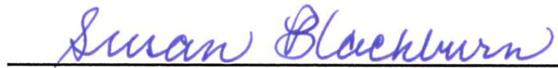
Providence St. Mary Medical Center Nurse Staffing Plan Submission 2021

I, the undersigned with responsibility for Providence St. Mary Medical Center, attest that the attached staffing plan and matrix was developed in accordance with RCW 70.41.420 for 2021 and includes all units covered under our hospital license under RCW 70.41. This plan was developed with consideration given to the following elements (please check):

- ☐ Census, including total numbers 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 patient care unit; and
- ☐ 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.

This staffing plan was adopted by the hospital on: December 29, 2021



As approved by Susan Blackburn, Chief Executive

Providence St. Mary Medical Center

Staffing Plan Submission

December 2021

The following is the nurse staffing plan for Providence St. Mary Medical Center, submitted to the Washington State Department of Health in accordance with Revised Code of Washington 70.41.420.

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Nurse Staffing Plan Purpose

This plan was developed for the management of scheduling and provision of daily staffing needs for the hospital, and to define a process that ensures the availability of qualified nursing staff to provide safe, reliable and effective care to our patients. This plan applies to all parts of the hospital licensed under RCW 70.41.

Nurse Staffing Plan Principles

- Access to high-quality nursing staff is critical to providing patients safe, reliable and effective care.
- The optimal staffing plan represents a partnership between nursing leadership and direct nursing care staff.
- Staffing is multifaceted and dynamic. The development of the plan must consider a wide range of variables.
- Data and measurable nurse sensitive indicators should help inform the staffing plan.

*These principles correspond to *The American Nursing Association Principles of Safe Staffing.*

Nurse Staffing Plan Policy

- The nurse staffing committee (committee) is responsible for the development and oversight of the nurse staffing plan to ensure the availability of qualified nursing staff to provide safe, reliable and effective care to our patients.
- The committee's work is guided by its charter.
- The committee meets on a regular basis as determined by the committee's charter.
- The committee's work is informed by information and data from individual patient care units. Appropriate staffing levels for a patient care unit reflect an analysis of:
  - Individual and aggregate patient needs;
  - Staffing guidelines developed for specific specialty areas;
  - The skills and training of the nursing staff;
  - Resources and supports for nurses;
  - Anticipated absences and need for nursing staff to take meal and rest breaks;
  - Hospital data and outcomes from relevant quality indicators; and
  - Hospital finances.

  *The American Nurses Association does not recommend a specific staffing ratio, but rather to make care assignments based on acuity, patient needs and staff competencies.

- The analysis of the above information is aggregated into the hospital's nurse staffing plan. Each individual patient care unit may use the Nurse Staffing Committee Checklist to guide their work.
- Staff continuously monitor individual and aggregate patient care needs and make adjustments to staffing per agreed upon policy and collective bargaining agreement (if applicable).
- The committee will perform a semiannual review of the staffing plan. If changes are made to the staffing plan throughout the calendar year, an updated staffing plan will be submitted to DOH.
- The hospital is committed to ensuing staff are able to take meal and rest breaks as required by law, or collective bargaining agreement (if applicable). The committee considers breaks and strategies to ensure breaks when developing the plan. A global break policy may be used, or individual patient care units may have discretion in structuring breaks to meet specific needs

while meeting the requirements of the law. Data regarding missed or interrupted breaks will be reviewed by the committee to help develop strategies to ensure nurses are able to take breaks.

Nurse Staffing Plan Scope

Acute care hospitals licensed under RCW 70.41 are required by law to develop a nurse staffing plan. The plan must cover areas of the hospital that: 1) are under the hospital's license (RCW 70.41) and 2) where a nurse(s) provides patient care (i.e., "patient care unit").

The following areas of the hospital are covered by the nurse staffing plan:

- Exhibit A – Emergency Department
- Exhibit B – Intensive Care Unit
- Exhibit C – Women's Services
- Exhibit D – Medical Unit
- Exhibit E – Surgical/Inpatient Rehab Unit
- Exhibit F – Operating Room
- Exhibit G – Outpatient Procedure Center/PACU
- Exhibit H – GI Services
- Exhibit I – Cardiac Cath Lab
- Exhibit J – Home Health
- Exhibit K – Cancer Center

Nurse Staffing Plan Critical Elements

- The following represents critical elements about the nurse staffing plan:
- Unit census
- Unit activity such as patient discharges, admissions and transfers
- Acuity
- Staff skill mix
- Level of experience and specialty certification/training
- Architecture and geography of patient care areas
- Staffing guidelines adopted by national professional nursing organizations
- Availability of support personnel
- Strategies to allow personnel to take meal and rest breaks

Nurse Staffing Plan Matrices

Matrices are developed as a guide for shift-by-shift unit-based staffing decisions and are adjusted up or down based on patient factors and skill-mix of hospital staff.

