Nurse Staffing Plan

Facility: St Charles Redmond Campus
Received Date: July 16, 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

Unit Staffing Plan & Scope of Service			
Department: Medical-Surgical Department - Redmond			
Staffing Committee representatives - Erin Olsen / Kristie Ebersole			
Presented to Shared Practice: 5/6/2024			
Approved by Staffing Committee: 05/07/2024			
Category Reference #	**Criteria**	**Details**	**References**
1	Nurse to Patient Assignment	Nursing assignments will be based on the unit's census and acuity of each patient as determined by the staffing matrix per shift as this unit has accepted the variance to ratio based staffing. Nurse to patient assignments for average acuity patients: Day Shift (0700-1930)- 1:4 Night Shift (1900-0730)- 1:5	**See Staffing Matrix Tab**
2	CNA Assignments	CNA Day Shift: 0630-1900, Evening Shift (N/A), Night Shift 1830-0700. When a CNA is placed in an assignment, the following applies, 7 patients at a time during a day shift, 11 patients at a time during a night shift. The Charge Nurse will evaluate CNA department needs and either assign a CNA to a patient assignment or place them in a tasking role where they will be assigned one task at a time.	
3	Nationally Recognized Standards	Nationally recognized standards (333-510-0110) There are no nationally recommended standards for Medical/Surgical nursing. Resources used include policy #7722 Medical, Surgical, Orthopedic, Neurosciences Units Inpatient Nursing Service Standard of Care - Admissions through Discharge.	
4	Meal and Break Coverage	1. A Lunch RN will be provided in accordance with unit based staffing matrix. If a Lunch RN is not available, the rest and meal break support steps will be utilized. 2. Staff and Charge RNs will be provided a schedule for all rest and meal breaks. 3. RN coverage will be provided to support RNs rest and meal periods. In the event a Staff RN is unable to take a rest or meal break at his or her scheduled time, the following steps will be taken: a. The RN assigned to cover meals and breaks and Staff RN will reschedule the assigned rest or meal break time. b. The Staff RN will request the Charge RN or covering RN identify another Staff RN who can safely cover the assignment in accordance with the department-based staffing plan maintaining nurse to patient assignment based on matrix and acuity and intensities. c. If the above options are not viable, meal and break coverage will be coordinated and/or given by the Charge RN or House Supervisor. d. If Charge RN or House Supervisor is unable to provide meal and break coverage, notify department manager within 24 hours of shift. e. If there is no coverage available after following the steps above, the Staff RN will acknowledge the missed rest or meal break through the time clock attestation summary at the end of the shift. 4. CNAs (or RNs working in place of CNAs in accordance with staffing matrix) will take rest and meal breaks using the following process: a. Coordinate with assigned RNs and other resources on rest and meal break time.	**See Staffing Matrix Tab**
5	Minimum Staffing	When any patient is present in the department there is a minimum staffing of 2 staff members present on the unit. Minimum staffing is maintained during rest and meal periods.	**See Staffing Matrix Tab**
6	Limitations to Admissions	The transfer center and system House Supervisors coordinate blocking beds for staffing purposes. After utilizing all staffing resources, the leader on call or manager escalates to the Director or designee for approval prior to closing beds.	
7	Recognition of Acuity and Intensity	All assignments will be balanced based on acuity and RN skill needs, adhering to staffing matrix tool, acuity tool, and intensities. The primary nurse enters acuities every 12 hours in the department acuity tool. If they are unable, the Charge Nurse will assist. Extreme acuity/intensity patients will be evaluated to be moved to a higher level of care. Acuity of new admissions are entered into the acuity tool. Acuity definitions are reviewed at least annually and more frequently as determined by the department SPC. (See the Matrix and Acuity Tool tabs)	**See Staffing Acuity Tab**

Med/Surg Matrix:

