Title: Staffing Guidelines

Policy Statement/Purpose:

This document describes the development, implementation, monitoring, evaluation and modification of the staffing plan for patient care. The Manager of each patient care service is responsible for his or her service-specific staffing plan as it relates to the hospital-wide staffing plan. Direct-care clinical staff’s input shall be considered in the development, implementation, monitoring, evaluation, and modification of the staffing plan, by way of the Staffing Committee. The primary purpose of this plan is to support the provision of safe patient care and adequate nursing staff.

Instructions:

The staffing philosophy is designed to support professional nursing practice in accordance with our mission and vision.

DEVELOPMENT AND IMPLEMENTATION

1. Development of the staffing plan shall include consideration of:
   a. Nursing care required by aggregate and individual patients’ needs, including coverage for all known patients, and taking into account the turnover of patients.
   b. Specialized qualifications and competencies of the nursing staff. The skill mix and competency of the nursing staff shall ensure the nursing care needs of the patient are met and shall ensure patient safety.
   c. The scopes of practice of registered nurses (RN) and authorized duties of certified nursing assistants (CNA).
   d. The numbers, qualifications, and categories of nursing staff needed for all units.
   e. Predetermined core staffing (see addendum), establishes the minimal numbers of patient care staff (licensed nurses and certified nursing assistants). The number of nursing staff on duty shall be sufficient to ensure nursing care needs of each patient are met. If a patient is present the minimum staff should be no less than one Registered Nurse and one other nursing staff member.
   f. Relevant infection control and safety issues.
   g. Budgets and care standards.
   h. Continuity of Care
   i. Nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations, such as, but not limited to, The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN).
   j. Each patient care service ensures consideration of input from direct-care clinical staff in the development, implementation, monitoring, evaluation, and modification of the staffing committees, or unit committees (such as staffing committees, or Unit Practice Committee). The team works within the parameters of its budgeted standard and makes recommendations to management based on data. This data may include productivity
reports, financial reports, hospital request off reports, corrective or preventative action, patient wait times from the call system, incident reports, and others as appropriate. Their recommendations are considered on a consultative basis for implementation, as appropriate, by their Manager/Director.

PATIENT ACUITY (Patient Classification)

The purpose of the acuity system is to sort patients into similar groups related to complexity of care, which triggers outputs of recommended staffing based on national standards, staff and leadership input, and budget allocations.

Requirements:

1. Direct care nurses will classify their own patients using the appropriate application. If however this is entered by the supervisor/manager, the acuity information must be given by the direct care nurses.
2. Classification will be done a minimum of every eight hours and more often if desired.
   Classification must be completed by 0330, 1130, and 1930.
3. Only patients whose acuity has changed need to be classified each shift

DAILY STAFFING

Daily staffing practices includes the following:

1. Staffing is evaluated and adjusted at least once every 8 hours and more often if needed by considering patient census and acuity level.
2. Responsibility for each shift is delegated to the leadership designee in each department. Staffing analysts are available to support the leaders in each department during hours they are available, and includes:
   a. Monitoring/maintaining budgeted FTEs within established parameters.
   b. Assisting with/providing input to variance management.
   c. Providing timely, accurate data to the staffing office when needs change.
   d. Documenting on the daily staffing sheets or in the staffing system any changes within the shift.
   e. Collaborating with the staffing office to correctly maintain call-off-data.
3. The staffing office maintains day-to-day data to ensure accurate staffing.
   a. Performs allocation/reassignment, notification of scheduled staff.
   b. Searches for additional staff as needed. Replacement Staff: Every reasonable effort will be made to obtain Registered Nurses for unfilled hours or shifts before requesting a nurse to work overtime. This includes seeking replacement at the time the vacancy is known.
   c. Provides units with daily staffing sheets.
   d. Workload intrashift demand (admissions, discharges, and transfers) must be reflected in the patient classification system.
Staffing Assignments:

Staffing assignments are designed to match patient needs with the qualifications/competence of the staff to allow the assigned staff to function within their scope of practice.

ADJUSTMENTS IN STAFFING

1. Adjustments in staffing are made by the designated nursing leader (charge nurse, supervisor) in collaboration with the department manager. Components of the staffing plan will include consideration of core staffing, projected budget, and patient acuity system.
   a. Core staffing and staffing/skill mix formulas are determined on each patient care unity and are defined as the minimum number of positions and mix of skill levels required to care for the typical patient census and acuity.
   b. The staffing budget is service-based and considers the needs of patient populations, evidence-based patient care standards, average daily census, and acuity. Adjustments must be made in staffing when census fluctuates to maintain overall productivity targets.
   c. If specialty patients are placed on a unit other than their typical placement, or if a nurse is floated to an area that is not his/her primary specialty, these situations may require staffing above targets based solely on acuity.

