MultiCare
Tacoma General Hospital

MultiCare
Allenmore Hospital

January 04, 2023

To: Washington State Nurse Staffing Coalition

I, the undersigned, Linda Alderson, with responsibility for Tacoma General Allenmore Hospital nursing staff, attest that the staffing plans and matrices were developed in accordance with RCW 70.41.420 for 2023 and includes all units covered under our hospital license under RCW 70.41. These plans were developed with consideration given to the following elements:

- Census, including total number of patients on the unit, on each shift and activity such as patient discharges, admissions, and transfers
- Level of intensity of all patients and nature of the care to be delivered on each shift
- Skill mix
- Level of experience and specialty certification or training of nursing personnel providing care
- The need for specialized or intensive equipment
- The architecture and geography of the patient care unit, including but not limited to placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment
- Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations
- Availability of other personnel supporting nursing services on the unit
- Strategies to enable registered nurses to take meal and rest breaks as required by law or the terms of an applicable collective bargaining agreement, if any, between the hospital and a representative of the nursing staff.

The staffing plans were adopted by the hospital on January 4, 2023.

As approved by Linda Alderson, Chief Nursing Officer for Tacoma General Allenmore Hospital.

This document is submitted for review by MultiCare Tacoma General Allenmore Hospital Administration and submission for the Washington State Nurse Staffing Coalition.

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Tacoma General Allenmore Hospital Administration:

By: Linda Alderson Date: 1/30/2023

Linda Alderson, MSN, RN, NEA-BC
Chief Nurse Executive for West Pierce (Tacoma General, Allenmore, and Kitsap)

By: Mark R Date: 01/30/2023

Mark Robinson
Tacoma General Allenmore Hospital
President

TACOMA GENERAL ALLENMORE HOSPITAL

2023 STAFFING PLANS

JANUARY 2023

MultiCare
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TACOMA GENERAL ALLENMORE HOSPITAL
2022 STAFFING PLANS
January 7, 2023

January 2023

TACOMA GENERAL HOSPITAL STAFFING PLANS

Presented by Nursing Services

MultiCare

FAMILY BIRTH CENTER (FBC)

INTENSITY OF UNIT AND CARE

The Family Birth Center consists of 45 in-patient beds, 4 OBED beds, 3 OR suites, 1 neonatal stabilization room and a 4-bed newborn observation nursery. The FBC is considered a “no divert” unit; exceptions are escalated to and evaluated by nursing and provider leadership and the hospital administrator on call.

SCOPE OF SERVICE:

- Labor management and labor induction management
- Vaginal delivery
- Immediate postpartum stabilization of mother
- Cesarean section delivery
- Post-anesthesia care of mother
- Transitional post-birth care of the term, ongoing care of low-risk normal newborn
- Post-birth care of high risk neonates, in collaboration with the NICU
- Mid-trimester induction of labor termination of pregnancy for terminal and severe fetal anomalies
- Bilateral tubal ligation
- Placement/removal of cervical cerclage
- Stabilization and surveillance of high risk antepartum complications, to include management of regional antepartum transport patients
- Stabilization and care of complicated postpartum patients
- D & C for excessive uterine bleeding
- Delivery and post-delivery management of fetal demise or non-viable live birth
- Care of post-partum patients
- Care of low risk post gynecological patient
- Care of high risk antepartum patients
- Offer OB ED services
- Offer ambulatory services (Non-stress tests, version, steroid injections)

EXCLUSIONS:

- Elective terminations other than other stated indications
- High risk or high acuity GYN patients
- Unstable newborns
- Cesarean sections, with anticipated complications resulting in a hysterectomy: these patients are delivered in the main OR with OB staff although emergency cases can be done in the FBC OR
- Obstetrical surgical cases involving morbidly obese patients are done with the main OR with OB staff although emergency cases can be done in the FBC OR
- High risk obstetric patients that require ICU level of care; OB staff sent to unit to assist with care

1. Admission is coordinated through collaboration with office staff, scheduled admissions/procedures, or admission via the OBED.
2. OBED is managed by on-site Laborist 24/7.

FBC CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the critically patient can rapidly change, the charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

FBC care is provided to patients based on AWHONN standards.

NURSE TO PATIENT RATIOS

1:1 for labor and delivery typically reflects:

- Active labor patients
- MgSO4 infusion
- Epidural placement
- OR and PACU care
- Early labor or induction with co-morbidities

2:1 for labor and delivery typically reflects:

- Early labor
- Early induction
- Observation

1:3 for antepartum typically reflects:

- Stable antepartum or post-partum patients to include PROM, HTN, diabetes, PTL

1:1 for antepartum patients typically reflects:

- Initial hour of MgSO4 infusion
- Labetalol administration
- Critically ill or immediate post-op patient

1:3 couplets (flex to 4 if LPN support available) for post-partum and newborn care typically reflects:

- Mother-baby couplets after the 2-hour recovery period
- Staffing adjustments for less than 1:3 are acuity based.

DAILY STAFFING

The FBC core staffing consists of RNs, LPNs, HUCs and CNAs. Staff is supported by in-house Laborist, Pharmacy, Respiratory Therapy, Vascular Access Team, Phlebotomy, Dietician, Social Work Services, NICU, Anesthesia, and Chaplain Services.

The assigned charge nurse makes patient care assignments based upon skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs/LPN's required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Assistant Nurse Manager
- Unit Nurse Manager
- Unit Director
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished using telephone, Everbridge, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the UBC.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem FBC staff
- Travel Staff or agency staff

CERTIFICATIONS

All RN's and LPN's in Labor and Delivery and in Post-Partum have:

- BLS
- NRP
- Annual Mandatory Education
- POCT

L&D RN's are required to have fetal monitoring education every 2 years.

Additional certifications are recommended but not required such as OB RNC, External Fetal Monitoring Certification and Maternal Newborn Certification.

QUALITY INDICATORS

- Falls
- HAPU
- CLABSI

- CAUTI
- Surgical Site Infections
- Exclusive Breastfeeding
- Employee injury events

CORE MEASURES

- Incidence of episiotomy
- Elective deliveries at >=37 and <39 weeks of gestation completed
- NTSV rate
- Antenatal steroids
- Exclusive breastfeeding

ENGAGEMENT AND SATISFACTION

- HCAHPS
- SCORE Survey
- 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model

EMERGENCY DEPARTMENT STAFFING PLAN

PATIENT POPULATION

Patient care in Tacoma General Emergency Department is based on the Multicare mission, vision, and core values, as well as the patient care needs for the communities served.

2021 Projected Data-

- 52,802 patients
- 10,492 admissions

Patient acuity categorized upon arrival using the Emergency Severity Index (ESI) 5 level scale per Emergency Nurses Association (ENA) recommendations. Percentages based on projected volume trend for 2021.

- Level 1- resuscitation 3%
- Level 2- Emergent 25%
- Level 3- Urgent 53%
- Level 4- Less Urgent 17%
- Level 5- Nonurgent 2%

ENVIRONMENT OF CARE

Triage: 2 care spaces

Fast track: 6 care spaces and 2 hallway spaces

Red Zone: 14 beds and 4 hallway beds. Red zone includes 4 reduced risk rooms and 2 negative pressure rooms.

Blue Zone: 10 beds and 4 hallway beds. Blue zone includes 3 Trauma bays.

Room 28: Main trauma bay

Green Zone (Surge): 12 care spaces

Gray Zone: 8 beds

SKILL MIX

Emergency Department Staffing

- Director
- Nurse Manager
- Assistant Nurse Managers

- Registered Nurses
- Emergency Services Techs
- Emergency Services Representatives
- Certified Nursing Assistants utilized as COSI/CORA for behavioral health population

Emergency Department Core Staffing Patterns

Employees are expected and encouraged to take rest and meal breaks pursuant to Multicare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this staffing plan.

Changes to the staffing plan may be required in the event of unscheduled absences. Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

Grid below represents the core staff daily with staff arriving at staggered times in alignment with arrival and saturation volumes.

Role	Days	Evenings	Nights
Charge RN	**1**	**1**	**1**
RN	**8**	**12-22**	**8**
EST	**4**	**7**	**4**
ESR	**1**	**2 (trauma days)**	**1**
CNA (CORA/COSI)	**3**	**4**	**3**

Additional Staffing may be obtained by:

- Regular FTE ED staff
- Per Diem ED staff
- System Float Pool
- Agency/Travelers
- Voluntary Standby

The nursing staff uses the following chain of command for any concerns or issues:

- Charge nurse
- Nurse manager or assistant nurse manager
- House supervisor (after hours and weekends)
- Director
- Chief Nurse Executive

STAFFING RATIOS

- Nursing leadership or charge nurse assigns patients based upon skill mix and acuity of patients.
- ED care is provided to patients following the Emergency Nurses Association (ENA) Staffing and Productivity Guidelines, which states:

"Evaluation of staffing and productivity is based on patient census and acuity, direct and indirect time for care delivery.
experience and skill mix of the ED staff; and include the impact on patient and emergency nurse safety and satisfaction,
and the recruitment and retention of qualified nurses."

- Current practice on the unit is to cohort patients according to acuity as feasible.
    - Critically ill patients can rapidly change, the charge nurse (or nursing leadership) will make immediate adjustments to support acuity. Relying on staffing ratios alone can overlook the variance in patient needs and acuity.
- Code Neuro, Code STEMI, Code Trauma patients, unstable/critically ill and/or injured patients and those admitted with Critical Care admission status are given nursing care according to acuity. Nurse assignments are flexed down to compensate for level of care of admitted patients based on ENA staffing guidelines.
- Patients being held in the Emergency Department will be staffed at the patients assigned ratio for care as per the admitting units' standards.

Required certifications for all ED RNs include

- BLS
- ACLS
- PALS
- NIH
- TNCC

Additional certifications recommended but not required- CEN, TCRN

BAKER CENTER GI LAB

INTENSITY OF UNIT AND CARE

The Tacoma General Baker Center GI Lab is a 4-procedure room unit providing care 24/7/365. The Tacoma General Baker Center GI Lab specializes in:

- Interventional Gastroenterology Procedures
- Diagnostic and Therapeutic Gastroenterology Procedures
- Diagnostic and Therapeutic Pulmonary Procedures
- Interventional Pain Procedures
- Support for surgical procedures requiring Flexible Endoscopes and Staff

The Charge Nurse is ideally a free charge.

The endoscopy/special procedures environment required both direct and indirect patient caregivers

OPERATING ROOM CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

Gastroenterology/Special Procedures staffing includes planned and urgent/emergent procedures and must take into consideration caring for patients whose procedures run over schedule

Procedural care is provided to patients following SGNA Standards, ASGE Guidelines, the Association of PeriOperative Registered Nurses (AORN) Guidelines for Perioperative Practice

Procedural care is provided to patients following the standards at a minimum of 1:1

Procedural care is also provided in accordance with Washington State Nurses Association (WSNA) contract as it relates to patient and RN ratios.

NURSE TO PATIENT RATIO

The WSNA contract reflects 1:1 ratio intra-procedure for staff

General procedural room staffing is as follows, however, due to the acuity of the patient additional staff may be necessary

- Standard GI procedures with general anesthesia: 1 circulator, 1 assistant, 1 Radiology tech for cases using fluoroscopy
- Standard GI procedures with procedural sedation: 1 circulator, 1 sedation nurse, 1 assistant.
- Pulmonary procedures with general anesthesia: 1 circulator, 1 assistant
- Pulmonary procedures with procedural sedation: 1 circulator, 1 sedation nurse, 1 assist
- Interventional Pain procedure: 1 circulator, 1 radiology technician
- Interventional Pain procedure with sedation: 1 circulator, 1 sedation nurse, 1 radiology tech.
- General Surgery procedures – dependent on the type of procedure: 1 assistant for endoscope and equipment assistance with the surgeon (surgical OR team present)
- General Surgery procedures that require a full team: 1 circulator, 1 assistant (surgical OR team present)
- General Surgery Sedation: 1 circulator, 1 assistant, 1 sedation nurse (No OR team)

*The circulating and sedation roles must be staffed with an RN; the assisting role can be either an RN or an LPN

Indirect patient care providers are utilized to provide breaks, lunches, assistance, and room setup/turnover.

DAILY STAFFING

The Procedure room core staffing varies daily. The schedule is designed around the Procedural block Matrix to include up to 4 0800 rooms to start, inclusive of Allenmore GI, with varying number of staff needed due to the acuity of cases being performed. The schedule is looked at the day before, staff are assigned to blocks of cases and whether more of less staff are needed is determined at that time.