Med/Surg	Day Shift					Noc Shift					NHPPD
Census	Charge RN	Lunch RN	Staff RN	CNAs	Minimum RN	Charge RN	Lunch RN	Staff RN	CNAs	Minimum RN	
1	1	0	1	1	1	1	0	1	1	1	72
2	1	0	1	1	1	1	0	1	1	1	36
3	1	0	1	1	1	1	0	1	1	1	24
4	1	0	1	1	1	1	0	1	1	1	18
5	1	0	2	1	1	1	0	1	1	1	14.4
6	1	0	2	1	2	1	0	2	0	1	13.33
7	1	0	2	1	2	1	0	2	0	2	11.43
8	1	0	2	2	2	1	0	2	0	2	10
9	1	0.75	3	2	2	1	0	2	1	2	10.67
10	1	0.75	3	2	2	1	0	2	1	2	10.4
11	1	0.75	3	2	3	1	0.75	3	1	3	9.45
12	1	0.75	3	2	3	1	0.75	3	2	3	9.33
13	1	0.75	4	2	3	1	0.75	3	2	3	9.69
14	1	0.75	4	2	3	1	0.75	3	2	3	9.86
15	1	0.75	4	3	3	1	0.75	3	2	3	10.27
16	1	0.75	4	3	4	1	0.75	4	2	3	10
17	1	0.75	5	3	4	1	0.75	4	2	3	9.88
18	1	0.75	5	3	4	1	0.75	4	2	3	9.78
19	1	0.75	5	3	4	1	0.75	4	2	4	10.11
20	1	0.75	5	3	4	1	0.75	4	2	4	10
21	1	0.75	6	3	5	1	0.75	5	2	4	9.52
22	1	0.75	6	4	5	1	0.75	5	2	4	9.45
23	1	0.75	6	4	5	1	0.75	5	3	4	9.39
24	1	0.75	6	4	5	1	0.75	5	3	4	9
25	1	1.5	7	4	5	1	0.75	5	3	5	9.28
26	1	1.5	7	4	6	1	0.75	6	3	5	8.92
27	1	1.5	7	4	6	1	0.75	6	3	5	8.89
28	1	1.5	7	4	6	1	0.75	6	3	5	8.86
29	1	1.5	8	4	6	1	0.75	6	3	5	9.1
30	1	1.5	8	4	6	1	0.75	6	3	5	8.8
									Total		10.03

Med/Surg Acuity Tool:

-In Progress-

Activity	0	0
Standby or Minimal Assist*	0.5	
1 Person Assist*	1	
1-2 Person Assist*	1.5	
2+ Person or Lift Assist*	1.5	1.0
Equipment Use with Mobility	0.5	
Sensory/Pain/Weight Complicating Activity	0.5	0.5
Q2 **Turns** or Braden < 14 or Total Care	1	1.0
Traction/C-Spine Precautions/Rare High Risk Activity	0.5	0.5
Specialty/Bariatric Bed	0.5	

Safety/Behavior/Psychosocial	4.5	0	
Mild **Behavior**/Personality/Emotional Issues*	1		
Moderate Behavior/Personality/Emotional Issues*	1.5	1.0	
Code Grey or **Combative** or 2 Person Approach*	3	2.0	
Call Light Usage or Demands Frequent Interaction	2	1.0	
Communication - **Language/Cognition/Speech**	1	1.0	
Complex Family Dynamics/More time communicating	2		x
Additional Time on **Education** (CHF, Ostomy, etc)	1		x
Fall Risk Average/High with Occasional Impusivity*	1.5		x
Fall Risk High AND Frequent Impulsivity*	2	1.0	
Restraints/Posey Bed	2	1.5	
1:1 Sitter	1	0.5	

Assessment/Charting	0	0
Capnography	1.0	
CIWA	2.0	1.0
Complex Physical Assessment and Charting	2.0	1.0
Isolation - Contact/Droplet/GI*	1.0	1.0
Isolation - Strict Airborne or Infestation Precautions*	2.0	1.0
Neurochecks/CMS	1.0	0.5
NIH	1.0	1.0
Observation Status	0.5	
Pulse Oximetry - Continuous	0.5	
Strict I/Os/Fluid Restriction	0.5	
Telemetry	0.5	

Cares/Nutrition/Elimination	0	0
Bladder Management - Cath, Retention, Scanning	1.5	0.8
Bowel Management - Enema's, Ostomy Leak, Nausea/Emesis	1.5	0.8
Bowel/Urinary High **Frequency**	1	0.8
Bowel/Urinary **Incontinence**	2	0.8
100% **Feed** Assist or Supervision	2	1.5
Minor Feed Assist - Intermittent/Set-Up/Meal Ordering	0.5	
Feeding Tube/GI/PEG -Nutrition and Management	2	1
Foley/Suprapubic/External Cath	0.5	
Oral Care/Suctioning	1	0.5
Ostomy/Illeostomy/Rectal Tube	1	

Acuity Score	9
5 to 9.9	Low
11 to 16.9	Average
17 to 24.9	High
25+	Extreme

Documented By:

Time (Rounded Hour and AM/PM):