Exhibit A – ED (Day Shift, [insert start and stop time])					
Projected Pt. Census	**Charge Nurse**	**RN**	**CNA (as applicable)**	**Health Unit Coordinator (as applicable)**	**Additional Support Staff/Other (as applicable)**
	[insert per plan]	[insert per plan]	[insert per plan]	[insert per plan]	[insert per plan]
***Matrices are developed as a guide for shift-to -shift unit-based staffing decisions and are adjusted up or down based on patient factors and skill-mix of hospital staff.**					

- Exhibit A – Emergency Department
- Exhibit B – Intensive Care Unit
- Exhibit C – Women's Services
- Exhibit D – Medical Unit
- Exhibit E – Surgical/Inpatient Rehab Unit
- Exhibit F – Operating Room
- Exhibit G – Outpatient Procedure Center/PACU
- Exhibit H – GI Services
- Exhibit I – Cardiac Cath Lab
- Exhibit J – Home Health
- Exhibit K – Cancer Center

Current Status: *Active*	**PolicyStat ID:** *10875159*

Implementation:	*09/1974*
Effective:	*12/2021*
Last Reviewed:	*12/2021*
Last Revised:	*12/2021*
Next Review:	*12/2024*
Owner:	*Alysa Kyle: Dir Emergency Svcs*
Policy Area:	*Emergency Department*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing Guidelines, 7230.4600

POLICY

There shall be a process to provide safe, qualified staff in the Emergency Department 24 hours a day, 7 days a week.

PURPOSE

Staffing guidelines will be developed to meet patient care requirements expected throughout the 24-day for average projected ED volumes. Changes in staffing may be required when an unusual number of patients present resulting in prolonged waiting times, when special procedures are performed requiring additional nursing, or the critical condition of one or more patients requires additional staffing to meet the immediate patient care needs on a temporary basis. This policy addresses volumes of patients less than required to activate the hospital Emergency Operations Plan.

PROCEDURE

1. Base Staffing

0700-1930	3 Registered Nurses
0900-2130	1 Registered Nurse
0900-1730	1 Registered Nurse
1100-2330	1 Registered Nurse
1200-0030	2 Registered Nurse
1700-0130	1 Registered Nurse
1900- 0530	1 Registered Nurse
1900-0730	3 Registered Nurses
0700-1930	1 E.D. technician
0900-1930	1 E.D. Technician
1100-2330	1 ED Technician
1200-0030	1 E.D. Technician

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1700-0130	1 E.D. Technician
1900-0730	1 E.D. Technician

1. Scheduling

   Scheduling is on a 6-week basis that maintains core staffing and included unit coordinators each shift. Kronos is used for scheduling.

2. Contingency Staffing

   Low census reduction in staffing is accomplished according to the UFCW RN Nursing Contract. Maintaining an ED Unit Coordinator RN and a second RN who is code/trauma team credentialed at all times is required.

3. The Department Director or Clinical Manager and the Hospital Administrative Supervisor after hours will be notified by the Unit Coordinator when there is a volume or acuity of patient in the Emergency Department exceeding the standard staffing in an emergency situation. In general, available in-house staff will be utilized that may include:

   A. Cross trained RN's to ED that are assigned elsewhere in house.

   B. ICU Registered Nurses

   C. Outpatient Procedure Nurses

   D. Respiratory Therapists if appropriate to assist with critical care ventilator cases (to manage the ventilator and monitor patient responses)

   E. Med-Surg nurses as appropriate to an assignment

   F. Float Unit Secretaries or CNA's if appropriate to department needs

   G. Clinical Supervisor (first) or Director when available

      If additional ED or ICU trained nurses needed:

      On call ED or ICU nurses
      Off duty ED or ICU nurses
      Off duty Med-Surg nurses with experience in floating to ED
      Off duty Department Director

      The ED Unit Coordinator or Clinical Manager will notify the Hospital Administrative Supervisor as soon as additional staff can be released.

4. Communicate with ancillary Department Supervisors or Hospital Administrative Supervisor after hours when there is a need for additional support from ancillary services so that support staff may be mobilized to meet the patient care requirements. This would typically include: Respiratory Therapy, Imaging, lab, CPD and Distribution.

5. Notify Switchboard Operator to screen/hold calls to the Emergency Department when assistance is needed due to excessive patient volume or critical events.

6. The Emergency Department Physician is responsible for diverting patients to an appropriate facility under County EMS protocols based on patient care requirements when essential resources, including staffing, are not available.

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REGULATION

Washington Department of Health Hospital Rules WAC 246-318-350 Emergency Services

Health Care Financing Administration Standards and Certification, Condition of Participation: Emergency Services (482.55).

Washington Department of Health Rules and Regulations for Designated Trauma Care Services: Chapter 246-976 WAC.

Oregon Health Division Trauma Hospital Resource Standards OAR 333-200-0080.