2. In an emergent situation, for instance rapid deterioration or code arrest, it is reasonable and prudent to utilize appropriately credentialed RNs currently in house, rather than incur a delay that would result from calling a nurse in from home. However, in the event that staff must be called in to replace the RN who responded to the emergency an RN from the receiving unit will be called in and the RN who responded to the emergency will return to his/her original unit.

FLOATING

1. Caregivers are expected to accept work outside their home department if they are qualified and oriented according to the following criteria:
   a. Float: Performs basic nursing skills from department list.
   c. Primary: Takes an equal assignment as other caregivers on the unit. May function alone.

2. The following tasks were approved by the Nurse Practice Committee, as appropriate expectations for RNs floating out to assist other units:
   a. Basic RN skills
   b. Vital signs
   c. Glucose checks
   d. IV starts
   e. AM/PM care
   f. Basic assessment (heart, lungs, GI, neuro)
   g. Pain meds
   h. Double checking insulin
i. Obtaining blood from blood bank and double-checking
j. Sitting with the confused or comfort care patient
k. Ambulating patients
l. Transporting patients
m. Admitting history
n. Desk work
o. Lunch relief

3. If a caregiver is asked to perform a task they are not competent doing, they must communicate this and ask to help in another way.

4. Guidelines for Floating:
   a. Specialty unit RNs must be retrievable to their own units if needed.
   b. Floating caregivers should seek the charge nurse for direction/assignment.

Adjustments of staff are made based on target (acuity) and ratio to actual (scheduled) by either calling off or adding staff

PEAK CENSUS PROTOCOL

Hospital leaders are responsible to ensure that the people of Central Oregon (CONet region) have access to appropriate acute hospital care. They are also responsible to ensure that services are provided consistent with the scope of service and level of care required. This protocol is to provide direction during varying levels of alert regarding hospital admission capacity due to high patient census or staffing difficulties. This protocol also provides guidance related to the temporary closure of the Hospitalist Service due to capacity concerns.

LEVEL 1 – Business as usual.
LEVEL 2 – Cautionary level indicating that we are nearing capacity for hospital admissions.
LEVEL 3 – At capacity and unable to admit patients.

1. When we are at Level 2 and are close to being unable to render adequate care due to unavailability of beds or lack of available staff, the Peak Census Protocol will be initiated. It is our intention to avoid transfer, diversion, or cancellation of procedures whenever possible in recognition of the hardship imposed by such actions on patients, families, physicians and referring hospitals.

2. If a direct care nurse is concerned that there is an inability to meet patient care needs or a risk of harm to existing and new patients, s/he may request an evaluation of potentially limiting admissions or diversion of patients by notifying their charge nurse, supervisor or manager.

3. The following factors are based on OAR 333-510-0002 and may be, but are not in all circumstances, evidence of potentially unsafe care:
   a. Inability to implement the written nurse staffing plan
   b. Inability to comply with the patient care plan
   c. Patients are reporting their nursing care needs have not been met
   d. Inability to give medications as scheduled
e. Inability to complete the nursing preparation for a procedure in a timely manner
f. Registered nurses and/or certified nursing assistants practicing outside of their scope of practice
g. The daily unit level staffing does not include coverage for all known patients, taking into account the turnover of patients
h. The skill mix of employees and the relationship of skill mix to patient acuity and intensity of the workload is insufficient to meet patient needs
i. Unreasonable delays in responding to a patient’s (or family member’s request on behalf of a patient) request for nursing care

4. MS/ICU Supervisor
   a. Identify need to initiate Level 2: Peak Census Protocol based on evaluation of bed or staff availability for additional admits. Consider need for Emergency Preparedness Plan.
   b. Determine need for expanded space capacity. Med/Surg patients may be admitted to ICU (do not fill last bed in ICU with Med/Surg patient or “clean” female medical/surgical patient may be admitted to FBC.
   c. Direct admit patients take priority over patients housed in the ED for admission to Med/Surg. (ED patient is already receiving care).
   d. Notify Chief Nursing Officer (CNO) or Chief Executive Officer (CEO) if rescheduling or cancellation of surgeries, outpatient procedures, if there is consideration of transferring an inpatient or ED patient for staffing reasons outside of the hospital, or there is consideration of declining acceptance of a patient from a regional facility related to staffing.
   e. For staffing difficulties unable to be resolved and after performing all actions normally followed by the staffing office for allocating additional nursing staff, notify management of the affected department. The Manager or designee on call will help problem-solve and find staffing solutions. Depending on the seriousness of the situation this may include the Manager or CNO coming into the hospital or activating the staffing reserves list.
   f. Notify Environmental Services coordinator to obtain additional housekeeping
h. Notify Central Communications of Peak Census Level.
i. Discontinue alert and/or diversion action after situation is resolved. Confer with appropriate leader as needed. Remove Alert Memo from Central Communications.
j. ICU: Evaluate patients for transfer to Med/Surg unit, discharge or transfer to another facility
   k. Med/Surg: Assist with phone calls to physicians as needed to facilitate patient disposition. Ensure that patients are stabilized and appropriate for disposition.