Patient Class:
Medical
Surgical
Placement
Other

Stability	0	0
Electrolyte Replacement/Protocol/Potential For	0.5	
Elevated WBC's and/or Sepsis	0.5	
End of Life - Imminent*	2	1
End of Life - Stable/Conscious/Comfort Care*	1	0.5
NEW Altered Mental Status	1.5	0.5
Oxgyen 1-6 L or CPAP when asleep	0.5	
Oxgyen >6 L or Respiratory Instability	2	1
Physician - Frequent Calls/Orders or Vitals not WNL	0.5	0.5
Recent Rapid/Code or High Risk for Decline in Status	2	1
Seizures Recent or High Potential For	1	1

Medications	0	0
CBGs - Rarely Insulin/Oral Meds*	0.5	
CBGs and Frequent Insulin*	1.5	0.5
Q1 CBGs or Insulin Drip*	1.5	1.5
Hypo/Hyperglycemic Events	0.5	0.5
Heparin Drip/TPN/Infusion with Monitoring	1	1
3+ **IV** Piggyback or **High**(>200ml/hr) Rate of IVF	1.5	0.5
PRN's Occasional 2-3x a Shift*	0.8	
PRN's Frequent or every 2 hours*	2	1
PCA/Epidural	1	1
Scheduled Meds - **Simple***	0.5	
Scheduled Meds - Multiple/Complex/Slow*	2	1

Interventions	0	0
Central Line	0.5	
Chemoprecautions/Unsafe for Pregnant	0.5	
Single/Simple **Drain** Care/NG Tube*	1	
Mult/Complex **Drain** Care/Chest Tube/Wound Vac Issues*	2	1
Ice/Heat Therapy	0.5	
Lymphedema/Acewraps/Mandatory Limb/Head Elevation	0.5	
Orthopedic Devices	0.5	
Poor IV Access/Frequent Restarts	0.5	
Wound Care Simple	0.5	
Wound Care Complex/Multiple	1	1

Complexity and ADT	0	0
Admit/New Post-op/ICU Transfer This Shift	0.5	0.5
Discharge - High Potential or Confirmed	0.5	0.5
Pre-Op Preparation	1	
Orders/Tasks Next Shift or Pending Specimen Collection	0.5	
Continuous Bladder Irrigation	3	2
Complex or Difficult Pain Management	1	1
Blood Product or HGB <7.5 with potential	1	1.5
Mult Tests/Procedures to Plan around (TEE, Imaging, etc)	1.5	1
IVIG/Chemo/High Risk Infusion	2	2
Patient takes time in other ways: Explain Simply Below	1	1

The first colmun is the value of points that decay as the acuity score rises
Second column of points are consistent regardless of acuity score
Asterisked areas prevent duplication of points if they grade similar traits

Score and point calculation is not final and still subject to change based on data and feedback. If you have a particular case of a patient that you think should have a higher or lower score, please email me with room number, date, shift and explanation of what you think should change.

Unit Staffing Plan & Scope of Service			
Department : ICU - Redmond			
Staffing Committee Representatives: Erin Olsen / Katie Hughes			
Presented to Shared Practice: 4/25/2024			
Approved at the 5/07/2024 Staffing Committee Meeting			
Category Reference #	Criteria	Details	Reference
1	Nurse to Patient Ratio	N/A	
1a	Non- Ratio Based Units	Nursing assignments will be based on the unit's census and acuity of each patient as determined by the staffing matrix per shift as this unit has accepted the variance to ratio based staffing. Nurse to patient assignments for average acuity patients: Day Shift (0700-1930): For ICU level patients- 1:2. For IMCU or Med/Surg level patients- 1:3. Night Shift (1900-0730): For ICU level patients- 1:2. For IMCU or Med/Surg level patients- 1:3.	See Staffing Matrix
2	C.N.A. to patient Ratio	N/A	
3	Nationally Recognized Standards	*(333-510-0110)* AACN synergy model.	
4	Rest and Meal Break Coverage Plan	1. Ratios must be maintained during rest and meal breaks. 2. Staff will be assigned times for all rest and meal breaks. 3. RN coverage will be provided to support RN's rest and meal periods. In the event a Staff RN is unable to take a rest or meal break at their assigned time, the following steps will be taken: a. The RN assigned to cover meals and breaks and Staff RN will reschedule the assigned rest or meal break time. b. The Staff RN will request the Charge RN or covering RN identify another Staff RN who can safely cover the assignment. 4. Covering breaks will be provided by the CCRN or another ICU RN, if no CCRN or ICU RN is available, the following steps will be taken: a. If ICU level of care patients are in the unit, the ICU RN's will acknowledge the missed rest or meal break through the time clock attestation summary at the end of the shift. b. If IMCU or Med/Surg patients are in the unit without any ICU level patients, a break will be provided by a Secondary level RN. If no secondary level RN available to provide breaks, breaks will be provided by the House Supervisor or other qualified RN. i. If there is no coverage available after following the steps above, the Staff RN will acknowledge the missed rest or meal break through the time clock attestation summary at the end of the shift.	
5	Minimum Staffing	When any patient is present in the department there is a minimum staffing of two nurses present on the unit. Minimum staffing is maintained during rest and meal breaks. If no patients are present within the unit, one ICU RN will be on site.	
6	Limitations to Admissions	The transfer center and system House Supervisors coordinate blocking beds for staffing purposes. After utilizing all staffing resources, the leader on call escalates to the Director for approval prior to closing beds.	
7	Recognition of Acuity and Intensity	All assignments will be balanced based on acuities and staffing matrix. The primary nurse enters acuities every 12 hours in the department acuity tool. If they are unable, the Charge Nurse will assist. Extreme acuity/intensity patients will be evaluated to be moved to a higher level of care or reduction of nurse to patient ratio. Acuity of new admissions are entered into the acuity tool. Acuity definitions are reviewed at least annually and more frequently as determined by the department Shared Practice Committee.	See Acuity Tool