The charge nurse assigns blocks/procedures based upon skill mix and acuity of patients. Phase II Recovery is managed within the department and staffed per ASPAN Guidelines of 1:3 ration dependent on patient acuity

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Unit Nurse Manager
- Perioperative Director
- Perioperative Administrator
- Chief Nursing Executive

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem staff

CERTIFICATIONS

All RNs in the GI Lab/Special Procedures must have:

- BLS and ACLS

Additional certifications are recommended but not required such as: CGRN

QUALITY INDICATORS

- SSI
- HLD per CDC, FDA, AORN, SGNA, ASGE, AND AAMI Guidelines
- Employee HARM

CORE MEASURES

- Prophylactic Antibiotic when appropriate (PEG)
- Appropriate hair removal (PEG)

ENGAGEMENT AND SATISFACTION

- Ambulatory Surgery 'likelihood of recommending'
- Employee Engagement

CARDIAC CATH LAB UNIT (CCL)

PATIENT POPULATION

Patients needing cardiac diagnostic or interventional procedure. (LHC/RHC, ASD/PFO, IABP, TAVR, Watchman, Mitral Clip, Pacer/ICD, RFCA, pediatric Cath needs)

Patients needing vascular diagnostic or interventional procedure. (AARO, endovascular AAA, fistula gram, carotid stents, thrombolytic therapy)

ENVIRONMENT OF CARE

The CCL consists of 4 labs plus 1 hybrid lab/room.

INTENSITY OF UNIT AND CARE

Critical care

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the CCL patient can rapidly change, the charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

The charge nurse/lead tech assigns patients based upon skill mix and acuity of patients. Census and acuity fluctuations are managed through increasing or decreasing the number of RN's required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse/Lead CVT
- Unit Nurse Manager
- Unit Director
- Chief Nursing Officer

NURSE TO PATIENT RATIO

Intra procedural care is provided to patients following the AORN standards at a minimum of 1:1.

CCL room staffing is as follows, however, due to the acuity of the patient, additional staff may be necessary

- Standard CCL case 1 RN, 2 CVT's, total of three staff (RN committed to patient care/conscious sedation).
- Complicated CCL case 2 RN's, 2 CVT's

DAILY STAFFING

The CCL core staffing varies daily depending upon scheduled cases and the potential acuity of the cases.

The charge nurse/lead CVT assigns rooms/cases based upon skill mix and acuity of patient/case.

Census and acuity fluctuations are managed through increasing or decreasing the number of staff required to support case.

All other times department is staffed by an on call team with RN and CVTs to provide coverage 24 hours/day, 7 days/week.

STRATEGIES SUPPORTING REST BREAKS AND MEALS

Charge nurse as well as staff not in cases are able to support rest breaks and meal breaks.

LEVEL OF EXPERIENCE

CCL RN's must have critical care or emergency room experience.

CERTIFICATIONS

All CCL RN's must have:

- BLS
- ACLS
- POCT
- NIHSS
- Annual mandatory education
- Conscious sedation

QUALITY INDICATORS

- Falls
- HAPI, CLABSI, CAUTI
- COAP

- Surgical/procedure site infections
- Employee harm
- Sheath site hematomas

CORE MEASURES

- Acute MI/CVA
- Appropriate hair removal
- Antibiotic prophylaxis
- DVT/PE

ENGAGEMENT AND SATISFACTION

- Employee engagement
- Culture of Safety Survey
- 1:1 leader rounding on employees

CORONARY CARE UNIT (CCU)

29 bed unit providing care 24/7/365. The CCU specializes in:

- Care and treatment of critically ill adults 18 years of age and older. Nursing care is provided for adults 18 years of age and older. The following patient conditions allow for admission or transfer to the CCU may include, but are not limited to:
    - Pre and Post cardiovascular surgery patients not requiring invasive hemodynamic monitoring
    - Vascular surgery patient not requiring invasive hemodynamic monitoring
    - Cardiac System:
        - TAVR
        - STEMI/NSTEMI
        - CHF
        - LVAD
- Other conditions that require intermediate care and treatment
- Admission is coordinated through the admitting Physician, Bed Expeditor, and Charge Nurse and is accordance with Admission, Discharge, and Transfer Criteria.

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.
Since the condition of critically ill patients can change rapidly, the charge nurse or nursing leadership makes immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs, skill of staff, and acuity.

- CCU care is provided to patients following the American Association of Critical-Care Nurses (AACN)
- CCU care is provided in accordance with Washington State Nurses Association (WSNA) contract with TG as it relates to patient and RN ratios

NURSE TO PATIENT RATIO

- 1:1 typically reflects:
    - Patient requiring active recovery
- 1:2 typically reflects:
    - Patient requiring intensive care
- 1:3 typically reflects:
    - Patient requiring progressive care

- 1:4 typically reflects

    - Patient requiring progressive care
- Charge Nurse does not have patient assignment
- Break Nurse does not have patient assignment

DAILY STAFFING

CCU core staffing to achieve full capacity is 10 RNs per shift to cover our average daily census. Core staffing also includes a licensed practical nurse, patient care technicians, and a monitor tech. Staff is supported by on floor Pharmacist during day and evening shifts, Respiratory Therapy, Hospitalists, Cardiologists, Intensivists/Pulmonologists, Cardiothoracic Team, LVAD team, CHF Team, Vascular team, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Chaplain Services, Environmental services personnel, and leadership staff.

Additional resources are available in times of increased acuity to support the core staff:

- Free standing charge nurse
- Free standing break relief nurse
- In house Transport RN and RT (when not out on transport)

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager or Assistant Nurse Manager
- Director of Inpatient Nursing
- Associate Chief Nurse Executive
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished using telephone, Telmediq, and text messaging.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem CCU staff
- Pulse Float Pool staff
- Travel or agency staff

CERTIFICATIONS

- CCU RNs must obtain and maintain:
    - BLS
    - ACLS
    - NIH
- LVAD training and certification
- Groin site and sheath recovery management
- Some CCU RNs have additional certifications including, but not limited to:
    - PCCN
    - CCRN

    - CMC
- Professional Standards
    - ANA Standards of Nursing Practice
    - AACN (American Association of Critical Care Nurses)
    - AHA (American Heart Association)

QUALITY INDICATORS/CORE MEASURES

- HAPI
- CLABSI
- CAUTI
- Patient Falls
- CMS Core Measures
    - Stroke
    - Heart Failure
    - Acute MI
    - Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement Survey
- Culture of Safety Survey
- 1:1 HRO Leader Rounding on Employees
- Shared Leadership Council Governance Model

CARDIOVASCULAR ADMIT RECOVERY UNIT (CVAR)

PATIENT POPULATION

Pre-op care for cardiac and vascular surgeries (CABG, AVR/MVR, VAD, TAVR, lobectomy, AAA, fistula, amputation, stab phlebectomy)

Pre-Anesthesia clinic (encounter includes pre-op labs, UA, Xray, ABG/PFT, anesthesia interview, ICD/pacer clearance from EP cardiologist, ensure vendor present for device changes needed day of surgery, assess social issues, patient teaching regarding pre/intra/post procedure)

Pre and post procedure care for Cardiac Cath Lab patients (LHC, RHC, CTO, ASD/PFO, IABP, pacer, ICD, RFCA, AARO, EP Ablation, Watchman, Mitral Clip)

Pre and post procedure care for Interventional Radiology

Procedures (TEE, DCCV, ILR insertion, bone marrow biopsies)

ENVIRONMENT OF CARE

CVAR is a 22-bay unit. Four bays are used for unit procedures, four bays are used for Phase 1-2 PACU, fourteen bays are used for admissions, returns, Pre-Anesthesia clinic/Pre-Admit.

INTENSITY OF UNIT AND CARE

Critical Care

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the CVAR patient can rapidly change, the charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

The charge nurse assigns patients based upon skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RN's/LPN's required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Unit Nurse Manager
- Unit Director
- Chief Nursing Officer

NURSE TO PATIENT RATIO

CVAR follows AORN standards.

- During procedures 1:1
- Phase 1 recovery 1:2 or 1:1
- Admissions/returns 1:3

This staffing ratio has been approved by our staffing committee

DAILY STAFFING

Staffing is done one day in advance depending upon the schedules listed in EPIC for the CVOR, CCL, IR, Pre-Anesthesia, in patient add-ons for recovery and pathology. Core staffing is 8-9 RN/LPN's, 1 HUC, 1 transporter, 1 CNA. Staff is staggered depending upon scheduled cases (late vs early), procedures, potential SDD. There are two staff members that are listed as "on call" for each day, staff takes approx. one day of call per week to include at least one Friday per month. Call consists of staying past 1830 to do late discharges/recoveries/care for patients without needed inpatient bed.

STRATEGIES SUPPORTING REST BREAKS AND MEALS

Staggered shifts support the ability to provide rest and meal breaks for CVAR staff. The charge RN does not count into the staffing mix, so charge is also able to support breaks/lunches.

LEVEL OF EXPERIENCE

CVAR staff need critical care or emergency room experience. We may consider telemetry experience.

CERTIFICATIONS

All RN's in CVAR have:

- BLS
- ACLS
- POCT
- NIHSS
- Annual mandatory education
- Conscious sedation
- Sheath management

All LPN's in CVAR have:

- BLS
- ACLS

- POCT
- NIHSS
- Annual mandatory education
- Sheath Management

QUALITY INDICATORS

- Falls
- HAPI, CLABSI, CAUTI
- COAP
- Surgical/procedure site infections
- Employee harm
- Sheath site hematoma

CORE MEASURES

- Acute MI, CVA
- Appropriate hair removal
- Antibiotic prophylaxis
- DVT/PE

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee engagement
- 1:1 leader rounding on employees

CARDIOVASCULAR INTENSIVE CARE (CVICU)

13 bed unit providing care 24/7/365. The CVICU specializes in:

- Care and treatment of critically ill adults 18 years of age and older. The following patient conditions allow for admission or transfer to the CVICU may include, but are not limited to:
  - Immediate post-operative surgical patients requiring invasive hemodynamic monitoring and treatment
  - High-acuity vascular surgery patients requiring hemodynamic monitoring and treatment
    - Endovascular and open aortic/abdominal aneurysm repair
  - Cardiovascular and Pulmonary systems:
    - AMI and post-arrest treatment, including therapeutic temperature management
    - Cardiac assist device insertion, monitoring, and management
      - Intra-aortic Balloon Pump
      - PA Catheter
      - Impella percutaneous LVAD
      - Centrimag
      - ECMO/ECLS - Cardiopulmonary bypass support
    - Advanced heart failure monitoring and treatment
    - Ventilator support for patients requiring advanced respiratory interventions/treatment
      - Temporary pacer insertion/monitoring
      - CRRT – Continuous Renal Replacement Therapy
      - Hemodynamic instability, requiring advanced cardiac monitoring and treatment, including vasoactive medicines.
      - Thrombolytics administration, monitoring, and maintenance (EKOS)
      - Other conditions that are deemed high risk and necessary for ICU admission
- Multidisciplinary rounds with Pulmonologist, Nursing, Respiratory, Dietary, Care Management, and Pharmacy daily. Other specialties like CT surgery, Heart Failure, and Vascular surgery round regularly on patients.
- Admission is coordinated through admitting Physician, Bed Expeditor, and Charge Nurse and is in accordance with Admission, Discharge, and Transfer Criteria.

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

Since the condition of critically ill patients can change rapidly, the charge nurse or nursing leadership makes immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs, skill of staff, and acuity.

- CVICU care is provided to patients following the American Association of Critical-Care Nurses (AACN).
- CVICU care is provided in accordance with Washington State Nurses Association (WSNA) contract with TG as it relates to patient and RN ratios

NURSE TO PATIENT RATIO

- 1:1 or greater typically reflects:
  - Complicated, hemodynamically unstable patients, immediate post-operative cardiovascular patients, open chest surgical patients, support devices requiring continuous monitoring
- 1:2 typically reflects
  - Critically ill patients requiring intensive care
- Charge Nurse does not have patient assignment
- Break Nurse does not have patient assignment

DAILY STAFFING

CVICU core staffing to achieve full capacity is 9 RNs per shift to cover our average daily census. Core staffing also includes a patient care tech during weekdays, and a monitor tech. Staff is supported by on floor Pharmacist during day and evening shifts, Respiratory Therapy, Hospitalists, Cardiology, Intensivists/Pulmonologists, Cardiothoracic Team, LVAD team, CHF Team, Vascular team, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Chaplain Services, Environmental services personnel, and leadership staff.