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021
Alysa Kyle: Dir Emergency Svcs	12/2021

Applicability

WA - Providence St. Mary MC

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Implementation:	*01/2009*
Effective:	*12/2021*
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Last Revised:	*12/2021*
Next Review:	*12/2024*
Owner:	*Melissa Bowe: Dir Acute Care*
Policy Area:	*Intensive Care Unit*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing Plan Intensive Care Unit, 6010.4700

Executive Sponsor:	**Louise Dyjur, CNO**
Policy Owner:	**Melissa Bowe, Director Acute Inpatient Nursing**
Specialty Contact Person:	**Patty Harmon, Clinical Manager Intensive Care Unit**

SCOPE

This policy applies to the Intensive Care Unit (ICU) and is a management level policy, reviewed and approved by Nursing Leadership and the Nurse Staffing Committee.

PURPOSE

To clearly outline the process for staffing and assigning nursing personnel in the ICU.

POLICY

Established guidelines will be followed to ensure that adequate nursing personnel are available to provide safe patient care in the intensive care unit at all times, accounting for variation in the types and acuity levels of patients served.

REQUIREMENTS

1. **Staffing**
   Staffing will be based on the American Association of Critical Care Nurses (AACN) recommended staffing guidelines at a minimum and will also take into consideration elements such as unit census, the needs and acuity of the patient and the ability to safely provide care needed for each individual patient.
2. **Unit Coordinator** A unit coordinator (UC) or charge nurse will be assigned every shift, to coordinate patient care. The UC works in cooperation with the team to ensure smooth overall functioning of the unit, lunch/break relief, the development of the staffing plan for the current and next shift and responds to emergent and urgent needs in the unit.
3. **Competency**

   Staff members will be fully oriented and credentialed as competent when functioning independently in the intensive care unit environment.

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4. **Assignments** Assignments are made by the ICU Unit Coordinator (UC) or Charge Nurse considering patient need, patient acuity, technical and clinical skills required and competencies of the staff available. Continuity of care is an important consideration when making patient assignments. Code/Trauma Team/Rapid Response will be assigned by the UC. Float nurses are usually assigned to Stepdown status patients with an ICU nurse assigned as a resource "buddy". The buddy nurse is available as a resource for the float nurse to answer questions and provide guidance around care.
5. **Scope of Service** The ICU is an acuity adaptable unit, and all beds are universal, accommodating intensive care, step down and medical or surgical overflow level of care patients. The unit is functional and staffed 24 hours per day, 7 days per week. The ICU provides intensive monitoring, assessment and intensive intervention by critical care trained nurses to patients from infancy through geriatrics. Patients with cardiovascular disease, pulmonary disease, neurological disease or injury, renal disease and inpatient hemodialysis, general surgery, peripheral vascular surgery, multisystem trauma, and acute medical illness are cared for in the ICU. For further details related to the scope of services provided, please see Scope of Service Policy # 6010.0110
6. **Base Staffing** A core staff of RNs, CNA, and one telemetry technician is scheduled for each shift. The core staffing is based on average daily census and typical acuity of patients.
7. **Scheduling** Scheduling is based on a 6-week cycle that maintains core staffing and includes charge assignments each shift. An electronic scheduling system is used for scheduling. The unit schedule is created based on average daily patient census data and unit capacity with staffing levels evaluated and adjusted for actual census at regular intervals each day.
8. **Contingency Staffing** Staffing is supplemented by:
    - Float Pool RNs or RNs from other units floated to ICU or called in depending on the needs of the department and ability to match skill mix to patient need.
    - On-call or part-time ICU-Trained RNs
    - Staff on overtime (voluntary)
    - ICU Clinical Manager and/or other Clinical Managers
9. **Department Closure procedure** The Department Closure Procedure is initiated if there is a lack of qualified staff available
10. **Low Census** Low census reduction in staffing is accomplished according to the RN Collective Bargaining Agreement. Maintaining an ICU Charge RN and a second RN who is code/trauma team credentialed and able to respond to codes/rapid responses must be in-house at all times even if the ICU is closed due to low census.
11. **Staffing Plan** The staffing plan will be evaluated semi-annually at the staffing committee meetings and as necessary. During evaluation, efforts will be made to determine if the staffing plan is appropriate based on the current patient population served. The plan will be adjusted as necessary. The unit of service is inpatient days and the annual budget is based on the average daily census.
12. **ICU Staffing Levels** RN Staffing levels for ICU are as follows:
    - Level II 1:1
    - Level I 1:2
    - Stepdown 1:3-4
    - Medical overflow patients are staffed depending on the volume and mixture of other ICU/Stepdown patients.

LEVEL II: Requires 10-12 hours of direct care per shift

The patient requiring physiological monitoring or treatments more frequently than every hour with instability such as:

- Unstable hemodynamics requiring interventions/assessments every 15-30 minutes, or vasoactive IV infusions requiring frequent titration
- Fibrinolytic therapy for the first 4 hours
- Unstable neurologic status requiring assessments and interventions every 15-30 minutes.
- Unstable respiratory status requiring continuous observation and interventions such as suctioning every 15-30 minutes or frequent ventilator adjustments.

****The patient who is in danger of harming himself where there is extreme confusion and agitation, such as certain drug overdose or neurological trauma cases, may require a constant observer and not a nurse 1:1 depending on the actual patient care needs.