Staffing Matrix:

ICU Patients:		
Staffing Matrix	All Shifts	NHPPD
Census	Staff RN	
0	1	-24
1	2	48
2	2	24
3	2	16
4	2	12
5	3	14.4
6	3	12

Mixed ICU, IMCU or Med/Surg Patients		
Staffing Matrix	All Shifts	NHPPD
Census	Staff RN	
0	1	-24
1	2	48
2	2	24
3	2	16
4	2	12
5	2	9.6
6	3	12

Acuity Tool:

Low	Average	High	Extreme
Responded to Treatment as Expected	New Admission: Stable	New Admission: Complex or Unstable	Cardiopulmonary arrest
ADL's Minimal or No Assist	Medications: Routine with routine education and assessment	Unstable being transferred to a higher level of care	Massive transfusion
Vital Signs Stable/Level of Conciousness Stable	Responding to some Treatment requiring 1 or 2 interventions	Complex/varied interventions due to patient being unresponsive to therapies	RN 1:1 due to life threatening conditions requiring emergent and immediate ne
Education/Emotional Needs: Minimal or reinforcement only	Stable Blood Transfusion: 2 units or less	High risk of airway decompensation or worsening respiratory status	
Routine Care with Minimal Assistance	One 1 titratable drip keeping patient homeostasis	On 2 or more drips to maintain patient homeostasis	
Discharge or Downgrade/Floor Transfer: uncomplicated, education and/or instructions comple	Respiratory status slightly comprimised but responding to treatment (bipap, highflow, ET	Out of department trips requiring RN to be present (MRI, CT, etc)	
Assessment Stable: Hemodynamically Stable	Discharge/Downgrade/Floor Transfer: Requiring some education/intervention but routin	1 or more bedside procedures requiring RN to be present (progressive mobility, chest tube/central line placement, intubation, etc)	
	Slight decrease in level of conciousness or fluctuating (not related to sedation)	IV medications requiring frequent intervention from RN (electolyte replacement protocol, endotool, etc)	
	End of Life Care: Routine or minimal interventions	Frequent calls/coordination with provider and other disciplines	
		Symptomatic unstable rhythm	
		3 or more blood transfusions or adverse reaction	
		End of life care: Requiring frequent interventions for either patient or family	
		Psych: Psychologically unstable/confused requiring frequent intervention from RN	
		Intensity: High patient needs requiring frequent RN interventions totaling more than 4 hours per shift	

Unit Staffing Plan & Scope of Service		
Department: Patient Care Support (PCS) - Redmond		
Staffing Committee Representatives: Andrew Baca/Erin Olsen		
Presented to Shared Practice: 4/25/2024		
Approved at the 5/07/2024 Staffing Committee Meeting		
Category Reference #	**Criteria**	**Details**
1	Nurse to Patient Ratio	N/A
2	Nationally Recognized Standards	N/A
3	Rest and Meal Break Coverage Plan	All roles are able to take lunches and breaks without the need for backup coverage. The roles can select lunch and break times when appropriate based on procedures and support to other departments. If there is a missed rest ormeal break, the RN will acknowledge the missed rest or meal break through the time clock attestation summary at the end of the shift.
4	Minimum Staffing	IV RN: There is one IVT RN that covers scheduled procedures M-F 0700-1730. CCRN: 1 RN per day and night shift 0700-1930, 1900-0730 HS: 1 RN per day and night shift 24/7. May cover RN meals and breaks if qualified
5	Limitations to Admissions	N/A
6	Recognition of Acuity and Intensity	IV RN: For procedures, the IV RN manages acuity and intensity and may call on other qualified staff.