Additional resources are available in times of increased acuity to support the core staff:

- Free standing charge nurse
- Free standing break relief nurse
- In house Transport RN and RT (when not out on transport)

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager or Assistant Nurse Manager

- Director of Inpatient Nursing
- Associate Chief Nurse Executive
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished using telephone, Telmediq, and text messaging.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem CVICU staff
- Pulse Float Pool Staff
- Travel or agency staff

CERTIFICATIONS

CVICU RNs must obtain and maintain:

- BLS
- ACLS
- NIH

Advanced Hemodynamics monitoring and treatment knowledge
Ventilator management
LVAD training and certification
Groin site and sheath management
Some CVICU RNs have additional certifications:

- PCCN
- CCRN
- CMC

Professional Standards

- ANA Standards of Nursing Practice
- AACN (American Association of Critical Care Nurses)
- AHA (American Heart Association)

QUALITY INDICATORS

- Patient Falls
- HAPI
- CLABSI
- CAUTI
- VAP / VAC / VAE
- Employee injury events

CORE MEASURES

- Stroke
- Heart Failure
- Acute MI
- DVT/ PE

- Pneumonia/VAPs

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement Survey
- Culture of Safety Survey
- 1:1 HRO leader rounding on employees
- Shared Leadership Council Governance Model

INTERVENTIONAL RADIOLOGY (IR)

PATIENT POPULATION

Adult and pediatric patients requiring body or neuro diagnostic or interventional procedures. This typically includes all body systems except cardiac. May include (but is not limited to) cerebral or spinal angiogram, aneurysm repair, carotid/vertebral/subclavian stenting, IVC filters, TIPS, nephrostomy tube placement, gastrostomy tube placement, PICC line placement, HD catheter placement, image guided biopsy, emergent embolization.

Radiology nurses also support all imaging modalities including MRI with GA, MR enterography, cardiac CTA, NM renal hydration.

ENVIRONMENT OF CARE

The Radiology nurses support cases performed in either of 2 IR suites, IR bays, and all other imaging modalities including CT, MRI, NM, DI.

INTENSITY OF UNIT AND CARE

Critical care

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The charge nurse/lead tech assign patients based upon skill mix and acuity of patients.

The charge nurse and other nurses not actively participating in patient care are available to provide break and lunch relief, as well as room set up/turnover.

NURSE TO PATIENT RATIO

Intraprocedural care is provided to patients following AORN standards at a minimum of 1:1 Minimum IR staffing is as follows, but additional staff may be added as necessary due to the acuity of the patient.

- Standard IR case: 1 RN, 2 IR technologists (RN dedicated to patient care/conscious sedation)
- Complex IR case: 2 RNs, 2 IR technologists

DAILY STAFFING

Staffed Monday-Friday 0700-1700 with RNs, RTs, scheduling coordinator. RNs staffed primarily in 8 hour shifts with staggered start and end times. After hours/weekends staffed on call with 2 RNs and 2 RTs 24 hours/day, 7 days/week.

Daily charge nurse assignment may provide direct patient care as needed based upon census and acuity.

CERTIFICATIONS

All IR RNs must have

- BLS
- ACLS
- PALS
- NIHSS
- POCT
- Annual mandatory education
- Conscious sedation

QUALITY INDICATORS

- Falls
- Employee harm
- Hand Hygiene
- CLABSI/CAUTI

CORE MEASURES

- Stroke

ENGAGEMENT AND SATISFACTION

- Employee Engagement
- Culture of patient safety survey
- HCAHPS - Inpatient “likelihood to recommend”
- 1:1 leader rounding on employees

MEDICAL SURGICAL ADULT INTENSIVE CARE UNIT (ICU)/ ADULT PROGRESSIVE CARE UNIT (PCU)

PATIENT POPULATION (ICU)

Nursing care is provided for unstable adult medical, surgical, neuro, and trauma patients. The ICU supports a Level II Trauma system and Comprehensive Stroke Program. Most of the patient population consists of the following

- Sepsis
- Respiratory Failure (COPD Exacerbation, Asthma, Pneumonia)
- MI
- GI Bleed
- DKA
- Post Cardiac and Respiratory Arrest
- Congestive Heart Failure (CHF)
- Drug overdose
- Cerebrovascular Accident (CVA)
- Diabetic Ketoacidosis (DKA)
- Renal Failure (Acute and Chronic)
- Alcohol/Drug addiction and withdrawal
- Cardiac Dysrhythmias
- Multi-System Organ Failure

PATIENT POPULATION (PCU)

Nursing care is provided for stabilized adult medical, surgical, neuro, and trauma patients. The PCU supports a Level II Trauma system and Comprehensive Stroke Program. Most of the patient population consists of the following

- Post SAH, SDH, Acute Stroke, TPA, Seizure - stabilized
- Trauma – Ortho, Spine, Thoracic, stabilized
- Sepsis requiring Q4 vital signs
- Resolving DKA
- Drug overdose - stabilized
- Suicide Ideation
- Cardiac Arrest - stabilized
- Abdominal surgeries - stabilized
- Delirium without drips
- GI Bleeding - stabilized
- Hypertensive Crisis – resolved/Stabilized

ENVIRONMENTAL OF CARE

5R Team 3: Adult PCU: 18 beds – all private rooms (516-533), all rooms have lifts, all dialysis capable, 1 med room, providing care 24/7/365.

6R Team 3: Adult ICU/PCU Mixed Acuity Adaptable Unit: 18 beds – all private rooms (617-634), all rooms have lifts, all dialysis capable, 1 med room, providing care 24/7/365.

TACOMA GENERAL ALLENMORE HOSPITAL STAFFING PLANS

Unit Mission: Provide a patient & family-centered - multidisciplinary approach environment conducive to healing with dignity through detection, coping with emergency situations, promoting optimal recovery, and preventing complications associated with various disease states.

The ICU/PCU Acuity Adaptable Unit cares for inpatients and observation status. Patient population range from young adults to geriatrics. The Progressive Care Unit have remote telemetry monitoring and provides care to patients with problems relating to Vascular, Neurological, orthopedic, respiratory, trauma, and variety of surgical and general medical conditions.

Patient throughput is coordinated through the Hospital Supervisor and is in accordance with Admission, Discharge, and Transfer Criteria.

Nursing care for patients by establishing a plan of care that includes assessment, implementation, and evaluation of the patient.

The Adult ICU/PCU Acuity Adaptable Unit admissions are from the emergency department, direct admission, and transfers from another medical surgical unit, ICU and PACU. Patient throughput is completed through a collaborative effort and close conversation with the Hospital Supervisor and inpatient unit

ADULT ICU/PCU MIXED ACUITY ADAPTABLE UNIT CORE STAFFING PATTERNS
Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the critically ill patient can rapidly change, the charge nurse or nursing leadership can make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs, skill of staff, and acuity.

ICU/PCU care is provided to patients following the American Association of Critical Care Nurses (AACN) Scope & Standards.

ICU and PCU care are provided to patients following the AHA, American Heart Association.

All staff are required to complete the Mandatory Educations required as part of their employment contract.

NURSE TO PATIENT RATIO

- 1:1 or greater typically reflects:
  - Unstable adult requiring multisystem support and complex critical care
- 1:1-2 typically reflects:

    - Adult requiring intensive care
  - 1:3-4 typically reflects:
    - Adult requiring intermediate care
- Charge Nurses do not have patient assignment
- Break Nurses do not have patient assignment
- CNA Ratio is 1:9

Staffing levels are determined by the average daily patient census, patient acuity and staff competency.

DAILY STAFFING

The ICU/PCU Mixed Acuity Unit core staffing is depended on the unit census. The core staffing includes RNs, CNAs, HUC and Break Nurses. Staff is supported by Hospitalist, Pharmacy, Phlebotomy, Respiratory Therapist, Care Managers, Dietician, Social Work Services, Personal Health Partners, and Chaplain Services.

The charge nurse assigns patients based upon skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The nursing staff uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor (after hours and weekends)
- Unit Nurse Manager or Assistant Nurse Manager
- Director of Clinical Inpatient Nursing
- Chief Nurse Executive

Nursing leadership work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, Everbridge, and text messaging. For long term and forecasted staffing issues, collaboration through a collaborative effort and close conversation with the Hospital Supervisor and inpatient departments.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem staff
- TG Float Pool
- System Float Pool
- Other RNs willing to float from other carelines
- Travel and/or agency staff

CERTIFICATIONS

All RNs in the ICU/PCU Mixed Acuity Adaptable Unit have:

- Basic Life Support (BLS), Advance Cardiac Life Support (ACLS), NIHSS

Additional certifications are recommended but not required such as PCCN/CCRN.

QUALITY INDICATORS

- Hand Hygiene
- Sepsis
- Falls
- Hospital Acquired Pressure Injury (HAPI)
- Central Line Associated Bloodstream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Clostridium Difficile
- Readmissions
- Length of Stay
- Employee injury/harm events

CORE MEASURES

- Stroke
- Heart Failure
- Deep Vein Thrombosis/ Pulmonary Thrombosis
- Acute MI
- Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement
- Culture of Patient Safety Survey
- 1:1 leader rounding on employees
- Unit Shared Leadership Governance Model

ADULT MEDICAL ONCOLOGY UNIT, ADULT MEDICAL UNIT, ADULT MEDICAL SURGICAL UNIT

PATIENT POPULATION

Patient care services provided by Tacoma General Hospital are based on the MultiCare mission, vision, and core values, as well as on the patient needs for the communities served. Scope of Services included in the Nurse Staffing Plan:

- Medical/Surgical Units (Medical, Pre-and Post-Surgical, Med Oncology)
- Progressive Care units (ACC, CCU, Medical Surgical PCU, CVSS, Neuro PCU)
- Critical Care (CVICU/MISCU/Neuro ICU)
- Emergency Department
- Perioperative Services
- NICU
- Family Birth Center
- Woman and Infant
- Antepartum
- GI Lab
- Wound and Ostomy
- Pulse Heart Institute
- Interventional Radiology
- IV Therapy

ENVIRONMENT OF CARE

- Adult Medical Oncology 6R – 36 beds – 28 private rooms and 4 semiprivate rooms, remote telemetry monitoring, 13 rooms are equipped with ceiling lift - 4 rooms (613, 614, 615, and 616) that can accommodate greater than 500 lbs. bariatric patients, 2 negative pressure rooms, and 7 rooms with dialysis capability.
- Adult Medical Unit 7O – 18 beds – all private rooms, 1 room equipped with a ceiling lift, and 4 negative pressure rooms

6R: Adult Medical Oncology Unit: 36 beds – 28 private rooms and 4 semi-private rooms providing care 24/7/365.

Unit Mission: Provide a patient & family-centered - multidisciplinary approach environment conducive to healing with dignity through detection, coping with emergency situations, promoting optimal recovery and preventing complications associated with various disease states.

The Medical Oncology Unit cares for inpatients and observation status. Patient population range from young adults to geriatrics. The Medical Oncology Unit have remote telemetry monitoring and provides care to patients with problems relating to pulmonology, cardiology, oncology, nephrology, neurology and other general medical patients.

Nursing care for patients by establishing a plan of care that includes assessment, implementation and evaluation of the patient.

The Adult Medical Oncology Unit patient admissions from the emergency department, direct admission, and transfers from another medical surgical unit, ICU and PACU. Throughput is completed through a collaborative effort and close conversation with the Hospital Supervisor, Bed Planner and inpatient unit.

ADULT MEDICAL ONCOLOGY UNIT CORE STAFFING PATTERNS

Staffing levels are determined by the average daily patient census, patient acuity and staff competency.

Role	Days	Nights
Charge RN	1	1
RN	1:5	1:5
CNA	1:9-10	1:9-10
HUC	1	none

The Adult Medical Unit also uses the Medical Surgical staffing ratios in the WSNA contract to determine staffing.

- 1:5 reflects RN with ancillary support
- RN assignment for chemo coverage is 1:3-4, depending on chemo regimen
- As situations dictate based on staffing, the Charge RN will assign ancillary support to ensure safe patient care.

DAILY STAFFING

The Adult Medical Oncology Unit core staffing is 1 charge RN, 8 RNs, and 4 CNAs, with ancillary support. . Staff is supported by Hospitalist, Pharmacy, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Respiratory Therapy, and Chaplain Services.

The Charge RN is scheduled on each designated shift and is responsible for making assignments, assessing staffing needs for the following shift, arranging for increased/decreased staff as needed, communicating with physicians, and nursing leadership as appropriate and collaborates with the house supervisor and Bed Planner for appropriate patient throughput. She/he provides direction and support to the nursing staff, including float staff and contract labor staff during her/his shift. Census and acuity fluctuations are managed through increasing or decreasing the number of RNs and ancillary support required to support safe patient care.

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development

and approval of this Staffing Plan. Break nurses do not have a patient assignment. Each break nurse can provide rest and meal breaks for 7 nurses.

