American Society of Peri Anesthesia Nurses (ASPAN) Nursing Standards and Recommendations 2023-2024

Ambulatory Infusion Staffing Plan:

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with the Oregon Administrative Rules (OARs)**
Narrative	**Ambulatory Services: Infusion Staffing Plan**
333-510-0110 2 (a) **Patient Population**	The Ambulatory Services: Infusion Center provides outpatient services five (5) days a week. Infusion hours are between 07:30 – 16:00. We care for patients of all ages, by provider referral.
Description of individual and aggregate patient needs	**Infusion center:** provides medication therapies and line accesses in the outpatient setting. Patient needs include but are not limited to scheduling, assessing and monitoring patients before, during and after giving blood or medications, administering medication via infusions or injections, administering blood, accessing ports, collecting labs, and coordinating care with providers for patients in the outpatient setting.

Staff qualifications and competencies	**<u>All RN staff in the Infusion Center must have</u>**: • Cardiopulmonary Resuscitation Basic Life Support (CPR BLS) • Advanced Cardiac Life Support (ACLS) • Complete Orientation Assessment Tool for RNs during orientation period • Annual assigned department competencies and education per the education grid. • The scope of practice for all licensed nurses as defined by the Oregon State Board of nursing: OAR 851-045-0040 (3) Standards related to the licensed nurses' responsibilities for ethics, including professional accountability and competence. (d) Accepts only nursing assignments for which one is educationally prepared and has the current knowledge, skills and ability to safely perform. • Oncology Nursing Society's Chemotherapy/Biotherapy/Immunotherapy Certificate within 1 year of hire. **<u>CNA1 or CNA2</u>**: • Cardiopulmonary Resuscitation Basic Life Support (CPR BLS) • Complete OAT during orientation period. • Annual assigned department competencies and education per the education grid
Average daily census	2023: 18 patients The highest volume days in Infusion Center are Mondays, Wednesdays and Fridays.
<u>333-510-0110 2 (b)</u> **Unit Acuity**	Nursing care time for the following activities are as follows, which are included as part of the determination for staffing and the NSP: • Time to complete admission 2 hours • Time to complete discharge is 15 minutes.
<u>333-510-0110 2 (c)</u> **Total Diagnosis/Scope of Care**	**The Infusion Center cares for the following diagnosis or treatments needed include, but not limited to:** • Cancer • Chemotherapy and immunotherapy • Autoimmune disorders • Anemia • Blood Transfusion • Iron infusion • Hemochromatosis/polycythemia • Therapeutic phlebotomy

	• Inflammatory Bowel Diseases • Simple hydrations and electrolyte infusions • Central line care • Port access and care • IV antibiotics • Intramuscular and subcutaneous injections •
333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	Ambulatory Services follow national guidelines put forth by • Oncology Nursing Society (ONS) • Infusion Nursing Society (INS)
333-510-0110 2 (e) **Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff**	Care is allocated by the unit needs primarily determined by the unit census. The patient's acuity is reviewed every 2 hours and with any acute change in the patient's condition. See Infusion Acuity Guidelines Infusion RN acuity shall be no more than a score of ten (10), per nurse, in an eight (8) hour shift. CNAs in both Infusion and in Wound care units are not to be assigned more than 7 patients at a time during their shift
Nursing intensity: the level of patient needs for nursing care as determined by nursing assessment	The following are examples of issues that increase the intensity of patients in Ambulatory Services: • Complex family dynamics • Emotional Support • Care Coordination with other healthcare team members • Homelessness • Mobility Issues • Interpretive Services • Impaired speech or communication • Patients with disabilities or multiple comorbidities • Adult Protective Services • Neutropenia

	• Patient response to interventions, such as chemotherapy/immunotherapy reactions • Bariatric Patients • Pediatric Patients • Cognitive impairments • Behavioral impairments • Add-on patients • Reviewing new treatment plans • Venous access availability • Delivering lunches • Delivering labs/medications • 911 transfers to Emergency Department
333-510-0110 2 (f) **Unit Matrix including the minimum number of nursing staff needed at any given time. May not be solely on national benchmarks (i)**	Minimum staffing: **Infusion** • One (1) RN • One (1) CNA • Two (2) RNs when chemotherapy or blood products are infusing, and/or therapeutic phlebotomy is being performed.
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	Based on Acuity/Intensity and available staff: • Limit appointments scheduled for 8-hour shifts • Staffing will follow the guidance of the SHS High Consequence Infectious Disease policy for routine scheduling of patients. • Utilize hospital Services • Schedule is reviewed on Friday for next week and then daily • Admission Limitation Management policy
333-510-0110 2 (g) **Meal and Break Coverage**	• Staff will receive One (1) thirty (30) minute lunch and two (2) fifteen (15) minute breaks according to BOLI and SHS policy.
333-510-0140 **Emergency staffing plan exceptions in the event of**	In the event of a State, Federal or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee.