Unit Staffing Plan & Scope of Service

Department: Emergency - Redmond

Staffing Committee representatives - Amber Peterson, Angela Felker, Amanda Johnstone, Dave Forbes
Presented to Shared Practice: 04/2024

Approved by Staffing Committee: 5/7/2024

Category Reference #	Criteria	Details
1	Nurse to Patient Ratio	N/A
1a	Non- Ratio Based Units	1:4 average acuity Nursing assignments will be based on the unit's census, acuity and intensity of each patient as defined below as the unit has accepted the variance to ratio based staffing.
2	Techs	Techs do not take patient assignments, however, are responsible for tasks delegated by nursing
3	Nationally Recognized Standards	Emergency Nurses Association Staffing Guidelines 2015 Emergency Severity Index, Version 4 American Heart Association Joint Commission Recommendations NIH Stroke Scale The Centers for Medicare and Medicaid Evidence Based Practice
4	Rest and Meal Break Coverage Plan	1. Ratios must be maintained during rest and meal breaks. 2. Staff and Charge RNs will be assigned times for all rest and meal breaks. 3. RN coverage will be provided to support RNs rest and meal periods. In the event a Staff RN is unable to take a rest or meal break at his or her assigned time, the following steps will be taken: a. The RN assigned to cover meals and breaks and Staff RN will reschedule the assigned rest or meal break time. b. The Staff RN will request the Charge RN or covering RN identify another Staff RN who can safely cover the assignment in accordance with the department-based staffing plan maintaining nurse to patient ratio. c. If there is no coverage available after following the steps above, the Staff RN will acknowledge the missed rest or meal break through the time clock attestation summary at the end of the shift. From 09:00 (11:00 latest)-03:00, a RN will be assigned to become the designated break nurse. The Charge RN will assist in coordinating break coverage. The Break Sheet will be used to track breaks. ED Charge RN will escalate to House Supervisor and unit leadership if staff are not receiving breaks as scheduled. ED Techs will take rest and meal breaks using the following process: a. Coordinate with assigned RNs and other resources on rest and meal break time.
5	Minimum Staffing	Minimum RNs: 2 staff RNs Charge RNs: 1
6	Limitations to Admissions	Divert will be managed per St. Charles Health Care policy #4508 Hospital Capacity Alert Protocol. This document also establishes a chain of command. # 3697 Divert of the Trauma Patient.
	Recognition of Acuity and Intensity	Minimum RNs: 2 staff RNs Minimum Charge RNs: 1 The charge nurse should not routinely take a full patient assignment but may be needed to take a primary nurse's assignment temporarily while evaluating and redistributing resources. The ED will schedule a minimum of 1 charge nurse and 2 staff nurses 24 hours a day, 7 days a week, even if patient census is zero. Staffing within the department may fall below or go above the Nurse Staffing Schedule numbers based on the census in the department, if acuity, intensity, and census allow. Staff will be sent home on standby, or sent home early on HR, or asked to come in late for their shift as outlined in the St. Charles Health System-Redmond contract guidelines. Unit target hours per patient is 2.76 hours (includes ALL productive hours). The nurse staffing template is staffed to the 75th percentile of patient arrivals. Each 24 hours period, # of nursing hours compared to # of patients (333-510-0110): 184 direct care hours to see 74 patients, adjusted based on census. Unit target patient per hours is 2.76 hours (includes all productive hours). Recognition of acuity and intensity (333-510-0110): The charge nurse shall take patient acuity and nursing intensity into consideration when creating staffing assignments and allocating resources. Emergency Severity Index (ESI) © criteria (ENA, 2021) will be used as a prioritization tool, not an acuitization tool. Higher acuity and/or intensity patients will be managed by reducing RN assignment or applying additional resources. Lower acuity assignments will be managed by increasing patients assigned to a given nurse, if patient census, acuity and intensity requires. EPIC ED Dashboard and EPIC ED track board will be utilized to evaluate the following information to determine acuity and intensity. ED Dashboard, RN Workload section provides the following information: • Number patients • Number orders acknowledge • Number of orders to perform • Admit order may show falsely elevated workload. Orders will need to be reviewed to determine what needs to be completed while the patient in the emergency department versus arrival to the floor • Number meds to be administered