The nursing staff uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor (after hours and weekends)
- Assistant Nurse Manager
- Unit Nurse Manager
- Director of Clinical Inpatient Nursing
- Chief Nurse Executive

Nursing leadership work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, Everbridge, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the Unit Shared Leadership Council (UBC).

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem Medical Surgical department staff
- TG Float Pool
- System Float Pool
- Travel and/or agency staff

CERTIFICATIONS

All RNs in the Adult Medical Oncology Telemetry Unit have:

- Basic Life Support (BLS)

Additional certifications are recommended such as Advance Cardiac Life Support, ONS Biotherapy/Chemotherapy Provider Certification, Oncology Certified Nurse (OCN), Medical Surgical Nursing Certification (MSNCB or ANCC).

QUALITY INDICATORS

- Hand Hygiene
- Falls
- Hospital Acquired Pressure Injury (HAPI)
- Central Line Associated Bloodstream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Clostridium Difficile
- Readmissions
- Length of Stay
- Employee injury/harm events

CORE MEASURES

- Stroke
- Heart Failure
- Deep Vein Thrombosis/ Pulmonary Thrombosis
- Acute MI
- Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement
- Culture of Patient Safety Survey
- 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model

7O The Adult Medical Unit: 18 beds – all private rooms providing care 24/7/365.

Unit Mission: The Adult Medical Unit provides a patient & family-centered - multidisciplinary approach environment conducive to healing with dignity through detection, coping with emergency situations, promoting optimal recovery and preventing complications associated with various disease states.

The Medical Unit cares for inpatients and observation status. Patient population range from young adults to geriatrics. The Medical Unit have remote telemetry monitoring and provides care to patients with problems relating to pulmonology, cardiology, oncology, nephrology, neurology and other general medical patients.

Nursing care for patients by establishing a plan of care that includes assessment, implementation and evaluation of the patient.

The Adult Medical Unit admissions comes from the emergency department, direct from physician clinics, urgent care, home, and transfers from another medical surgical unit, ICU and PACU. Throughput is completed through a collaborative effort and close conversation with the Hospital Supervisor, Bed Planner and inpatient unit.

ADULT MEDICAL UNIT CORE STAFFING PATTERNS

Staffing levels are determined by the average daily patient census, patient acuity and staff competency.

Staff		Days	Nights
Charge RN		1	1
RN		1:5	1:5
CNA		1:9-10	1:9-10
HUC		1	none

The Adult Medical Unit also uses the Medical Surgical staffing ratios in the WSNA contract to determine staffing.

- 1:5 reflects RN with ancillary support
- As situations dictate based on staffing, the Charge RN will assign ancillary support to ensure safe patient care.

DAILY STAFFING

The Adult Medical Unit core staffing is 1 charge RN, 4 staff RNs, and 2 CNAs per shift, with LPN and HUC support. Staff is supported by Hospitalists, Pharmacy, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Respiratory Therapy and Chaplain Services.

The Charge RN is scheduled on each designated shift and is responsible for making assignments, assessing staffing needs for the following shift, arranging for increased/decreased staff as needed, communicating with physicians, and nursing leadership as appropriate and collaborates with the house supervisor and Bed Planner for appropriate patient throughput. She/he provides direction and support to the nursing staff, including float staff and contract labor staff during her/his shift.
Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan. Break nurses do not have a patient assignment. Each break nurse can provide rest and meal breaks for 7 nurses.

The nursing staff uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor House Supervisor (after hours and weekends)
- Assistant Nurse Manager
- Unit Nurse Manager
- Director of Inpatient Nursing
- Chief Nurse Executive

Nursing leadership work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, Everbridge, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the Unit Shared Leadership Council (UBC).

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem Medical Surgical department staff
- TG Float Pool
- System Float Pool
- Travel and agency staff

CERTIFICATION

All RNs and CNAs in the Adult Medical Unit have:

- Basic Life Support (BLS)

Additional certifications are recommended such as Advance Cardiac Life Support, Medical Surgical Nursing Certification (MSNCB or ANCC).

QUALITY INDICATORS

- Hand Hygiene
- Falls
- Hospital Acquired Pressure Injury (HAPI)
- Central Line Associated Bloodstream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Clostridium Difficile
- Readmissions
- Length of Stay
- Employee injury/harm events

CORE MEASURES

- Stroke
- Heart Failure
- Deep Vein Thrombosis/ Pulmonary Embolism
- Acute MI
- Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement
- Culture of Safety Survey
- 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model

ADULT MEDICAL SURGICAL UNIT

- **Medical-Surgical Unit 2R**-12 beds – all private rooms, remote telemetry monitoring and 1 room equipped with a ceiling lift. No negative pressure rooms. Central nursing station with workstations located in each patient room.
- **Medical-Surgical Unit 4R** – 19 beds – all private rooms, remote telemetry monitoring, 10 rooms are equipped with ceiling lifts, 4 negative air flow rooms, and 19 dialysis capable rooms. Computer workstations located outside patient rooms and each room is equipped with a workstation.
- **Medical-Surgical Unit 5R** – 35 beds – 27 private rooms and 4 semi-private rooms, remote telemetry monitoring, 18 rooms are equipped with ceiling lifts -1 room (501) with double lifts that can accommodate bariatric patients greater that 1000 lbs., 5 negative pressure rooms, and 9 rooms with dialysis capability.

Unit Mission: The Adult Medical-Surgical Unit provides a patient & family-centered, multidisciplinary approach to the management of patients in an environment that is conducive to healing with dignity, through identification of urgent and emergent situations, prevention, and monitoring for complications, promoting optimal recovery, and restoring the patient to maximum functional capacity.

The 2R, 4R & 5R Adult Medical-Surgical Unit cares for inpatients and observation status. All three units are capable of remote telemetry monitoring. Surgical patients range from young adult to geriatrics. The Adult Medical-Surgical patients include Urological, Post Trauma, Spine, Orthopedic, EENT, Abdominal, General Surgeries, Neurology, Bariatric, OB/GYN and other general medical and oncology patients.

The nursing team care for patients by establishing a plan of care that includes assessment, implementation, and evaluation of nursing interventions.

The Adult Medical-Surgical Unit admissions come from the emergency department, directly from physician clinics, urgent care, home, as well as transfers from other medical-surgical units, ICU, PACU, and procedural departments. Throughput is facilitated through a collaborative effort and close conversation with the Hospital Supervisor, Clinical Expediter, and inpatient units.

ADULT MEDICAL SURGICAL UNIT CORE STAFFING PATTERNS

Staffing levels are determined by the average daily patient census, patient acuity and staff competency.

2R, 4R & 5R Adult Medical-Surgical Staffing Grid:

Staff	Days	Nights
Charge RN	2	2
RN	1:5	1:5
CNA	1:9-10	1:9-10
HUC	2	0
Break Nurse	2	2

The Adult Medical-Surgical Unit also uses the Medical-Surgical staffing ratios in the WSNA contract to determine staffing.

- 1:5 ratio reflects RN with ancillary support
- As situations dictate based on staffing, the Charge RN will assign ancillary support to ensure safe patient care.

CORE STAFFING PATTERNS

The Adult Medical-Surgical Unit core staffing is 2 Charge RNs, 14 staff RNs, and 7 CNAs per shift, with ancillary support. Staff is supported by Hospitalists, Pharmacy, Phlebotomy, Dietician, Social Work Services, Care Managers, Respiratory Therapy, and Spiritual Care Services.

The Charge RN is scheduled on each designated shift and does not have a patient assignment. The Charge RN is responsible for making assignments, assessing staffing needs for the following shift, arranging for increased/decreased staff as needed, communicating with physicians, and nursing leadership as appropriate and collaborates with the house supervisor and Bed Planner for appropriate patient throughput. The Charge RN provides direction and support to the nursing staff, including float staff and contract labor staff during their shift. Census and acuity fluctuations are managed through increasing or decreasing the number of RNs and ancillary support to provide safe patient care.

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan. Break nurses do not have a patient assignment. Each break nurse can provide rest and meal breaks for 7 nurses.

The nursing staff uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor House Supervisor (after hours and weekends)
- Assistant Nurse Manager
- Unit Nurse Manager
- Director of Inpatient Nursing
- Chief Nurse Executive

Nursing leadership works collaboratively to address staffing issues. For emergent circumstances, this is accomplished using telephone, text messaging, email, and other system messaging platforms. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the Unit Shared Leadership Council.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem Medical Surgical department staff
- TG Float Pool
- System Float Pool
- Travel or agency nurses

CERTIFICATIONS

All Staff except for HUCs on the Adult Medical-Surgical Units must have:

- Basic Life Support (BLS)

Additional certifications for RNs are recommended such as Advance Cardiac Life Support, Medical Surgical Nursing Certification (MSNCB or ANCC).

QUALITY INDICATORS

- Hand Hygiene
- Falls
- Hospital Acquired Pressure Injury (HAPI)
- Surgical Site Infections

- Central Line Associated Bloodstream Infection (CLABSI)
- Catheter Associated Urinary Tract Infection (CAUTI)
- Clostridium Difficile
- Readmissions
- Length of Stay
- Employee injury/harm events

CORE MEASURES

- Stroke
- Heart Failure
- Deep Vein Thrombosis/ Pulmonary Embolism
- Acute MI
- Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement
- Culture of Safety Survey
- 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model

NEURO TRAUMA INTENSIVE CARE UNIT (NT-ICU)

PATIENT POPULATION

Nursing care is provided for unstable adult medical, surgical, neuro, and trauma patients. The ICU supports a Level II Trauma system and Comprehensive Stroke Program. Most of the patient population consists of the following

- Neuro – SAH, SDH, Acute Stroke, TPA, Seizure
- Trauma – Ortho, Spine, Thoracic
- Sepsis
- DKA
- Drug overdose
- Suicide Ideation
- Cardiac Arrest
- Multi-System Organ Failure
- Complex high risk antepartum and postpartum patients
- Major abdominal surgeries
- Severe Delirium
- Severe GI Bleeding
- Hypertensive Crisis
- Alcohol Withdrawal

ENVIRONMENT OF CARE

4 Olympic ICU – 18 beds, locked doors, all rooms have lifts, all dialysis capable: negative pressure rooms (484, 485), 2 med rooms
5 Olympic ICU – 9 beds, locked doors, all rooms have lifts, all dialysis capable, negative pressure rooms (592), 2 med rooms

INTENSITY OF UNIT AND CARE

The Neuro | Trauma ICU is a 27-bed unit providing care 24/7/365. The ICU specializes in:

- Ventilator Support
- Vasoactive gtts
- Post NIR stroke recovery
- Post Cardiac arrest resuscitation
- Trauma Resuscitation
- CRRT

1. The Charge Nurse is a free charge, primary responder to in house codes
2. Admission is coordinated through the Hospital Supervisor and is in accordance with Admission, Discharge, and Transfer Criteria.
3. The ICU is considered a “no divert” ICU and coordinates outside transfers as required
4. PCCM and Trauma round daily and is considered multidisciplinary. Other services round with their own team which includes Trauma, TFM, and MIS.

ICU CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the critically ill patient can rapidly change, the charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

ICU care is provided to patients following the American Association of Critical Care Nurses (AACN) Scope & Standards for Acute and Critical Care Nursing Practice.

ICU care is provided to patients following the American Society of Peri-Anesthesia Nurses (ASPAN) to support 1:1 care of urgent post-surgical or NIR cases

ICU care is also provided in accordance with Washington State Nurses Association (WSNA) contract as it relates to patient and RN ratios.

NURSE TO PATIENT RATIO

2:1 typically reflects:

- Active Resuscitation involving massive transfusion

1:1 typically reflects:

- Active hypothermia post cardiac arrest
- NIR stroke recovery
- CRRT
- Hemodynamically unstable
- Organ Donation
- Proning

1:2 Normal ICU patient care ratio

1:3 PCU care assignment in the ICU

DAILY STAFFING

The ICU core staffing is 18 RNs per shift to achieve full capacity staffing and support one 1:1 patient. This also includes 3 Break RNs which also support our PCU within our careline.
Staff is supported by in house Pulmonologist, Hospitalist, Pharmacy, Respiratory Therapy, IV Therapy, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Chaplain Services. The core staffing for the ICU also includes 2 CNAs and 1 HUC.
Changes to the staffing plan may be required in the event of unscheduled absences.

The charge nurse assigns patients based upon skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Unit Nurse Manager or Assistant Nurse Manager
- Director of Critical Care

Staffing issues are collaborative and to accomplish we use phone, Everbridge, and text messages.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem ICU staff
- System Float Pool
- Other RNs willing to float from other carelines
- Travelers as needed

The ICU is considered a “no divert” ICU. If the unit is at full capacity, all efforts are to be made to move out lower level of care patients. This is completed through a collaborative effort and close conversation with the Hospital Supervisor and inpatient departments.