LEVEL I: Requires 6-10 hours of direct care per shift

The patient requiring physiologic monitoring or treatments hourly or less often, but who requires frequent observation and assessment by the ICU nurse. These patients may include:

- Patients requiring vital signs, medications, dressing changes, respiratory care, assessments or interventions every 1-2 hours.
- Hemodynamic assessments no more frequently than every 30 minutes
- Intubated and stable respiratory status with infrequent ventilator or O2 adjustments.
- Patients requiring close monitoring of arrhythmias or response to medications
- Stable on vasoactive IV infusions

STEPDOWN: Requires 4-6 hours of direct care per shift

The patient who does not require direct observation within the ICU, but who requires cardiac monitoring and observation/assessment by the ICU nurse. These patients include:

- Ventilator patients or patients requiring non-invasive positive pressure ventilation (NIPPV)
- Patients who do not require hemodynamic monitoring
- Interventional patients requiring post interventional monitoring
  Every 3-4 hour assessment and monitoring
  Every 3-4 hour IV medication administration, titration, and/or monitoring

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021

Applicability

WA - Providence St. Mary MC

Current Status: *Active* **PolicyStat ID:** *10938559*

Implementation:	*04/1990*
Effective:	*12/2021*
Last Reviewed:	*12/2021*
Last Revised:	*03/2021*
Next Review:	*12/2024*
Owner:	*Robyn Rivera: Dir Womens Childrens Svc Line*
Policy Area:	*Women's Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing Plan, 6085.4700

POLICY

The Women's Services Department is staffed with Registered Nurses and Certified Nursing Assistant/Ward Secretaries. Staffing is determined by volume, needs and acuity of patients.
Department specific standards for allocation of staff are developed with input from nursing staff, the Department Director and the Vice President, Chief Nursing Officer. In the OB setting, the number and mix of staff allocated to the department each shift is based on nursing hours per patient day and a staffing matrix utilizing those hours. The matrix provides the number of staff allotted based on the patient census. Personnel hours are evaluated and adjusted on an ongoing basis considering the care needs of the patients, the skill mix and level of competency of the caregiver.

1. Staffing Plans are reviewed and revised annually using ante partum, labor and delivery, post partum and special care nursery volumes, historical data and peer group comparisons.

PURPOSE

To provide safe patient care with adequate staffing in compliance with Washington law.

PROCEDURE

Assignment

As providers of Obstetrical, Newborn, Special Care Nursery(SCN) (Level IIA), Gynecological, and other surgical services, we offer inpatient and outpatient care 24 hours per day. A charge nurse who is an experienced perinatal, registered nurse is assigned each shift to make assignments. We will make every attempt to schedule one nurse who is experienced in SCN and one in Post Partum. The charge nurse also assists in determining the amount of staffing required for the oncoming shift. The charge nurse/unit coordinator, in collaboration with the AC and Director or designee, if necessary, will ultimately determine the staffing for Women's Services.

Staffing the Women's Services area:

Staffing requirements may change dramatically and suddenly in any Obstetrical unit. In an effort to assure that skilled nursing is readily available for each patient we have based staffing on the following:

- There shall be two Perinatal nurses in Women's Services at all times.
- Census based staffing matrix guidelines are attached.
- Recognize that individual patient acuity may raise or lower the staffing needs.
- Recognize that triage, admissions, transfers and discharges may raise or lower staffing needs.
- When Women's Service's nurses are unavailable, the float pool provides additional nurses to assist with staffing needs.

Assignment Guidelines:

Labor	1:2 until in Active Labor
Labor -2ND Stage	1:1
Couplets/Postpartum pairs	1:3-4
Antepartum (stable) & Gyn	1:6
Epidural	1:1 Placement and stabilization
Labor Medically Complicated	1:1
Pitocin	1:2
Stable Newborn	1:3-6
Intermediate Newborns	1:2-3
Unstable newborn/obstetrical patient	1:1
Critical Newborns	1:3
Postpartum mothers	1:5-6 (without complications) 1:3 (with complications but stable)
PACU after Cesarean	2:1 Until stable 1:1 (pair) if stable 2:1 if unstable or critically ill
Triage	1:1-3
Cervical Ripening	1:2
Magnesium Sulfate Infusion	Antepartum: 1:1 during first hour and until no longer contracting to the degree that preterm delivery is of eminent concern. 1:2 there after Intrapartum: 1:1 while laboring on Magnesium Postpartum: 1: 2 (pairs)

Assignment Planning

1. The Unit Coordinator shall determine the nurse/patient ratio based on the patient acuity. They are also responsible to evaluate staffing on an ongoing basis throughout the shift, and make adjustments as patient numbers and acuities change.
2. Unit Coordinators assume responsibility for staffing, break oversite, stocking, fiscal accountability, and leadership in all situations. In order to meet the needs of the unit the Unit Coordinator shall take a lighter post partum/gyn assignment, including triaging of outpatients.
3. The Unit Coordinator is responsible for developing a plan for meal breaks for each staff member. If staff are unable to get breaks, the Coordinator will notify a manager or Nursing Supervisor.
4. Chain of command will be accessed in the event that available staffing and/or room availability options have been exhausted. Need to initiate Surge Capacity Plan will be determined.