7		ED Track Board All Pts provides the following information: • Overdue vital signs highlighted in red. • ESI acuity • Fall risk • Elopement risk • SI risk • Lab status- Complete/Pending/Ordered • Pt Rad status • Isolation status Charge nurse rounds on department and may need to review patient chart to obtain information on acuity: • Behavioral health level of agitation/aggression elopement risk • New onset clinical instability (RN should notify charge if clinical condition deteriorates) • Psychological needs such as dementia or difficult family dynamics • Patient hold status The ED Charge RN will consider an admitted patient's admission destination when creating ED nurse patient assignments and will attempt to match the ED RN's assignment to that of the patient's admitting department. For example, if the patient is to be admitted to the ICU, where patient ratios are 1:2. Nurses with 1:1 or 1:2 patient ratio, will have their patient assignment reduced, or will be assisted by having additional resources provided to them (nurses, techs, etc.). The preference is that the primary nurse will assume and maintain care of high acuity patients throughout their stay, whenever possible. The remainder of their assignment will be managed by another qualified RN, as assigned by the charge nurse. Patients who will be high acuity for a short period of time, i.e., conscious sedation, cardioversion may be managed by the resource nurse until stabilized, at which time the primary nurse will assume care. The above-listed ratios will be adhered to until the patient is stabilized, transferred out of the department, expires, or additional nursing resources are brought in to manage the patient's care. These high acuity patients will be assigned to a nurse by the charge nurse. Minimum Nurse-to-Patient Ratios, Based on Acuity: 1:1 nurse-to-patient ratio (until stabilized) Trauma, STEMI, stroke, pediatric or neonatal critical care, unstable patient of any age, laboring mother, conscious sedation, acutely confused/violent/combative/suicidal/homicidal patient, patient requiring frequent titration of medications, cardioversion, cardiac or respiratory distress or arrest of any age. 1:2 nurse-to-patient ratio (until stabilized) ICU patient, unstable sepsis, NSTEMI, patient requiring Bi-Pap/C-Pap, diabetic ketoacidosis. Nursing care intensity" is defined as the "level of patient needs for nursing care as determined by the nursing assessment." OAR 333-510-0002(9). Examples of high intensity patients in the emergency department include, but are not limited to: • Total care patients (patients who are dependent on others to perform ADLs) • Confused and/or impulsive • Patients in isolation • Neonatal/pediatric patients • Assisting provider with procedure (ex: lumbar puncture, central line insertion) • Patients falling into the 1:1 nurse-to-patient and 1:2 nurse-to-patient ratio listed above

Competencies

Staff Skill Mix	Registered nurses and ED Techs as UAP
Staff Competencies	Required Nursing Skills, Qualifications, and Certifications(333-510-0110(2)(a)): **Registered Nurses** • AHA BLS, ACLS, and PALS • TNCC • Workplace violence prevention program • Computer Based Learning modules as assigned • Unit specific new hire orientation From St. Charles Health Care Policy #2067 Certifications, Training and Mandatory Education **ED Technicians** Must maintain current certification in AHA, BLS and workplace violence prevention program • Unit specific new hire orientation

Unit Staffing Plan & Scope of Service		
Department: Redmond Main Operating Room		
Staffing Committee representatives - Angela Smith BSN, RN, CNOR/ Ken Kettle BSN, RN		
Staffing Committee Approval: 7/2/2024		
Category Reference #	**Criteria**	**Details**
1	Nurse to Patient Ratio	The average staffing for 1 surgical patient is: 2 RNs , 1 Certified Scrub Technician (CST) and 1 Operating Room Assistant (ORA)
2	CNA Assignments	NA
3	Nationally Recognized Standards	Association of Operating Room Nurses (AORN) www.aorn.org, Association of Surgical Technologists (AST) www.ast.org, Guidelines for PeriOperative Practice (2021 ed.) Denver, CO
4	Rest and Meal Break Coverage Plan	Meals and breaks coverage plan (333-510-0110) Staff RN's will be offered time for all rest and meal breaks allowing for the nurse to leave the unit. 1. Ratios must be maintained during rest and meal breaks. 2. The following steps will be taken to support rest and meal breaks for all nursing members: a. The staff RN will be offered a rest or meal break at coordinated time. b. If the Staff RN is unable to be the relieved at this time, the Charge RN will identify another staff RN who can safely cover the rescheduled meal break in accordance with the unit based staffing plan. This can include the Charge RN as relief. c. The Manager will cover the Charge RN lunch break if a relief Charge RN is not available for the rest or meal break period, task appropriate. d. If the above options are not viable, the staff RN's will acknowledge the missed rest or meal break through the time clock attestation summary at the end of shift. e. If there is no coverage available after following the steps above, notify department manager within 24 hours of shift.
5	Minimum Staffing	During operating hours or when any patient is present in the department there is a minimum staffing of 1 RNs, 1 CST, and 1 ORA present on the unit. Minimum staffing is maintained during rest and meal breaks.
6	Limitations to Admissions	Hospital Capacity Alert Protocol (#4508)
7	Recognition of Acuity and Intensity	All assignments will be balanced based on department acuity and RN skill needs, adhering to ratios. Specialty needs are determined on a case and patient basis.