CERTIFICATIONS

All RNs in the ICU have:

- BLS
- ACLS
- NIH

Additional certifications are recommended but not required such as CCRN.

QUALITY INDICATORS

- Falls
- HAPU
- CLABSI
- CAUTI
- C.difficile
- VAP / VAC / VAE
- Employee HARM

CORE MEASURES

- Stroke
- Heart Failure
- DVT/ PE
- Acute MI
- Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement once / year
- Culture of Safety Survey once / year

NEURO TRAUMA PROGRESSIVE CARE UNIT (NT-PCU)

PATIENT POPULATION

Nursing care is provided for stabilized adult medical, surgical, neuro, and trauma patients. The PCU supports a Level II Trauma system and Comprehensive Stroke Program. Most of the patient population consists of the following

- Post SAH, SDH, Acute Stroke, TPA, Seizure - stabilized
- Trauma – Ortho, Spine, Thoracic, stabilized
- Sepsis requiring Q4 vital signs
- Resolving DKA
- Drug overdose - stabilized
- Suicide Ideation
- Cardiac Arrest - stabilized
- Abdominal surgeries - stabilized
- Delirium without drips
- GI Bleeding - stabilized
- Hypertensive Crisis - resolved
- VEEG patients – Epilepsy

ENVIRONMENT OF CARE

5 Olympic PCU – 12 beds, 4 Rooms wired for VEEG patients, Reverse Isolation (1574, 1575), 1 Med Room

INTENSITY OF UNIT AND CARE

The Neuro | Trauma PCU is a 12-bed unit providing care 24/7/365. The PCU specializes in:

- Epilepsy
- Stroke transfers from the Neuro | Trauma ICU
- Sepsis
- Continuous Bipap patients not requiring ICU level interventions
- Stable Trach patients requiring vent support but no intervention (SNF)
- IV Push Cardiac Medications and drips (Nitroglycerine, Diltiazem)
- Continuous Telemetry

1. Neuro | Trauma PCU Charge RN coordinates staffing assignments, admission, discharge, transport as needed
2. Admission is coordinated through the Hospital Supervisor and in accordance with Admission, Discharge, and Transfer Criteria.
3. 2018 - The PCU is considered a “no divert” PCU and coordinates outside transfers as required
4. The unit is supported by a multidisciplinary team: Trauma, MIS, TFM, Neuro, Surgical, Ortho

PCU CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the progressive level patient can rapidly change, the charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

NURSE TO PATIENT RATIO

1:3-4 typically reflects:

- Stabilized, noncritical patients requiring q4 vital signs
- Break Relief are supported through the ICU and coordinated between the Break RN and PCU Charge RN

DAILY STAFFING

The PCU core staffing is 4RNs per shift to achieve full capacity staffing. Staff is supported by in house Pulmonologist, Hospitalist, Pharmacy, Respiratory Therapy, Vascular Access Team, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Chaplain Services. Changes to the staffing plan may be required in the event of unscheduled absences.

The PCU Charge Nurse assigns patients based upon skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Unit Nurse Manager or Assistant Nurse Manager
- Director of Critical Care

Staffing issues are collaborative and to accomplish we use phone, Everbridge, and text messages.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem ICU staff
- System Float Pool
- Other RNs willing to float from other carelines

The PCU is considered a “no divert” PCU. If the unit is at full capacity, all efforts are to be made to move out lower level of care patients. This is completed through a collaborative effort and close conversation with the Hospital Supervisor and inpatient departments.

CERTIFICATIONS

All RNs in the ICU have:

- BLS
- ACLS
- NIH

Additional certifications are recommended but not required such as PCCN.

QUALITY INDICATORS

- Falls
- HAPI
- CLABSI
- CAUTI
- C.difficile
- VAP / VAC / VAE
- Employee HARM

CORE MEASURES

- Stroke
- Heart Failure
- DVT/ PE
- Acute MI
- Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement once / year
- Culture of Safety Survey once / year

NEONATAL INTENSIVE CARE (NICU)

70 bed unit providing care 24/7/365. The NICU specialized in:

- Care and treatment for critically ill infants with a variety of diagnoses requiring extensive physiologic monitoring, intravenous therapy, respiratory therapy and nutritional support
- Multidisciplinary rounds with Neonatology, Nursing, Respiratory, Dietary, Personal Health Partners, Lactation, and Pharmacy daily. Other specialties, like Surgery or Neurosurgery also round regularly on patients.
- Admission is coordinated through Neonatologist and Charge Nurses and is in accordance with Admission, Discharge, and Transfer Criteria.

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

Since the condition of critically ill patients can change rapidly, the charge nurse of nursing leadership makes immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs, skill of staff, and acuity.

- NICU care is provided to patients following the National Association of Neonatal Nurses (NANN) scope of practices for Nursing Practice.
    - NANN staffing ratios are in line with the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Guideline for Professional Registered Nurse Staffing for Perinatal Units.
- NICU care is provided in support of the Washington State Department of Health Level IV staffing recommendations.

NURSE TO PATIENT RATIO

- 1:1 or greater typically reflects:
    - Unstable neonates requiring multisystem support and complex critical care
- 1:1-2 typically reflects:
    - Neonates requiring intensive care
- 1:2-3 typically reflects:
    - Neonates requiring intermediate care
- Charge Nurses do not have patient assignments
- Delivery Nurse does not have an assignment

DAILY STAFFING

Staff is supported by in house Neonatologist, Neonatal Nurse Practitioner, Pharmacy, Respiratory Therapy, Dieticians, Social Work Services, Case Managers, OT, PT, Speech Therapy, Lactation, Music Therapy, and Chaplain Services. The core staffing for the NICU also includes 1-2 HUCs.

Additional resources are available in times of increased acuity to support the core staff:

- Free standing charge nurses
- Free standing delivery nurse
- Free standing break relief nurses
- Transport RN and RT (when not out on transport)

The assigned charge nurses make patient assignments based on skill mix and acuity of patents. Census and acuity fluctuations are managed through increasing or decreasing the number of RN's required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager or Assistant Nurse Manager
- Director of Inpatient Nursing
- Chief Nurse Executive
- Executive on-call

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, Everbridge, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the UBC.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem NICU staff
- Travel or agency staff

The NICU is considered a "no divert" NICU. If the unit is at full capacity, all efforts are made to arrange for placement of lower level of care patients. This is completed through a collaborative effort and close conversation with the Hospital Supervisor and inpatient departments.

CERTIFICATIONS

All RNs in the NICU have:

- BLS
- NRP

Additional certifications are recommended but not required such as RNC.

QUALITY INDICATORS

- IVH
- HAPU
- CLABSI/VAP
- CLD
- NEC
- ROP
- Employee injury events

CORE MEASURES

- IVH
- CLD
- NEC
- ROP
- CLABSI/VAP

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement
- Culture of Safety Survey
- 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model

PERIANESTHESIA SERVICES

PATIENT POPULATION

Patient care services provided by Tacoma General Hospital are based on the MultiCare mission, vision, and core values, as well as on the patient needs for the communities served.

Tacoma General PeriAnesthesia –Comprised of three (3) units.

Tacoma General Post Anesthesia Care Unit (PACU)- Located on 5 Phillips is a 16 bay unit (including 1 isolation room), equipped with hemodynamic and cardiac monitoring capabilities.

Surgical Admission Short Stay (SASS) Unit – Located on 6 Phillips is a 15-bay unit. The unit utilizes workstations on wheels (WOWs) for bedside documentation.

Baker Ambulatory Surgery Center Admissions & Post Anesthesia Care Unit (PACU) – Located on the 1st floor of the Baker Center is comprised of 3 Admission Bays + 3 Admission Rooms, 7 recovery bays + 1 Isolation room, 1 discharge area with a capacity for two patients.

INTENSITY OF UNIT AND CARE

The Tacoma General Hospital Post Anesthesia Care Unit (PACU) is a 16-bay unit providing care Monday through Friday from 0800 to 2330. On Saturday and Sunday, the PACU is minimally staffed from 0800 to 1800 to support scheduled into the available surgery block. From 2330 to 0800 Monday through Friday and from 0800 on Saturday to 0800 on Monday the unit is able to support urgent and emergent surgical cases with staff on call. The PACU specializes in:

- The recovery and all immediate care required for those directly out of surgery having gone under general anesthesia or monitored anesthesia care (MAC).

The Charge Nurses are responsible for running the unit and care of patients in Phase I of Post Anesthesia

Transfer to the PACU from the surgical suites is coordinated with OR Nursing Staff and Anesthesiologist.

Anesthesia providers hand off the patients to nursing staff at the bedside and are available to provide support to the PeriAnesthesia Staff.

PACU is supported by Anesthesiology

PACU CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and

meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the PACU patient can be stable to critically ill. The charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

PACU care is provided to patients following the American Society of PeriAnesthesia Nurses (ASPAN) guidelines set forth in PeriAnesthesia Nursing Standards,
Practice, Recommendations and Interpretive Statements.

The PACU is staffed at a minimum with two Registered Nurses, one who is an RN competent in Phase I PostAnesthesia Care.

NURSE TO PATIENT RATIO

ASPAN standards of care recommend 1:2 Nurse to patient ratios for PACU Level of Care

1:2 typically reflects:

- Two conscious patients, stable and free of complications but not yet meeting discharge or transfer criteria.
- One unconscious patient, hemodynamically stable, with a stable airway, over the age of eight years and one conscious patient, stable and free of complications

1:1 typically reflects a patient with:

- Airway and/or hemodynamic instability

2:1 typically reflects:

- One critically ill, unstable patient

DAILY STAFFING

Due to the nature and flow of the PACU, core staffing has RNs scheduled over the time period of 0730 to 2330 with the seven to twelve start times; the first shift start time beginning at 0730 and the last beginning as late as 1500. Staff are supported by in house Anesthesiologist, Pharmacy, Respiratory Therapy, IV Therapy, Phlebotomy, Physical Therapy, Social Work Services, Chaplain Services and the House Supervisor. The core staffing for the PACU also includes 2 Patient Care Technicians and 1 HUC. Daily staffing needs are discussed the day before in collaboration with all unit charge RNs and the management team.

The assigned charge nurse makes patient assignments based on skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager
- Director of PeriOperative Services
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, Everbridge, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the UBC.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem PACU staff
- Travel or agency staff
- Other RNs willing to float from other care lines

CERTIFICATIONS

All RNs in the PACU have:

- BLS
- ACLS

Additional certifications are recommended but not required such as CPAN and CAPA.

QUALITY INDICATORS

- Surgical Site Infections
- Employee injury events

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement two times per year
- Culture of Safety Survey
- Quarterly 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model
- Various scheduled employee events throughout the year

INTENSITY OF UNIT AND CARE

The Surgery Admission Short Stay Unit (SASS) is a 15 bay unit located on the 6th floor Phillips Wing of the hospital. The unit is open to provide care Monday through Friday from 0515 to 2030. The SASS specializes in:

- The admission of surgical patients coming from home.
- Phase II recovery/discharge of patients once Phase I/PACU level of care complete and transfer criteria has been met after surgery.

The Charge Nurses are responsible for the running the unit.
Staff RNs are expected to be skilled in admitting, Phase II, and discharging of patients.

Nurses in the admitting role responsible for admitting patients, pre-surgical care, and documentation. The admitting RN hands-off to the Operating Room nurse for the surgical case.
Nurses that are in the Phase II/discharge role are responsible for accepting patients from the PACU, discharging the patient, and providing care during the interim.

Transfer to the surgical suites from the SASS is coordinated with SASS and OR Nursing Staff.

Transfer from the PACU to the SASS post procedure is coordinated with the PACU and SASS Staff.

The SASS is supported by Anesthesiology and Surgeons

SASS CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

The condition of the SASS patient post-operatively should be stable with orders and plans for discharge to home or extended care.

Phase II care is provided to patients following the American Society of PeriAnesthesia Nurses (ASPAN) guidelines set forth in Perianesthesia Nursing Standards,
Practice, Recommendations and Interpretive Statements.

Admissions and Phase II care is also provided in accordance with Washington State Nurses Association (WSNA) contract as it relates to patient and RN ratios.

The SASS is staffed at a minimum with one Registered Nurse and one other staff member.