5. DUTY ADMINISTRATOR
   a. The Duty Administrator has the decision-making authority to not accept transfers from hospitals in our region, to postpone/cancel procedures and/or surgeries, or to transfer an inpatient or ED patient due to capacity reasons. The Duty Administrator makes these
decisions in consultation with the department leadership, CNO and appropriate physician leadership.

6. DEPARTMENT MANAGER
   a. Assess the situation and help with problem solving as requested.
   b. Request assistance from the Duty Administrator, CNO, or Administrator, as appropriate.
   c. Notify campus Administrator of situation and plan of action.
   d. Notify Medical Director Chief of Service or Hospitalist
   e. Staffing difficulties: assess situations, consider recall of staff attending educational functions, assign self or Supervisor as appropriate, confer with CNO.
   f. Consider re-activating any rooms currently configured as private to semi-private if headwall and furnishings available.

7. MEDICAL DIRECTOR OF PHYSICIAN RELATIONS/VP MEDICAL AFFAIRS
   a. Medical Director of Physician Relations/VP Medical Affairs assists with physician communications, conflict resolution and facilitation of cancellations.

8. NURSES
   a. Prioritize work to facilitate transferring or discharging patients.
   b. Phone physicians regarding patients who may potentially be discharged to request orders to do so.
   c. Communicate needs for assistance to designated leader, supervisor or manager.

9. CASE MANAGERS/SOCIAL SERVICES
   a. Prioritize work to facilitate transferring or discharging patients.
   b. Check with patient’s nurse and assist with: Phoning physicians regarding patients who may potentially be transferred or discharged to request orders to do so.
   c. Communicate needs for assistance to designated leader, supervisor, or manager.
   d. Assist with transfers as appropriate

10. EMERGENCY DEPARTMENT MANAGER
    a. Notify ED physician
    b. ED physician to instruct any admitting physician that they need to come see patient personally and expeditiously, if they wish to admit a patient.

11. OR MANAGER
    a. If necessary, review surgery cases for cancellations or rescheduling. Notify CNO, Administrator or Duty Administrator.
    b. Cancellations/rescheduling will be performed on a collaborative basis between the hospital and physicians. Conflicts may be resolved through the Chief of Surgery or the CNO.

12. HOSPITALIST OR INTERNAL MEDICINE PHYSICIAN
    a. The Hospitalist/Internal Medicine Physician on-call and department leader (Supervisor, Manager, CNO) will triage all patients in ICU and for potential transfers to the Med/Surg Unit. Direct admits to the unit will not be accepted until the patient has been evaluated in the ED by the admitting physician.

13. FBC MANAGER
a. One OB bed will be reserved within the FBC for the admission of OB patients presenting to the FBC for assessment of their care needs (a Med/Surg patient may not be admitted to the last open FBC bed).
b. In the event that the FBC reaches bed capacity or it is identified that all trained staff have been utilized, the FBC Manager will ensure that all resources have been identified and will confer with the CNO or campus administrator.

SCHEDULES

1. Operational master schedules are developed at the unit level by the Manager/Supervisor and maintained in staffing system in a centralized staffing office. The operational unit schedules are prepared for each month and posted in each unit by the 15th of the preceding month.
2. Requests for time off must be received by the first day of the month proceeding the month in which the absence is planned. All requests not meeting this parameter must be arranged and approved by the manager or supervisor.
3. All requests for time off, time off for education with or without ETO, and trades with other caregivers must follow the process, “Requests for Earned Time Off on Patient Care Units,” Requests for Earned Time Off. ETO may be requested up to 12 months into the future.
4. Once schedules have been posted, they are not subject to change unless the caregivers desiring the change makes arrangements to trade shifts with another caregiver who is qualified, or finds his/her own replacement that is qualified. Changes to the posted schedule must be mutually approved in advance by management the affected caregiver. Schedule changes which result in overtime may not be approved.
5. Once a request for time off has been approved and replacement caregivers scheduled, the request should not be rescinded by the caregiver, unless approved by the manager as well as agreement by covering caregiver. Requests for time off are granted based on core staffing parameters and on a first come, first serve basis.
6. Shift needs are posted in the staffing office from the first through the 10th for the following month’s schedule. Caregivers can sign up for future needs for up to one year in advance. Caregivers may indicate availability to fill open shifts by signing up on the calendar in the staffing office or by e-mailing the staffing analyst their availability. Only caregivers signing up for straight time should be listed as available on the needs list.
7. Winter holiday scheduling, covering an approximate eight-week period, is completed by October 31 to cover the major holidays: Thanksgiving, Christmas, and New Year’s.
   a. Caregivers are encouraged to sign up for their preference for holidays off by mid-October
   b. Schedules for the past two years are reviewed, with holiday time off rotated equitably among employees scheduled on each unit, each shift.
   c. After the holiday schedule is posted, scheduled caregivers may request to be off if census should be low. Requests are considered by seniority.