Support Services

The following departments support and assist with providing quality patient care when needed:

1. **Respiratory Therapy:** Neonatal resuscitation, oxygen services, treatments and ventilation support.
2. **Surgery/PACU:** Emergent and routine surgical support, post-anesthesia care and labor analgesia/anesthesia service.
3. **Pharmacy:** Medications, patient teaching, and clinical support.

4. **CPD:** Supplies and processing.
5. **Radiology:** Ultrasound, Xray, amniocentesis.
6. **Lab:** Clinical lab services and blood bank.
7. **ER:** Emergency backup 24 hours per day.
8. **Dietary:** Patient nourishment's, patient teaching, clinical dietitian services.
9. **Chaplaincy/Social Services:** Patient and family support, counseling, discharge planning support, adoptions.
10. **Cancer Center Support:** Patient Education and referral.

REFERENCE

Guidelines for Perinatal Care "Seventh Edition, 2012, authorized by the American College of Obstetrics and Gynecology.

Charge Nurse Roles and Responsibilities (8720.4610)

Guidelines for Professional Registered Nurse Staffing for Perinatal Units, AWHONN, 2010

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021
Robyn Rivera: Dir Womens Childrens Svc Line	12/2021

Applicability

WA - Providence St. Mary MC

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Next Review:	*12/2024*
Owner:	*Melissa Bowe: Dir Acute Care*
Policy Area:	*Medical/Pediatric Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing plan

Executive Sponsor:	**Louise Dyjur, CNO**
Policy Owner:	**Melissa Bowe, Director Acute Inpatient Nursing**
Specialty Contact Person:	**Kristan Kuenzi, Clinical Manager**

SCOPE

This policy applies to the Medical unit and is a management level policy, reviewed and approved by Nursing Leadership and the Nurse Staffing Committee.

PURPOSE

To clearly outline the process for staffing and assigning nursing personnel on the medical unit.

POLICY

The purpose of this policy is to establish guidelines to ensure that adequate nursing personnel are available to provide safe patient care on the medical unit at all times for the variety of patients served and variation in acuity levels.

REQUIREMENTS

1. **Staffing**
   Staffing will be based on a department specific matrix and the Academy of Medical Surgical Nurses (AMSN) recommended staffing guidelines at a minimum. Staffing will take into consideration elements such as unit census, the needs and acuity of patients and the ability to safely provide care needed for each individual patient. The department specific matrix is determined by using data collected, the scope of service provided, the type of patients served, the method of care delivery utilized, as well as historical trends and strategic planning goals.
2. **Unit Coordinator**

   A unit coordinator (UC) or charge nurse will be assigned every shift, to coordinate patient care. The UC works in cooperation with the team to ensure smooth overall functioning of the unit, lunch/break relief, the development of the staffing plan for the current and next shift and responds to emergent and urgent needs in the unit.

3. **Competency**

   Staff members will be fully oriented and credentialed as competent when functioning independently on the medical unit.

4. **Assignments**
   Assignments are made by the UC or Charge Nurse considering patient need, patient acuity, technical and clinical skills required and competencies of the staff available. Continuity of care is an important consideration when making patient assignments. Code Response will be assigned by the UC.

5. **Scope of Service**
   The medical unit accommodates general medical, pediatric and oncology patients. The unit is functional and staffed 24 hours per day, 7 days per week. The medical unit provides monitoring, assessment and intervention by trained nurses to patients from infancy through geriatrics. A multidisciplinary approach is utilized to aid the transition of the patient's care through the health care continuum based upon the individual's physical, social and psychological needs. For further details related to the scope of services provided, please see Philosophy/Scope of Service Policy # 6071.0105

6. **Base Staffing**
   A core staff of RNs, CNAs, and one ward secretary is scheduled. The core staffing is based on average daily census and typical acuity of patients.

7. **Scheduling**
   Scheduling is based on a 6-week cycle that maintains core staffing and includes charge assignments each shift. Kronos staffing and scheduling is used. The unit schedule is created based on average daily patient census data and unit capacity with staffing levels evaluated and adjusted for actual census at regular intervals each day.

8. **Contingency Staffing**
   Low census reduction in staffing is accomplished according to the RN Collective Bargaining Agreement. High census coverage is accomplished by the following process :

   a. Staffing is supplemented by the Float Pool or staff from other units are floated or called in depending on the needs of the department and ability to match skill mix to patient need.
   b. On call or part-time staff called in from home.
   c. Staff on overtime (voluntary) work over or come in extra
   d. 4E Clinical Manager and/or Float Pool Clinical Manager called into staffing
   e. Department closure procedure initiated for lack of bed availability or lack of qualified staff.

9. **Staffing Plan**

   The staffing plan will be evaluated semi-annually at the staffing committee meetings and as necessary. During evaluation, efforts will be made to determine if the staffing plan is appropriate based on the current patient population served. The plan will be adjusted as necessary. The unit of service is inpatient days and the annual budget is based on the average daily census.