NURSE TO PATIENT RATIO

ASPAN standards recommend a 1:3-5 Nurse to patient ratios for Phase II Level of Care

DAILY STAFFING

Due to the nature and flow of the SASS, core staffing has RNs scheduled from 0530 to 2030 with the five to seven start times; the first shift start time beginning at 0530 and the last

beginning at 1200. Staff is supported by in house Anesthesiologist, Pharmacy, Respiratory Therapy, IV Therapy, Phlebotomy, Physical Therapy, Social Work Services, Chaplain Services and the House Supervisor. The core staffing for the SASS also includes 3 Patient Care Technicians and 1 HUC. Daily staffing needs are discussed the day before in collaboration with all unit charge RNs and the management team.

The assigned charge nurse makes patient assignments based on skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager
- Director of PeriOperative Services
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the UBC.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem PACU staff
- Travel or agency staff
- Other RNs willing to float from other care lines

CERTIFICATIONS

All RNs in the SASS have:

- BLS
- ACLS

Additional certifications are recommended but not required such as CPAN and CAPA.

QUALITY INDICATORS

- Surgical Site Infections
- Employee injury events

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement two times per year
- Culture of Safety Survey
- Quarterly 1:1 leader rounding on employees

- Unit Based Council Shared Governance Model
- Various scheduled employee events throughout the year

INTENSITY OF UNIT AND CARE

Baker Ambulatory Surgery Center (ASC) PeriAnestheisa area has 3 primary admitting bays + 3 secondary admitting rooms. There are 7 PACU bays and one isolation room on the unit. The ASC is open to admit and provide care Monday through Friday from 0600 to 1900. From 1900 to 2100 Monday through Friday the unit can remain open with the use of staff on call.

The ASC specializes in:

- The admission and discharge, as well as recovery and all immediate care required for those directly out of surgery having gone under general anesthesia or monitored anesthesia care (MAC).

The Charge Nurses are responsible for running the unit and care of patients on the unit.

The admissions nurse is responsible for admitting patients and pre-surgical care and documentation. The admissions RN hands-off to the Operating Room nurse for the surgical case.

Transfer to the PACU from the surgical suites is coordinated with OR Nursing Staff and Anesthesiologist.

Anesthesia providers hand off the patients to nursing staff at the bedside and are available to provide support to the PeriAnesthesia Staff.

Surgical Admissions and PACU are supported by Anesthesiology.

BAKER ASC CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

Per policy patients being admitted for surgery at the Baker ASC should have an American Society of Anesthesia (ASA) score of I to II. A patient with an ASA score of III must be approved by the Anesthesiology Provider. ASA IV and above should not be scheduled at the Baker ASC

The condition of the PACU patient post-operatively can be stable to critically ill, however, the majority of Baker ASC post-surgical patients are stable. The charge nurse or nursing leadership will make immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs and acuity.

PACU care is provided to patients following the American Society of PeriAnesthesia Nurses (ASPAN) guidelines set forth in PeriAnesthesia Nursing Standards,
Practice, Recommendations and Interpretive Statements.

PACU care is also provided in accordance with ASPAN Standards as it relates to patient and RN ratios.

For Phase I care the PACU is staffed at a minimum with two Registered Nurses, one who is an RN competent in Phase I PostAnesthesia Care and remain on the same unit where the patient is receiving Phase I Level of Care.

For Phase II care the PACU is staffed with two competent personnel, one of whom is a RN competent in Phase II PostAnesthesia nursing.

For day of surgery admissions, the unit is staffed with personnel competent in this phase of care.

NURSE TO PATIENT RATIO

ASPAN standards recommend 1:2 Nurse to patient ratios for Phase I PACU Level of Care

1:2 typically reflects:

- Two conscious patients, stable and free of complications but not yet meeting discharge or transfer criteria.
- One unconscious patient, hemodynamically stable, with a stable airway, over the age of eight years and one conscious patient, stable and free of complications

1:1 typically reflects a patient with:

- Airway and/or hemodynamic instability

2:1 typically reflects:

- One critically ill, unstable patient

ASPAN standards reflect 1:3-5 Nurse to patient ratios for Phase II PACU Level of Care

Day of surgery admissions is a 1:5 nurse to patient ratio with acuity taken into consideration

DAILY STAFFING

Due to the nature and flow of patients through the ASC, core staffing has RNs scheduled from 0545 to 1900 with up to seven start times; the first shift start time beginning at 0545 and the last beginning at 1030. Staff is supported by in house Anesthesiologist, Pharmacy, Respiratory Therapy, IV Therapy, Phlebotomy, Physical Therapy, Social Work Services,
Chaplain Services and the House Supervisor. The core staffing for the ASC also includes 1 Patient Care Technician and 1 HUC. Daily staffing needs are discussed the day before in collaboration with all unit charge RNs and the management team.

The assigned charge nurse makes patient assignments based on skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager
- Director of PeriOperative Services
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished through the use of telephone, and text messaging. For long term and forecasted staffing issues, collaboration is accomplished through shared governance model utilizing the UBC.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem PACU staff
- Travel or agency staff
- Other RNs willing to float from other care lines

CERTIFICATIONS

All RNs in the Baker ASC have:

- BLS
- ACLS

Additional certifications are recommended but not required such as CPAN and CAPA.

QUALITY INDICATORS

- Surgical Site Infections
- Employee injury events

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement two times per year
- Culture of Safety Survey
- Quarterly 1:1 leader rounding on employees
- Unit Based Council Shared Governance Model
- Various scheduled employee events throughout the year

PULSE HEART UNIT (PHU)

8 bed unit providing care 24/7/365. The PHU specializes in:

- Care and treatment of critically ill adults 18 years of age and older. Nursing care is provided for adults 18 years of age and older. The following patient conditions allow for admission or transfer to the CCU may include, but are not limited to:
  - Pre and Post cardiovascular surgery patients not requiring invasive hemodynamic monitoring
  - Vascular surgery patient requiring minimal invasive hemodynamic monitoring
  - Cardiac System:
    - TAVR
    - STEMI/NSTEMI
    - CHF
    - LVAD
  - Lytic Therapy
  - Single low level ICU vasoactive infusions
  - Other conditions that require progressive care and treatment
- Admission is coordinated through the admitting Physician, Bed Expeditor, and Charge Nurse and is accordance with Admission, Discharge, and Transfer Criteria.

CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.
Since the condition of critically ill patients can change rapidly, the charge nurse or nursing leadership makes immediate adjustments to support acuity. Relying on staffing ratios alone can ignore the variance in patient needs, skill of staff, and acuity.

- PHU care is provided to patients following the American Association of Critical-Care Nurses (AACN)
- PHU care is provided in accordance with Washington State Nurses Association (WSNA) contract with TG as it relates to patient and RN ratios

NURSE TO PATIENT RATIO

- 1:1 typically reflects:
  - Critically ill patient requiring active recovery
- 1:2 typically reflects:
  - Critically ill patients requiring intensive care
- 1:3 typically reflects:
  - Patients requiring progressive care
- 1:4 typically reflects

    - Patient requiring progressive care
- Charge Nurse does not have patient assignment

DAILY STAFFING

PHU core staffing to achieve full capacity is 3 RNs per shift to cover our average daily census. Core staffing also includes a monitor tech in CVICU. Staff is supported by on floor Pharmacist during day and evening shifts, Respiratory Therapy, Hospitalists, Cardiology, Intensivists/Pulmonologists, Cardiothoracic Team, LVAD team, CHF Team, Vascular team, Phlebotomy, Dietician, Social Work Services, Personal Health Partners, Chaplain Services, Environmental services personnel, and leadership staff.
Additional resources are available in times of increased acuity to support the core staff:

- Free standing charge nurse
- Free standing break relief nurse
- In house Transport RN and RT (when not out on transport)

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- House Supervisor
- Unit Nurse Manager or Assistant Nurse Manager
- Director of Inpatient Nursing
- Associate Chief Nurse Executive
- Chief Nurse Executive

Unit leadership and nursing work collaboratively to address staffing issues. For emergent circumstances, this is accomplished using telephone, Telmediq, and text messaging.

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem CCU staff
- Pulse Float Pool staff
- Travel or agency staff

CERTIFICATIONS

- PHU RNs must obtain and maintain:
    - BLS
    - ACLS
    - NIH
- Groin site and sheath recovery management
- Some PHU RNs have additional certifications:
    - PCCN
    - CCRN
    - CMC
- Professional Standards
    - ANA Standards of Nursing Practice
    - AACN (American Association of Critical Care Nurses)
    - AHA (American Heart Association)

QUALITY INDICATORS/CORE MEASURES

- HAPI
- CLABSI
- CAUTI
- Patient Falls
- CMS Core Measures
  - Stroke
  - Heart Failure
  - Acute MI
  - Pneumonia

ENGAGEMENT AND SATISFACTION

- HCAHPS
- Employee Engagement Survey
- Culture of Safety Survey
- 1:1 HRO Leader Rounding on Employees
- Shared Leadership Council Governance Model

OPERATING ROOM (OR)

INTENSITY OF UNIT AND CARE

The Tacoma General Operating Room is a 19 bed unit providing care 24/7/365. The Tacoma General Operating Room specializes in:

- General Surgery
- Cardiothoracic Surgery
- Vascular Surgery
- Plastic Surgery
- Pediatric Surgery
- Orthopedics Surgery
- Neuro/Spinal Surgery
- ENT Surgery
- Urology Surgery
- Robotic Surgery
- Trauma Surgery
- GYN Surgery

1. The Charge Nurse is ideally a free charge.
2. The perioperative environment required both direct and indirect patient caregivers

OPERATING ROOM CORE STAFFING PATTERNS

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

Perioperative staffing includes planned and urgent/emergent procedures and must take into consideration caring for patients whose procedures run over schedule

The operating room care is provided to patients following the Association of PeriOperative Registered Nurses (AORN) Guidelines for Perioperative Practice

Operative care is provided to patients following the AORN standards at a minimum of 1:1

NURSE TO PATIENT RATIO

General surgical room staffing is as follows, however, due to the acuity of the patient additional staff may be necessary

- Standard surgical cases: 1 circulator, 1 scrub
- Cardiothoracic surgical cases: 2 circulators, 2 scrubs
- Dental procedures: 1 circulator
- Robotic Procedures: 1 circulator, 2 scrubs

- Endovascular procedures: 1 circulator, 1 scrub

*The circulating role must be staffed with an RN; the scrub role can be either an RN or a surgical technologist

Indirect patient care providers are required to provide breaks, lunches, assistance and room setup/turnover. This recommended ratio by AORN is an additional RN per 2 surgical rooms

DAILY STAFFING

The operating room core staffing varies daily. The schedule is designed around the surgical block Matrix to include (19) 0730 rooms to start with varying number of staff needed due to the acuity of cases being performed. The schedule is looked at the day before, staff are assigned to blocks of cases and whether more of less staff are needed is determined at that time.

The charge nurse assigns blocks based upon skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs and support staff required to support patient care.

The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Unit Nurse Manager or Assistant Nurse Manager
- Perioperative Director
- Chief Operating Officer / Chief Nursing Executive

Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem staff
- Traveler or Agency staff

CERTIFICATIONS

All RNs in the OR must have:

- BLS

Additional certifications are recommended but not required such as CNOR, ACLS, PALS.

QUALITY INDICATORS

- SSI
- IUSS
- HAPU
- CLABSI
- CAUTI
- VAP / VAC / VAE
- Employee HARM

CORE MEASURES

- DVT/ PE prevention

- Active warming device for maintaining normothermia
- Clipper removal of hair prior to surgery
- Proper selection and timing of antibiotic medication
- Urinary catheter removed by post-operative day two

ENGAGEMENT AND SATISFACTION

- OAS CAHPS - Ambulatory Surgery 'likelihood to recommend'
- Employee Engagement survey
- Physician Engagement survey
- 1:1 leader rounding on employees

ADOLESCENT BEHAVIORAL HEALTH UNIT (ABHU)

27 beds, locked unit, (updated 11.7.2022) 26 Is max census without medical bed

ABHU CORE STAFFING PATTERNS

The condition of the milieu can rapidly change; the charge nurse or nursing leadership can make immediate adjustments to support changes to unit milieu needs. For medical instability, acute situations will be transferred to the MaryBridge Emergency Department for evaluation and treatment.

Care is provided through least restrictive measures and aligns with the Recovery Model and Trauma Informed Care.

ABHU care is provided to patients following the APNA, American Psychiatric Nurses Association

Staff	Days	Nights
Charge	1:0	1:8
RN	1:8	1:8
MHT	1:6-8	1:8
CNA (CORA/COSI)	1:1 as needed	1:1 as needed
Resource RN	11:00-2330 (7 days a week) 1500-0330 RN (7 days a week for census 24 +)	

NURSE TO PATIENT RATIO

The staffing matrix reflects an 8:1 ratio.