ADDITIONAL WORK
1. Caregivers who want to pick up shifts will notify the staffing office by indication date/shift 
availability on the “Availability Log” in the staffing office. This may be accomplished by emailing, 
calling or signing up on the log. The availability log is only for “straight time” shifts.
2. Full-time or part-time caregivers who make themselves available for additional work that does 
not result in overtime or premium will be called, in order of seniority and offered such work 
before the relief nurses are offered the available work.
3. If a nurse has been cancelled from his/her scheduled shift and work becomes available on a unit 
later in the shift, the first calls will go to the regularly scheduled RN who was cancelled and has 
made themselves available for that shift at straight time. If the RN does not respond, 
subsequent calls will go to other RNs who have made themselves available at straight time, 
including relief RN staff by the order specified in the contract. Additional available work will be 
granted the most senior caregiver who has been called off during the present 4 week schedule 
and has indicated availability for work at straight time followed by those who have indicated 
availability for work.
4. If shift remains open or is open due to an unplanned absence after the schedule has been 
posted, a full seniority call back will be done, followed by accessing the Shared Nursing pool, 
and/or agencies for coverage.
5. HR and Standby: If census is low and a caregiver is asked to HR, but also asked to remain on 
Standby, the caregiver will be on standby for their entire shift. If they are called back in at any 
time during the shift, they will receive callback pay.
6. HR: if census is low and a caregiver is asked to HR, they are no longer obligated to the hospital. If 
they are needed, can be reached and agree to come back, it is considered a pick-up shift and is 
paid as premium.
7. Caregivers may replace scheduled agency staff on a scheduled work shift prior to and up to 4 
hours before a shift starts, providing the open shift hours are fully covered prior to the start of 
the shift.

DOCUMENTATION OF STAFFING/SCHEDULING PROCESSES

1. Master schedules, the operational schedule and daily staffing records will be maintained in the 
One-Staff computer program.
2. Phone calls will be logged in staffing system or on a telephone log. The log should be sent to the 
staffing office daily.

STAFFING INCIDENT REPORT

The Staffing Incident Report documents concerns and issues related to staffing in-patient care areas and 
follow-up and management of issues. It is also used to facilitate data collection for monitoring, 
identification of trends, analysis of staffing effectiveness, and process improvement. The individual (RN, 
CNA, Staffing Analyst, Supervisor, Manager, CNO) who first identifies a staffing occurrence or concern 
initiates the staffing incident report.

INSTRUCTIONS:
1. When a staffing occurrence or concern arises, discuss with immediate supervisor and initiate staffing incident report (must be filled out within 7 days) (Staffing Incident Report).

2. Complete first portion of incident report, with name, date/time of occurrence, and unit where issue occurred. Check appropriate descriptor of event. If “other variance,” provide brief description of what the variance was. Complete brief description of event to support analysis.

3. Circle “yes” or “no” to indicate if a follow-up response is desired.

4. Check section to indicate who was notified and at what time. If resolution occurs at any level, notification of next level is optional.

5. Charge nurse, Supervisor, or manager completes next portion of report to indicate severity of event and how the event was managed at that time.

6. If severity of event is assessed as level 3, probable risk, with some omission of care, or level 4, high risk, with a negative patient outcome, the event must be logged in the Event Management System (EMS) at that time. Staffing Incident Report must be filled out in accordance to #1 as stated above.

7. When the front of the form is complete, send to the manager of the specific department where the event occurred.

8. When the investigation is complete, send all forms to the staffing office within 10 days. All reports will be logged into the staffing incident log located on the Bend I drive by the staffing analyst.

9. If trends are identified a plan for corrective action, education and/or coaching will be initiated by the department manager.

10. If the Caregiver that initiated the report requests a response, the department manager or designee must send a summary of findings and outcome, preserving the individual confidentiality, to the requesting caregiver. A copy of the actual report will not be made due to the confidential nature of incident reports.

11. Confidentiality of reports must be maintained, and copies are not to be made. The reports will be returned to the Staffing Office after review.