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021
Louise Dyjur: CNO St Mary Med Ctr	12/2021

Applicability

WA - Providence St. Mary MC

Current Status: *Active*	PolicyStat ID: *10846233*
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Next Review:	*12/2024*
Owner:	*Linda Jackson: Mgr Clinical Surgical Floor*
Policy Area:	*Surgery - Neuro/Ortho*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing Plan Surgical Unit

Executive Sponsor:	**Louise Dyjur, CNO**
Policy Owner:	**Melissa Bowe, Director Acute Inpatient Nursing**
Specialty Contact Person:	**Linda Jackson, Clinical Manager Surgical Unit**

SCOPE

This policy applies to the Surgical Unit and is a management level policy, reviewed and approved by Nursing Leadership and the Nurse Staffing Committee.

PURPOSE

To clearly outline the process for staffing and assigning nursing personnel on the surgical unit.

POLICY

Established guidelines will be followed to ensure that adequate nursing personnel are available to provide safe patient care on the surgical unit at all times, accounting for variation in the types and acuity levels of patients served.

REQUIREMENTS

1. **Staffing**
   Staffing will be based on a department specific matrix and the Academy of Medical Surgical Nurses (AMSN) recommended staffing guidelines at a minimum. Staffing will take into consideration elements such as unit census, the needs and acuity of patients and the ability to safely provide care needed for each individual patient. The department specific matrix is determined by using data collected, the scope of service provided, the type of patients served, the method of care delivery utilized, as well as historical trends and strategic planning goals.
2. **Unit Coordinator**
   A unit coordinator (UC) or charge nurse will be assigned every shift, to coordinate patient care. The UC works in cooperation with the team to ensure smooth overall functioning of the unit, lunch/break relief, the development of the staffing plan for the current and next shift and responds to emergent and urgent

needs in the unit.

3. **Competency**
   Staff members will be fully oriented and credentialed as competent when functioning independently on the surgical unit.
4. **Assignments**
   Assignments are made by the Unit Coordinator (UC) or Charge Nurse considering patient need, patient acuity, technical and clinical skills required and competencies of the staff available. Continuity of care is considered when making patient assignments. Code Response will be assigned by the UC/charge nurse to ACLS certified staff.
5. **Scope of Service**
   The surgical unit serves patients with acute neurological conditions and post neuro/ortho/general surgical procedures. The unit serves as an overflow unit for general medical patients as needed. The unit is functional and staffed 24 hours per day, 7 days per week. The surgical unit provides monitoring, assessment and intervention by trained nurses to patients from adolescence through geriatrics. A multidisciplinary approach is utilized to aid the transition of the patient's care through the health care continuum based upon the individual's physical, social and psychological needs. For further details related to the scope of services provided, please see Philosophy/Scope of Service Policy # 6071.0105
6. **Base Staffing**
   A core staff of RNs, CNAs, and one ward secretary (day & evening shift) is scheduled. The core staffing is based on average daily census and typical acuity of patients.
7. **Scheduling**
   Scheduling is based on a 6-week cycle that maintains core staffing and includes charge assignments each shift. Scheduling software is utilized to create staffing patterns, adjust schedules, and monitor needs. Staff can access their schedules through this software. The unit schedule is created based on average daily patient census data and unit capacity with staffing levels evaluated and adjusted for actual census at regular intervals each day.
8. **Contingency Staffing**

Low census reduction in staffing is accomplished according to the RN Bargaining Contract. High census coverage is accomplished by the following process:

a. Staffing is supplemented by the Float Pool or by appropriately oriented staff who float from other units.
b. In addition, part-time, per diem or on-call staff can be called in based on the needs of the Unit.
c. If still unable to meet the need, overtime can be offered in the form of staying late, coming early, or unscheduled shift. Productivity, overtime, staff health and safety are all considered in staffing decisions.
d. When other options have been exhausted, the Unit charge nurse can take a limited patient load – up to 3 patients on day shift and 4 patients on night shift.
e. Surgical Unit Clinical Manager or other Clinical Managers.
f. Department closure procedure initiated for lack of bed availability or lack of qualified staff after consulting with Unit Manager and/or Director.

9. **Staffing Plan**

The staffing plan will be evaluated semi-annually at the staffing committee meetings and as necessary. During evaluation, efforts will be made to determine if the staffing plan is appropriate based on the current patient

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population served. The plan will be adjusted as necessary. The unit of service is inpatient days and the annual budget is based on the average daily census.

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021
Linda Jackson: Mgr Clinical Surgical Floor	12/2021

Applicability

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Current Status: *Active*	PolicyStat ID: *9086810*

Implementation:	*08/2008*
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Last Revised:	*11/2017*
Next Review:	*01/2024*
Owner:	*David Stites: Dir Perioperative Svcs*
Policy Area:	*Surgical Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing, 7020.4021

POLICY

The purpose of this policy is to establish guidelines to assure that adequate nursing personnel are available to render safe patient care in the intraoperative area at all times for a variety of patient acuity and patient population served. Refer to scope of service 7020.0105 for a list of populations served and types of procedures. Except when specifically defined staffing and assignment of nursing personnel will follow nursing administration policy 8720.4702.