DAILY STAFFING

The ABHU core staffing is 4 RNs on days and 3RNs on nights which allows us to achieve full capacity staffing. Staff is supported MB Code Team, Hospitalist, Pharmacy, Phlebotomy, Dietician, and Chaplain Services. The core staffing for the ABHU also includes 4 MHTs on days and 3MHTs on nights, and 1 HUC during daytime hours. We use the CORA/COSI CNAs in addition for more resources for milieu stability. Resource RNs are available from 1100-0330. The assigned charge nurse makes patient assignments based on skill mix and acuity of patients.

Census and acuity fluctuations are managed through increasing or decreasing the number of RNs, MHTs, and/or CNAs required to support patient care.
The RN uses the following chain of command for any concerns or issues:

- Charge Nurse
- Provider (if related to patient care)
- Unit Nurse Manager, Assistant Nurse Manager, Program Manager
- Director of Nursing and/or Director of SW and Programming/Medical Director
- Nursing Administrator
- Chief Nurse Executive/Chief Medical Office

Unit leadership and nursing work collaboratively to address staffing issues. The weekly and 6-week schedule needs are communicated via Email. For emergent circumstances, this is accomplished using telephone and text messaging.
Additional Staffing may be obtained by:

- Regular FTE staff
- Per Diem staff
- System Float Pool
- Travel and agency staff
- Other RNs willing to float from AMC campus

CERTIFICATIONS

All RNs in the ABHU have:

- BLS
- De-escalation certification

QUALITY INDICATORS

- Falls
- Restraint and Seclusion
- Employee injury events

CORE MEASURES

- HBIPs

ENGAGEMENT AND SATISFACTION

- Patient Survey Results
- Employee Engagement two times per year
- Culture of Safety Survey
- Quarterly 1:1 leader rounding on employees
- Various scheduled employee events throughout the year

January 2023

STAFFING PLAN

Presented by Nursing Services

Allenmore Hospital

MultiCare Allenmore Hospital is licensed for 130 beds. For generations, Allenmore has been known as the trusted hospital that provides a variety of medical services to the community. Patient care services provided by Allenmore Hospital are based on the MultiCare mission, vision, and core values, as well as on the patient needs for the communities served.

NURSING DEPARTMENTS

- Adult Medical/Surgical Units (Ortho Medical-Surgical Department)
- Adult Progressive Care units (Medical-Surgical Intermediate Care)
- Adult Critical Care (Medical-Surgical Intensive Care Unit)
- Adult & Pediatric Emergency Department
- Adult Perioperative Services

QUALITY INDICATORS

- CAUTI
- C-Diff
- SSI
- VAP
- Hospital Acquired Pressure Injuries
- Patient Falls
- CMS Core Measures
- Employee Injuries

EMPLOYEE ENGAGMENT

- Employee and Physician Engagement survey – Press Ganey
- Culture of Patient Safety Survey
- Clinical Practice Council/Shared Governance
- Unit Practice Council

PATIENT EXPERIENCE

- HCAHPS

CHAIN OF COMMAND

The following is the nursing chain of command for concerns or issues:

- Charge Nurse
- Hospital Supervisor
- Assistant Nurse Manager
- Manager
- Director
- Chief Nurse Executive

STAFFING RESOURCES

- Regular FTE staff
- Per Diem staff
- Hospital Based Resource Pool
- System Float Pool
- Travel or Agency staff

ADULT Interim Med/Surg/ PROGRESSIVE CARE UNIT - 2W

DESCRIPTION OF SERVICE

The mission of the Allenmore Medical/Surgical Intermediate Care Unit is to provide safe, individualized, quality, compassionate care to adult patients with moderate and/or potentially severe physiologic instability, requiring technical support but not necessarily artificial life support, or extensive hemodynamic monitoring. Allenmore Two West Unit provides care for patients that require intermediate level care, as well as general medical/surgical care services.

ENVIRONMENT OF CARE

- 29 patient beds
- 11 patient rooms are private rooms with family seating areas.
- 5 rooms are permanently semi-private rooms
- additional 4 rooms are staged as private rooms with the ability to flex to semi-private as needed for patient census
- Rooms 2105, 2106, 2111, 2114 and 2115 have negative air pressure for use with patients who require isolation.

The unit is telemetry monitor capable up to 32 patients combined with the surgical unit.

Continuous cardiac monitoring is provided remotely by monitor technicians located in the Intensive Care Unit on the first floor.

PATIENT POPULATION

- In general, the population served by the Medical/Surgical Intermediate Care Unit are patients 18 years and older.

- Patients younger than 18 years may be cared for until other services or arrangements are available, or as appropriate but must be reviewed by CMO & CNE on a case by case basis.

COMMON TREATMENT/PROCEDURES

- Medication administration including vasoactive drugs, intravenous therapy including blood and blood product administration, and continuous cardiac monitoring via telemetry.
- Patient's progress is monitored through an interdisciplinary approach
- A registered nurse (RN) is assigned each shift as Charge RN to coordinate the delivery of patient care. Registered nurses assess, plan, implement and evaluate the care and response to medical and nursing interventions.

STAFFING PLAN

Direct care is provided by registered nurses (RNs), licensed practical nurses (LPN) and certified nursing assistants (CNAs). The administrative and charge functions are supported by health unit coordinator (HUC). RNs are certified in Advanced Cardiac Life Support (ACLS) within the 6 months of transfer/employment.

CERTIFICATIONS

- ACLS & BLS

PROFESSIONAL STANDARDS

- ANA Standards for Nursing Practice
- Society of Critical Care Medicine
- American Heart Association
- American Association of Critical Care Nurses
- Academy of Medical-Surgical Nursing

STAFFING MIX

26 patients AVERAGE DAILY CENSUS:

- 1 Charge Nurse
- 6 RNs
- 3 CNAs
- 1 HUC

RN to patient ratio:

- 1:4 PCU level of care
- 1:5 Med/Surg level of care

CNA patient ratio:

- 1:12
- 1:1 cora/cosi patients

CNAs will provide care to the patients under delegation and supervision of a Registered Nurse.

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

ORTHO-MED/SURGICAL UNIT – 2E

DESCRIPTION OF PROGRAM/SERVICE

The mission of the Allenmore General Ortho-Surgical Acute Care Unit is to provide safe, individualized, quality, compassionate care to adult patients who have undergone a surgical procedure and support their return to an optimal level of function.

ENVIRONMENT OF CARE

- 30 patient beds (combination of private and semi-private rooms)
- 10 private rooms
- 13 bariatric ceiling lifts
- 2 negative airflow rooms
- All rooms are equipped with oxygen, suction and a vital sign monitor interface EMR
- Each room has toilet and shower facilities.
- telemetry monitor capacity up to 16 patients for continuous cardiac monitoring of stable postoperative patients provided remotely by monitor technicians located in the Intensive Care Unit on the first floor.
- Monitor Tech Stations with audible alarms
- 1 Pyxis Medication Stations
- 1 Centralized clean equipment room
- 1 Centralized dirty utility room
- Staff lounge area with lockers and kitchen

POPULATION SERVED

- **Age Criteria**: In general, the population served is adults age 18 and older. However, under some circumstances, patients younger than 18 years may be cared for until other services or arrangements are available, or as appropriate. Most patients are between the ages of 40 and 90 years.
- **Common Diagnoses**: The most common diagnoses of the adult surgical patients are orthopedic injuries and diseases, including hip fractures and total joint replacements, postoperative care of surgical patients with gastrointestinal, gynecological and urological disorders.
- **Common Treatments/Procedures/Activities:** Treatment activities include, but are not limited to, medication administration, intravenous therapy, blood and blood production administration, pre- and post-surgical care and treatment. The unit has a total joint program and staff assist patients to the discharge class held on the 1st floor total joint class. Staffing is adjusted to accommodate this during days with total joint classes.
- **Aspects of Care:** The patient's progress is monitored through an interdisciplinary approach, minimizing negative physical and psychological effects of the disease and/or postoperative recuperative processes. Two East clinical staff is prepared to intervene and quickly respond to changes in patient condition. A Registered Nurse (RN) is assigned each shift as Charge RN to coordinate the delivery of patient care

and unit activity. Registered Nurses assess, plan, implement and evaluate the care and response to medical and nursing interventions. Our key. Case Managers coordinate the care required by patients who have complicated or extensive care needs.

NURSE STAFFING PLAN

- Two East is under the direction of the Clinical Nurse Manager.
- Direct care is provided by registered nurses (RNs), Licensed Practical Nurse (LPN) and certified nursing assistants (CNAs).
- Administrative and charge functions are supported by health unit coordinators (HUC).
- The method of care delivery is consistent with the current Provision of Nursing Care for MultiCare Health System. An RN assesses and develops individual plans of care for each patient. Implementation of the plan of care and specific tasks and duties may be delegated to CNAs. The RN accomplishes evaluation and adjustment to the patient's plan of care.

CERTIFICATIONS

- BLS

PROFESSIONAL STANDARDS

- ANA Standards for Nursing Practice
- American Heart Association
- Academy of Medical-Surgical Nursing

STAFFING MIX

- **RN – 39**
  - 14 are ADN/Diploma nurses (45%)
  - 17 are BSN prepared nurses (55%)
  - 9 are certified (MSRN, Wound care, Stop the Bleed and Ortho)
- **LPN – 4**
- **CNA- 19 FTE, 2 per diem**
- **HUC– 3**
- **RN Manager**
- **RN ANM**

STAFFING MATRIX

- The RN patient ratio is 1:5
- 1:12 CNAs will provide care to the patients under delegation and supervision of a Registered Nurse 1:1 CNA/Patient ratio for CORA/COSI patients

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.
Changes to the staffing plan may be required in the event of unscheduled absences.

ADULT INTENSIVE CARE UNIT

DESCRIPTION OF SERVICE

The mission of the Allenmore Adult ICU is to provide safe, individualized, quality, compassionate care to critically ill patients who need intensive monitoring and care to support the preservation of life, promotion of healing, prevention of complications and restoration to maximal functional status.

PATIENT POPULATION

18 years and older. Under some circumstances, patients younger than 18 years may be cared for until other services or arrangements are available, or as appropriate. Average age of patient population is between the ages of 60 and 90 years.

COMMON DIAGNOSES

Cardiac and respiratory-related illnesses and injuries, diagnoses related to infectious diseases and/or processes including pancreatitis, illnesses related to diabetes or post-operative care.

COMMON TREATMENT/PROCEDURES

Treatment activities may include but are not limited to medication administration including vasoactive drugs, intravenous therapy including blood and blood product administration, continuous cardiac monitoring, hemodynamic monitoring both invasive and noninvasive monitoring, ventilator support, and emergent life support procedures.

ENVIRONMENT OF CARE

- The Medical/Surgical Intensive Care Unit (ICU) is a secured unit
- 6 private rooms, equipped with bariatric ceiling lifts, hardwire cardiac and invasive hemodynamic monitoring capability, oxygen and suction.

CERTIFICATIONS

- BLS
- ACLS
- NIH

PROFESSIONAL STANDARDS

- ANA Standards for Nursing Practice
- Society of Critical Care Medicine
- American Heart Association
- American Association of Critical Care Nurses
- Academy of Medical-Surgical Nursing

ADULT INTENSIVE CARE UNIT

STAFFING MATRIX

1RN/2-3 patient ratio
1CNA/4-6 patients

AH ICU Staffing plan

ICU

Patients	1	2	3	4	5	6
Nurses	2	2	2	2	3	3
C.N.A	0	0	0	1	1	1
MT	1	1	1	1	1	1

PCU

Patients	1	2	3	4	5	6
Nurses	2	2	2	2	2	2
C.N.A	0	0	0	0	1	1
MT	1	1	1	1	1	1

MIX

# ICU	0	1	2	3	4	5	6
#PCU	6	5	4	3	2	1	0
Nurses	2	2	2	3	3	3	3
C.N.A	1	1	1	1	1	1	1
MT	1	1	1	1	1	1	1

COSI If the matrix says there is no C.N.A on and you have a 1:1 use the floor C.N.A

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

ADULT/PEDIATRIC EMERGENCY DEPARTMENT

DESCRIPTION OF SERVICE

Trauma level IV ED provides a full range of emergency services to patients of all ages. This department has been operating with 16 patient rooms however, the department has recently expanded to increase capacity to 30 patient care spaces, 4 Triage and 1 Decontamination room. Each patient care space is equipped to implement emergency cardiac/respiratory resuscitation, medical treatment, stabilization and minor procedures.

The ED is involved in Pierce County Emergency Preparedness by participating in disaster drills, mass casualty and decontamination incidents.