2					
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Staff *	3	3	3	4	4
Equipment**	None	Minimal	Moderate	Moderate	Moderate
Instruments	1-2 sets	1 - 2 sets	3 - 5 sets	3 - 5 sets	5 + Sets
Case Level***	Minor	Minor	Minor	Major	Major

MINIMAL STAFF:

1 RN, 1 CST and 1 ORA

EQUIPMENT:		
Minimal = 1 -2 pieces		
Moderate = 2-3 pieces		
High = 4 or greater		

Direct care: Direct patient care staff include registered nurses, surgical technologists, and Operating Room Assistant.

Unit Staffing Plan & Scope of Service		
Department: Redmond Same Day Unit/ PACU Department		
Staffing Committee representatives - Angela Smith, BSN, RN, CNOR and Teresa Gillette, RN		
Presented to DPC: 5/7/2024 Approved: 5/7/2024		
Approved by Staffing Committee: 5/7/2024		
Category Reference #	**Criteria**	**Details**
1	Nurse to Patient Ratio	2:01
2	CNA Assignments	Day shift (0600 - 1630): Not to exceed 7 patients at a time. CNAs do not take assignments, however, are responsible for delegated tasks by nursing.
3	Nationally Recognized Standards	Staffing is based on ASPAN guidelines. Acuity is determined by referencing ASPAN staffing guidelines, and the department acuity tool.
4	Rest and Meal Break Coverage Plan	Meals and breaks coverage plan (333-510-0110) Staff RN's will be offered time for all rest and meal breaks allowing for the nurse to leave the unit. 1. Ratios must be maintained during rest and meal breaks. 2. An RN wil be scheduled each day for breaks. 3. The following steps will be taken to support rest and meal breaks for all nursing members. a. The Staff RN will be offered a rest or meal break at coordinated time. b. If the Staff RN is unable to be relieved at this time, the Charge RN will identify another staff RN who can safely cover the rescheduled rest/meal break in accordance with the unit based staffing plan. This can include the Charge RN as relief. c. Manager will cover the Charge RN lunch break if a relief Charge RN is not available for the rest or meal break period, task appropriate. d. If the above options are not viable , the staff RN's will acknowledge the missed rest or meal break throught the timeclock attestation summary at the end of shift. e. If there is no coverage available after following the steps above, notify department manager within 24 hours of shift. 4. CNA will coordinate rest/ meal breaks with CN
5	Minimum Staffing	When any patient is present in the department, there is a minimum staff of two RNs present on the unit. Minimum staffing is maintained during rest and meal breaks. (See the Staffing Matrix) Peri-Anesthesia business hours are from 0600 - 2100, Monday - Friday.
6	Limitations to Admissions	Hospital Capacity Alert Protocal (#4508)
7	Recognition of Acuity and Intensity	All assignments will be balanced based on acuity and RN skill level, adhering to ratios. Acuity definitions are reviewed at least annually. (See the Acuity Tool)

AREA: PERIANESTHSIA

SDU/PACU & ENDOSCOPY				
VOLUME	WEEKDAYS			
	CHARGE	CNA	Nurse	Break RN
28	1	1	11	1
27	1	1	11	1
26	1	1	11	1
25	1	1	11	1
24	1	1	11	1
23	1	1	11	1
22	1	1	10	1
21	1	1	10	1
20	1	1	10	1
19	1	1	10	1
18	1	1	10	1
17	1	1	9	1
16	1	1	9	1
15	1	1	8	1
14	1	1	8	1
13	1	1	8	1
12	1	1	7	1
11	1	1	7	1
10	1	1	6	0
9	1	1	6	0
8	1	1	4	0
7	1	1	4	0
6	1	1	3	0
5	1	0	3	0
4	1	0	2	0
3	1	0	2	0
2	1	0	1	0
1	1	0	1	0