national/state emergency	
Environmental Factors	The focus to provide outpatient wound care and infusion services for patients in the outpatient clinical setting including assessments, care coordination and management, documentation, procedures, and patient/family/caregiver education and participation. **Infusion Center has:** • Seven (7) stations with privacy curtains and all of the medically necessary equipment at each station (i.e. repositioning chairs with lockable wheels, IV pumps on wheeled poles). • One private room for bladder instillations with electronic repositioning chair equipped with IV pumps and wheeled pole, hand washing station, and chemotherapy, biohazard, and sharp safety waste containers. – (room may be used if needed as an eighth chair when all other chairs are occupied) • Four (4) locked rolling IV start and port access medical supply carts. • Supply room • Blanket warmer • PPE • Locked medication drawers and refrigerator • Nourishment station
Standards and Quality	**2024 Quality Metrics:** **Infusion:** • Vital signs taken at titration of medication for titratable medications. • Completed Assessments per visit. **Other measurable standards and quality outcomes:** • Adverse events • Patient Satisfaction • Nursing Satisfaction • Infections • Hand hygiene audits
Addendum List:	Infusion Acuity Guidelines

References	

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	• Oregon State of Board of Nursing. (n.d.). Oregon Nurse Practice Act Administrative Rules *Chapter 851 Division 45: Standards and scope of practice for the LPN and RN*. Oregon State Board of Nursing : Oregon Nurse Practice Act : State of Oregon • Standards of Care for Outpatient Infusion Center Policy - SNLH • Staffing Plan for Nursing Services Policy – SNLH

Ambulatory Wound Clinic Staffing Plan:

PURPOSE	**To define a staffing plan for all hospital nursing units in accordance with the Oregon Administrative Rules (OARs)**
Narrative	**Ambulatory Services: Wound Staffing Plan**
333-510-0110 2 (a) **Patient Population**	The Ambulatory Services: Wound Care provides outpatient services five (5) days a week and is open 08:00-16:30. We care for patients of all ages, by provider referral.
Description of individual and aggregate patient needs	**Wound Clinic:** provides services for all types of skin and wound care. Patient needs include but are not limited to wound assessments, therapy and care planning, case management, home health care coordination, inpatient consults, wound debridement, dressing changes, diabetic foot and nail care, negative pressure wound therapy application and maintenance, lower extremity compression therapy, lower extremity vascular assessments, ostomy care, continence care and assistance in coordinating home care supplies.

Staff qualifications and competencies	**<u>All RN staff must have</u>**: • Cardiopulmonary Resuscitation Basic Life Support (CPR BLS) • Complete Orientation Assessment Tool for RNs during orientation period • Annual assigned department competencies and education per the education grid. • The scope of practice for all licensed nurses as defined by the Oregon State Board of nursing: OAR 851-045-0040 (3) Standards related to the licensed nurses' responsibilities for ethics, including professional accountability and competence. (d) Accepts only nursing assignments for which one is educationally prepared and has the current knowledge, skills and ability to safely perform. **<u>CNA1 or CNA2</u>**: • Cardiopulmonary Resuscitation Basic Life Support (CPR BLS) • Complete OAT during orientation period. • Annual assigned department competencies and education per the education grid
Average daily census	2023: 18 patients The highest volume days in Wound Care are Tuesdays, Wednesdays and Thursdays.
<u>333-510-0110 2 (b)</u> **Unit Acuity**	Nursing care time for the following activities are as follows, which are included as part of the determination for staffing and the NSP: • Time to complete admission 2 hours • Time to complete discharge is 15 minutes.
<u>333-510-0110 2 (c)</u> **Total Diagnosis/Scope of Care**	**The Wound Care team cares for the following diagnosis or treatments needed include, but not limited to:** • Acute, chronic, and non-healing wounds • Neuropathic, vascular, arterial, and diabetic lower extremity ulcers • Advanced wound therapies – silver products, collagen, skin substitutes • Wound debridement • Chemical cauterization • Dressing Changes • Diabetic foot and nail care • Negative Pressure Wound therapy - VAC application and maintenance.