Hours of operation may be found in the block policy 7020.5003 and the scheduling policy 7020.5002.

PROCEDURE

1. Basic staffing for one operating room will consist of one RN and one surgical technologist. Staff members will be fully oriented and credentialed as competent when functioning independently in the intraoperative environment. The nurse and the surgical tech will be meet all requirements within the job description prior to working independently within the intraoperative area.
2. A unit coordinator or charge nurse will be assigned on a daily basis. They will work in cooperation with anesthesia to develop a plan to assure smooth efficient turnovers, lunch and break relief, a staffing plan for the next day, and respond to emergent/urgent needs in OR.
3. The care delivery components are pre operative, intraoperative and post operative. Refer to policy 7020.1600 for explanation of each care delivery component.
4. The RN functions as the circulating nurse. His/her primary responsibilities include, but are not limited to:
    - Application of the nursing process in directing and coordinating all nursing activities related to the care and support of the patient within the OR to meet individualized patient needs.
    - Creation and maintenance of a safe and comfortable environment for the patient through implementing and continual monitoring the principles of asepsis, and safety.
    - Provision of assistance to any member of the OR team in any manner. This requires knowledge of instrumentation, equipment and supplies as well as available resources.
    - Identifies potential environmental danger or stressful situation and acts in an efficient, rational manner in emergency situations.
    - Maintains the communication link between events and team members at the sterile field and persons not in the OR but concerned with the outcome of the operation.

◦

The surgical technologist who functions as the scrub person. His/her primary responsibilities include, but are not limited to:

- Maintaining the integrity, safety and efficiency of the sterile field throughout the operation.
- Prepare and arrange instruments and supplies and assist the surgeon throughout the operation by providing the sterile instruments and supplies required.

5. Daily Assignments:
   A. Registered nurses and scrub techs are assigned to cases by either a designated unit coordinator or a member of OR management. Additional Staff needs will be provided on a case by case basis, dependent on operational needs of the department. Cases deemed complex or high in acuity may have additional staff assigned to include additional RN, ST, anesthesia techs or PSA's.
   B. Factors taken into consideration when making assignments are:
      1. Technology to be utilized during case.
      2. The individual needs of the patient.
      3. Patient acuity
      4. Skills and ability of assigned nursing staff to fulfill requirements of patient and surgeon with little or limited supervision.
      5. Ongoing competency needs of staff.
      6. The safety needs of the patient in the intraoperative environment.
6. A formal process to evaluate and initiate limitations on admission or to divert a patient when unable to meet their needs will exist. Refer to Scope of service policy 7020.1600.
7. Staffing will be based on AORN recommended staffing guidelines at the minimum and, will also take into account the needs of the patient, the needs of the department and the ability to safely provide the care needed for each individual patient.
8. The staffing plan will be evaluated semi-annually at the staffing committee meetings and as needed. During evaluation, efforts will be made to determine if the staffing plan is appropriate based on the current patient population served. The plan will be adjusted as needed.
9. Staffing Plans are reviewed and revised annually using historical data and peer group comparisons. The unit of service for OR is patient minutes and the annual budget is based on hours of surgery.

Attachments

No Attachments

Approval Signatures

Approver	Date
Yvonne Strader: CNO St Mary Med Ctr	01/2021

Approver	Date
Mary Crawford: Exec Dir Operations	01/2021
David Stites: Mgr Clin Opr Rm/Card Surg Svcs	01/2021

Applicability

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Current Status: *Active*	PolicyStat ID: *10919205*
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Last Reviewed:	*12/2021*
Last Revised:	*12/2021*
Next Review:	*12/2024*
Owner:	*Cindy Moramarco: Mgr Clinical Outpatient PACU*
Policy Area:	*Post Anesthesia Care Unit (PACU)*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing, 7030.4021

Executive Sponsor:	Louise Dyjur, Chief Nursing Officer
Policy Owner:	Cindy Moramarco Mgr Clinical Outpatient PACU
Contact Person:	Cindy Moramarco Mgr Clinical Outpatient PACU

SCOPE

This policy applies to Providence St. Mary's Medical Center Post-Anesthesia Care Unit (PACU). This is a management level policy.

PURPOSE

To ensure proper staffing levels based upon best practice standards of care.

POLICY

To establish guidelines to assure that adequate nursing personnel are available to render post anesthesia-nursing care at all times. Except when specifically defined staffing and assignment of nursing personnel will follow nursing administration policy 8720.4702.

DEFINITIONS

Preoperative: The time period spent preparing the patient for a procedure; prior to sedation.
Phase I recovery: The time period immediately following the end of anesthesia, until Phase I discharge criteria set by Anesthesia is met.
Phase II recovery: The time period immediately following discharge from phase I or end of the procedure with moderate sedation, local anesthesia, or monitored anesthesia care; until the patient is discharged from the facility or transferred to an inpatient unit.
Regular SPC Staff: Staff with a set FTE position that are guaranteed hours
On-Call SPC Staff: Staff with no set FTE position and no guaranteed hours; will be asked to work as needed to provide safe staffing levels.