ENDOSCOPY					SEDATION	
VOLUME	WEEKDAYS				MAC	MOD SED
	CHARGE	CNA	Nurse	Break RN		
25	1	1	5	1	5	6
24	1	1	5	1	5	6
23	1	1	5	1	5	6
22	1	1	4	1	5	6
21	1	1	4	1	5	6
20	1	1	4	1	5	6
19	1	1	4	1	4	5
18	1	1	4	1	4	5
17	1	1	4	1	4	5
16	1	1	4	1	4	5
15	1	1	4	1	4	5
14	1	1	4	0	4	5
13	1	1	4	0	4	5
12	1	1	4	0	4	5
11	1	1	4	0	4	5
10	1	1	4	0	4	5
9	1	1	4	0	4	5
8	1	1	4	0	4	5
7	1	0	4	0	3	4
6	1	0	3	0	3	4
5	1	0	3	0	3	4
4	1	0	3	0	3	4
3	1	0	3	0	3	4
2	1	0	2	0	3	4
1	1	0	2	0	3	4

SDU Intensity and Acuity

LEVEL / ACUITY 1 (3:1)	LEVEL / ACUITY 2 (2:1)	LEVEL / ACUITY 3 (1:1)	LEVEL / ACUITY 4 (1:2)	PPROPRIATE - HIGHER LEVEL OF
Ambulatory Ad Lib	Special Needs (Communication/Social/Emotional	Port Access (Task Specific)	Critical Unstable Patient	Unstable Cardiac Rhythm
Completed Admission	Contact Precautions	New Cardiac Rhythm	Blood Administration	Newly Established Tracheotomy
Low-Moderate Fall Risk	High Fall Risk	Nerve Block / Epidurals		Mechanical Ventilators (Home)
Stable VS/ Labs	Labs	Isolation Precautions		High Risk Titrating Drips
Standard Education	12 Lead ECG	High Risk IV Medications		New Onset Chest Pain
Extended Care	Supervised / Standby Assist	Telemetry Monitoring		
	CBG Monitoring	High Anxiety		
	4 Hour Fluid Infusions	Assisted Living / SNF		
	VS outside of norm	Active Behavioral Disorders		
	Difficult IV (Task Specific)	Mental Status/ Panic or Agitation		
	Low Risk Medications (BP Medications)	Difficult IV Access (Task Specific)		
	Interfacility Transfer (Task Specific)	ASA 4		
		Unstable Patient		
		Interpreter Needs (Task Specific)		
		No Clinic Phone Call		
		Mechanical/ Manual Transfer (Task Specific)		

PACU Intensity and Acuity

LEVEL / ACUITY 1 (3:1)	LEVEL / ACUITY 2 (2:1)	LEVEL / ACUITY 3 (1:1)	LEVEL / ACUITY 4 (1:2)	PPROPRIATE - HIGHER LEVEL OF
Ambulatory Ad Lib	Special Needs (Communication/Social/Emotional	Port Access (Task Specific)	Critical Unstable Patient	Unstable Cardiac Rhythm

Completed Admission	Contact Precautions	New Cardiac Rhythm	Blood Administration	Newly Established Tracheotomy
Low-Moderate Fall Risk	High Fall Risk	Nerve Block / Epidurals		Mechanical Ventilators (Home)
Stable VS/ Labs	Labs	Isolation Precautions		High Risk Titrating Drips
Standard Education	12 Lead ECG	High Risk IV Medications		New Onset Chest Pain
Extended Care	Supervised / Standby Assist	Telemetry Monitoring		
	CBG Monitoring	High Anxiety		
	4 Hour Fluid Infusions	Assisted Living / SNF		
	VS outside of norm	Active Behavioral Disorders		
	Difficult IV (Task Specific)	Mental Status/ Panic or Agitation		
	Low Risk Medications (BP Medications)	Difficult IV Access		
	Interfacility Transfer (Task Specific)	ASA 4		
		Unstable Patient		
	Phase 1 after 15	Interpreter Needs (Task Specific)		
	Phase 2	No Clinic Phone Call		
		Mechanical/ Manual Transfer		
		Contact Precautions		
		Phase 1 First 15 minutes		
		Unstable Airway		
		Hemodynamic Instability		
		Reversal Patients		
		Patient transferring to Higher Level of Care		