	• Lower extremity assessment/vascular care services • Compression therapy • Ostomy care – including peristomal skin assessments, pre-operative stoma site marking; education, ostomy appliance fitting and support. • Assistance with home supplies • Continence care – including urinary catheter insertion (urostomy, suprapubic and foley), maintenance and care • Post-Operative Surgical Care • Pressure injuries • Venous Consultation, Pre- and Post- Operative Care
333-510-0110 2 (d) **Evidence based staffing standards/guidelines (must ref. nationally recognized standard)**	Ambulatory Services follow national guidelines put forth by: • Wound, Ostomy, and Continence Nurses Society (WOCN) • National Alliance of Wound Care and Ostomy (NAWCO)
333-510-0110 2 (e) **Patient acuity: complexity of patient care needs requiring the skill/care of nursing staff**	Care is allocated by the unit needs primarily determined by the unit census. The patient's acuity is reviewed every 2 hours and with any acute change in the patient's condition. Wound RN acuity shall be no more than ten (10) patients, per nurse, in an eight (8) hour shift. CNAs in both Infusion and in Wound care units are not to be assigned more than 7 patients at a time during their shift
Nursing intensity: the level of patient needs for nursing care as determined by nursing assessment	The following are examples of issues that increase the intensity of patients in Ambulatory Services: • Complex family dynamics • Emotional Support • Care Coordination with other healthcare team members • Homelessness • Mobility Issues • Interpretive Services • Impaired speech or communication • Patients with disabilities or multiple comorbidities • Adult Protective Services • Bariatric Patients

	• Pediatric Patients • Cognitive impairments • Behavioral impairments • 911 transfers to Emergency Department
333-510-0110 2 (f) **Unit Matrix including the minimum number of nursing staff needed at any given time. May not be solely on national benchmarks (i)**	Minimum staffing: **Wound** • One (1) RN • One (1) CNA • Two (2) RNs on provider days.
333-510-0110 2 (g) **Formal process for evaluating and or limiting admissions or diversions of patients**	Based on Acuity/Intensity and available staff: • Limit appointments scheduled for 8-hour shifts • Staffing will follow the guidance of the SHS High Consequence Infectious Disease policy for routine scheduling of patients. • Utilize hospital Services • Schedule is reviewed on Friday for next week and then daily • Admission Limitation Management policy
333-510-0110 2 (g) **Meal and Break Coverage**	Staff will receive One (1) thirty (30) minute lunch and two (2) fifteen (15) minute breaks according to BOLI and SHS policy.
333-510-0140 **Emergency staffing plan exceptions in the event of**	In the event of a State, Federal or Hospital declared disaster, the hospital is not required to follow staffing plans approved by the staffing committee.

national/state emergency	
Environmental Factors	The focus to provide outpatient wound care for patients in the outpatient clinical setting including assessments, care coordination and management, documentation, procedures, and patient/family/caregiver education and participation. **Wound Care has:** • Three (3) private rooms with all the medically necessary equipment (i.e. repositionable electronic exam chair with foot pedal control, sink with locked cabinets, vitals cart) • One Vascular doppler and ultrasound gel kit • Supply room • Locked medication cart • Foot & nail Dremel • Sara steady stand assist • PPE
Standards and Quality	**2024 Quality Metrics:** **Wound:** • ABI assessment on all Lower Extremity Wounds within two (2) weeks of wound clinic admissions. **Other measurable standards and quality outcomes:** • Adverse events • Patient Satisfaction • Nursing Satisfaction • Infections • Hand hygiene audits
Addendum List:	N/A

References	• Oregon State of Board of Nursing. (n.d.). Oregon Nurse Practice Act Administrative Rules *Chapter 851 Division 45: Standards and scope of practice for the LPN and RN*. Oregon State Board of Nursing : Oregon Nurse Practice Act : State of Oregon • Staffing Plan for Nursing Services Policy – SNLH

	• Wound, Ostomy and Continence Nurses Society Task Force (2018). Wound, Ostomy, and Continence Nursing: Scope and Standards of WOC Practice, 2nd Edition: An Executive Summary. *Journal of wound, ostomy, and continence nursing: official publication of The Wound, Ostomy and Continence Nurses Society*, *45*(4), 369–387. https://doi.org/10.1097/WON.0000000000000438

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