Direct care is provided to approximately 28,000 patients annually and patients of all ages

SKILL MIX

- Emergency Medicine Board Certified Physician
- PA/ARNP
- Registered Nurses
- Health Unit Coordinator/Monitor Technician
- Emergency Service Technicians
- Social Worker

Competencies for Each Position

	RN	EST/LPN	ANM	CM
Blood Administration	X		X	
ACLS	X		X	X
CPR	X	X	X	X
Sedation	X			
Glucometer/POCT	X	X	X	
5-Tier Triage	X			
HIPAA	X	X	X	X
PALS	X		X	X
TNCC	X			

ADULT/PEDIATRIC EMERGENCY DEPARTMENT

NURSE STAFFING PLAN

- Registered Nurses (RN) is responsible for providing, delegating and supervising nursing care.
- Licensed Practical Nurses (LPN) provide patient care under the supervision of the RN. Some of the activities (defined in the MultiCare Scope of Practice Provision) include medication administration, vital signs, dressing and splint application.
- Emergency Service Technicians (EST) assist the Registered Nurses in patient care delivery. Responsibilities include stocking of supplies and linen, cleaning and location of equipment, order entry, and patient care activities performed under the direction of an RN. Such activities may include collection of vital signs, set up and immobilization for special procedures and obtaining EKGs.
- Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.
- Changes to the staffing plan may be required in the event of unscheduled absences.

STAFFING MATRIX

- ❑ **1 RN:4 PATIENTS**
- ❑ **1 EST:8 PATIENTS**
- ❑ **1 LPN:8 PATIENTS**
- ❑ **1 RN :TRIAGE**
- ❑ **1 RN:CHARGE**
- ❑ **1 EST/HUC assigned to desk**

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences.

ADULT SURGERY DEPARTMENT

DESCRIPTION OF SERVICE

The Allenmore Operating Room provides a continuum of highly skilled and specialized surgical care to all patients whether routine, elective, urgent or emergent. The Operating Room at Allenmore Hospital is located on the first floor. It consists of nine surgical suites including a medically integrated endoscopy suite, urology suite, and a robotics suite. Each is designed to meet the needs of patients requiring surgical intervention.

The perioperative staff collaborates to provide skilled and specialized care for the patient undergoing invasive inpatient and outpatient surgical procedures. OR personnel utilize family centered care models, function as patient advocates and collaborate with other departments to provide comprehensive, coordinated care across the healthcare continuum. Patients are admitted to the Operating Room from the Inpatient Unit, Day Surgery or the Emergency Department.

POPULATION SERVED

Allenmore Hospital provides a multi-specialty surgical environment that meets the needs of patients of all patients thirteen years to geriatrics. Those patients that are thirteen to eighteen years of age should not have a diagnosis of sleep apnea.

Scope of Services / Surgical Services: Orthopedics, including Total Joint Replacements, Plastic and Reconstructive, Robotics, Otorhinolaryngology, Urology, General Surgery, Bariatric, Pain, Ophthalmology and Podiatry. Organ procurement is occasionally done when coordinated by an outside Organ Transplant Program.

Limitations of Unit: Cardiovascular, Neurological, Spine, Pulmonary, Thoracic and Organ Transplantation except for corneal transplants.

Important Aspect of Care:

- Performance improvement efforts will reflect our role as patient advocates.
- Provide a safe, effective and efficient environment that meets the needs of surgical patients and their families.
- Promote a surgical environment that meets or exceeds the recommended practice standards and/or legislative guidelines.

HOURS OF OPERATION

The Allenmore Operating Room is located on the first floor of the hospital. Scheduled procedures are performed Monday-Friday, 0700- 1900. Up to eight operating rooms are utilized. Urgent/Emergent surgical procedures are accommodated 24 hours a day, seven days a week.

ADULT SURGERY DEPARTMENT

STAFFING PLAN

Staffing is composed of RN's, Surgical Technologists and Anesthesia Assistants. Staffing will be sufficient at all times in numbers, skill mix and competency to meet the needs of patients.

Skill requirements:

- Registered Nurses: Must be competent in the Perioperative services specialty as determined by education, orientation, and experience.

- Surgical Technologists: Must be graduates of a qualified Surgical Technology School and be registered with the State of Washington, with skills and abilities measured during the orientation process by precepting and mentoring.

- Anesthesia Assistants: Requirements are specialized training in Anesthesia Assistance for individuals from a variety of healthcare backgrounds. Requirements are High School graduate with special orientation to the Perioperative environment.

- Determinate of Staffing Levels: The standard for each O.R. room is two staff members; one RN circulator and one Surgical Technologist, or one RN circulator and one RN in the scrub role. For certain robotic procedures, an additional RN or Surgical Technologist may be required for optimum patient care.

- The Operating Room usage is as follows:
    - Located on the first floor of Allenmore Hospital
        - Open Mon-Fri 0700-1900 for elective inpatient and outpatient cases
            - 0700-1700 Monday, Wednesday, Thursday, Friday 8 rooms
            - 0700-1700 Tuesday, 7 rooms
            - 1700-1900 2 rooms everyday
            - 1900-2200 1 room everday
        - On call 24 hours for emergency cases
        - Cares for primarily adults to geriatrics, pts must be at least 13 years old
        - 8 surgical suites, and 1 endoscopy suite
        - Specific urology suite

- Anesthesia Assistant coverage is from 0500-2200. Monday through Friday.

Call Team: Consisting of one RN and one Surgical Technologist, coverage is from 1530-0700 Monday through Friday. On weekends and holidays, coverage is from 0630-0700 the following day. On weekends and holidays, anesthesia assistant coverage is from 0700-1900. Response time for call is 30 minutes.
Staff working overnight on-call have the option to excuse themselves from scheduled work hours the day following the call shift if he/she/they do not feel safe caring for patients due to hours worked.

ADULT SURGERY DEPARTMENT

	Charge Nurse	RN	ST	AA
Regular Business Hours	1: Monday-Friday 0600-2200	Monday-Friday 0645-2200 (1 per OR room plus back hall and turnover support of 1:4 Rooms) Breaks 3 per 8 rooms	Monday-Friday 0645-2200 (1 per OR room plus back hall and turnover support of 1:4 Rooms) Breaks 3 per 8 rooms	Monday-Friday 0500-2200 (3 for 7-8 rooms)
On-Call Hours	None	Week Day: 1: 1515-0630 Week End/Holiday: 1: 0630-0630 (24 Hours)	Week Day: 1: 1515-0630 Week End/Holiday: 1: 0630-0630 (24 Hours)	Week End: 1: 0730-1600 (8 hours)

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan

PROFESSIONAL STANDARDS

In accordance with regulatory requirements all staff will participate in orientation and ongoing education programs. Demonstration of competency in job performance is defined by job descriptions, position specific skills evaluations and competency assessments. Competency based practice integrates knowledge, skill and behaviors to maintain a consistent standard of practice to meet AORN, JCAHO and CMS recommendations and guidelines.

Association of Perioperative Nurses Recommended Standards and Practices (AORN)

DAY SURGERY UNIT

DESCRIPTION OF SERVICE

This area is designed to provide care to inpatient and ambulatory patients pre-operatively and pre-procedurally, coming from a variety of settings. The nursing staff provide highly skilled and specialized functions for patients including, but not limited to preoperative assessment and testing, patient and family teaching, and maintaining continuity of care in a setting that respects human dignity and privacy with caring and compassionate services; as well as, utilizing the clinical pathway in coordination with Anesthesia, Surgeons and OR staff to provide a safe and seamless peri-anesthesia experience. The Day Surgery nurses are skilled in managing routine and complex medical, surgical and acutely ill patients with a wide variety of diagnoses and surgical problems.

ENVIROMENT OF CARE

- 12 beds, with 6 of those having the ability to flex to Phase 2 Recovery Beds as needed.
- Cardiac monitoring/oxygen/suction
- Medication Pyxis room
- Clean and soil utility rooms

PATIENT POPULATION

- The patient population comprises a wide variety of diagnoses requiring surgery or interventional technology supported with anesthesia or procedural sedation.
- The Perioperative areas admit patients from age 13 to geriatrics.
- All patients thirteen to eighteen will be without a diagnosis of sleep apnea.
- Age specific criteria are applied throughout the life span as appropriate to the age group including individualized care plan to address specific developmental needs.

COMPETENCIES

In accordance with regulatory requirements all staff will participate in orientation and ongoing educational programs. Demonstration of competency in job performance is defined by job descriptions, position specific skills evaluations, and skill validations to determine actual or real-life knowledge and skill in the work setting. Competency based practice integrates knowledge, skill and behaviors to maintain a consistent standard of practice.

Competencies to be assessed in the PACU include but are not limited to these areas:

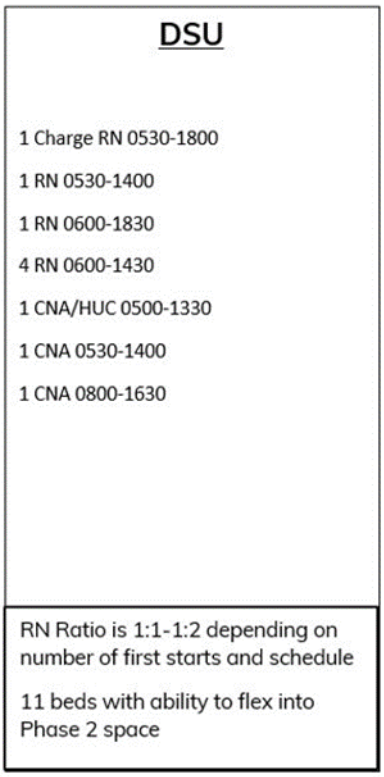
- Airway Management
- Cardiovascular Assessment
- Peripheral IV, Central Line and Port (access, maintenance and removal)
- Malignant Hypothermia
- Infection Control Policies
- Restraints

- IV, PCA, and Epidural Pumps
- Other Department Specific Equipment

CERTIFICATIONS

- BLS
- PALS

STAFFING PLAN



- The staff mix includes RNs, LPNs, and CNA's to allow for rapid surges of census.
- A skilled PACU RN and second licensed nurse must be in attendance of PACU phase 2 patients whenever patients are in the department.
- Additional Staffing and staff mix will be determined by the census and acuity of cases.
- Structure includes a RN Flow Facilitator

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

POST ANESTHESIA CARE UNIT

DESCRIPTION OF SERVICE

The nursing staff of the post-anesthesia care unit (PACU) provide highly skilled and specialized functions for patients including intensive vital sign monitoring, airway management and pain management.

Registered nurses are skilled in managing routine and complex medical, surgical and acutely ill patients with a wide variety of diagnoses and surgical problems. A primary focus for nursing care is based on rapid assessment of evolving physiological issues supported by careful vigilance, prompt action and physician involvement; in collaboration with Surgeons and Anesthesia providers.

Nurses are skilled in managing routine and complex medical, surgical and acutely ill patients with a wide variety of diagnoses and surgical problems.

ENVIRONMENT OF CARE

- 12 bed (Phase 1) Recovery
- 6 bed (Phase 2) Recovery with the option of an additional 6 flex beds as needed.
- Unit is equipped with oxygen, suction, air, and monitoring including hemodynamic, cardiac, oximetry and capnography.
- Crash Cart and emergency resuscitation equipment available always.
- 3 PYXIS med stations
- soiled utility, clean utility, staff lounge and both employee and patient locker space.

SKILL MIX

- RN
- LPN
- CNA
- HUC

CERTIFICATIONS

- CPR
- ACLS
- PALS

PROFESSIONAL STANDARDS

- American Society of Peri Anesthesia Nurses (ASPAN)

POST ANESTHESIA CARE UNIT

STAFFING PLAN

Phase 1	Phase 2
2 RN 0800-1630 * 1 is charge nurse with lesser or no pt assignment 1 RN 8:30- 1700 1 RN 0900-1730 3 RN 0930-2200 1 RN 1000-1830 1 CNA 0900-1730	1 RN 0830-2100 1 RN 0930-2200 1 LPN 0830-1700 1 LPN 1000- 2030 1 CNA 1000- 2030 Waiting Room Attendant 1 CNA 0800-1630
RN Ratio is 1:1-1:2 depending on patient acuity 12 Phase 1 beds	RN Ratio is 1:3 5 Phase 2 beds, with ability to flex into Day Surgery space

*model is based on 27 pts at minimum/or starting with 8 OR rooms... it is a fluid model based on case types

Employees are expected and encouraged to take rest and meal breaks pursuant to MultiCare policy, state and federal law, and any applicable collective bargaining agreement. Rest and meal break relief is determined by each department and has been considered in development and approval of this Staffing Plan.

Changes to the staffing plan may be required in the event of unscheduled absences