PROCEDURE

1. An RN with phase I recovery training and experience will always be present during the recovery of patients. The Charge Nurse designated for SPC Monday – Friday 0600-2330, will have oversight for PACU as well.
2. All phase I recovery staff will have ACLS and PALS training.
3. Any patient who has had surgery with general, spinal or regional anesthesia may be admitted to PACU for recovery from anesthesia. Any patient who has had surgery with local or MAC (monitored anesthesia care) with significant medical history with problems intraoperatively or at high risk for problems post-operatively may be monitored in PACU, per the discretion of Anesthesiologist or Surgeon (if local case) involved in case.
4. The following is a guideline for staffing in the PACU. It is the responsibility of the registered nurses in the PACU to assess patient acuity and allow for flexibility in assignments based on patient acuity, discharges, and new admissions. Two Registered nurses, one of whom is an RN competent in phase I postanesthesia nursing, are in the same room/unit where4 the patient is receiving phase I level of care.

   CLASS 1:2 ONE NURSE TO TWO PATIENTS WHO ARE

   a. one unconscious, stable without artificial airway and over the age of 8 years; and one conscious, stable and free of complications.
   b. two conscious, stable and free of complications
   c. two conscious, stable, 8 years of age and under; with family or competent support staff present

   CLASS 1:1 ONE NURSE TO ONE PATIENT

   a. at the time of admission, until patient is critical elements are met*
   b. requiring mechanical life support
   c. any unconscious patient 8 years of age and under
   d. unstable airway**
   e. a second nurse must be available to assist as necessary

   CLASS 2:1 TWO NURSES TO ONE PATIENT

   a. one critically ill, unstable, complicated patient

      **Critical elements can be defined as:*

      - *report has been received from anesthesiologist, questions answered, and the transfer of care has taken place.*
      - *patient has a secure airway.*
      - *initial assessment is complete.*
      - *patient is hemodynamically stable.*

***Examples of an unstable airway include, but are not limited to:*

- *requiring active interventions to maintain patency such as manual jaw lift or chin lift.*
- *evidence of obstruction, active or probable, such as gasping, choking, crowing, wheezing, etc.*
- *symptoms of respiratory distress including dyspnea, tachypnea, panic, agitation, or cyanosis.*

5. Phase I recovery is done 0800-2330 in the PACU Monday – Friday.

   Phase I recovery is done 2330-0800 Monday – Friday and 24 hours a day on weekends and holidays in either the PACU or ICU based on staffing considerations. All Regular SPC staff will participate in a call rotation during these times.
6. All Regular SPC RN's in are cross-trained to work three phases of care: preoperative, phase I recovery, and phase II recovery.
7. Meal and rest periods will be provided in accordance with state law. Each staff member will receive an unpaid 30 minute meal break during any shift longer than 5 hours. Each staff member will be allowed one rest period of 15 minute during each four hours of work. These breaks may be intermittent, including coffee, bathroom breaks, and personal phone calls. It is the responsibility of the charge nurse to ensure each staff member receives their meal break. If unable to do so, the Clinical Manager will be notified in order to provide coverage or approve the staff to stay on duty. The missed meal break will be documented by staff to be reflected on their time card. Documentation of meal breaks will be on a daily basis on the staffing white board.

Reference

Standards of Perianesthesia Nursing Practice, 2019-2020. The American Society of Perianesthesia Nurses.

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021
David Stites: Dir Perioperative Svcs	12/2021
Cindy Moramarco: Mgr Clinical Outpatient PACU	12/2021

Applicability

WA - Providence St. Mary MC

Current Status: *Active*	PolicyStat ID: *10931151*

Implementation:	*03/1993*
Effective:	*12/2021*
Last Reviewed:	*12/2021*
Last Revised:	*12/2021*
Next Review:	*12/2024*
Owner:	*Cindy Moramarco: Mgr Clinical Outpatient PACU*
Policy Area:	*GI Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing, 7238.4021

Executive Sponsor:	Louise Dyjur: Chief Nursing Officer
Policy Owner:	Cindy Moramarco Mgr Clinical Outpatient PACU
Contact Person:	Tamara Jones GI Unit Coordinator

SCOPE

This policy applies to Providence St. Mary's Medical Center Endoscopy GI Services department caregivers (employees). This is a management level policy.

PURPOSE

To ensure proper staffing levels based upon best practice quality standards.

POLICY

To establish guidelines to assure that adequate nursing personnel are available to render safe patient care at all times. Except when specifically defined staffing and assignment of nursing personnel will follow nursing administration policy 8720.4702.

PROCEDURE

1. A registered nurse will assess, plan, implement, and evaluate nursing care.
2. Registered nurses who are moderate sedation credentialed and ACLS prepared will provide care according to policy 8720.5492. The endoscopy assistant will be present to assist the physician. (2 RN's required for moderate sedation cases. 1 RN and Anesthesia staff for propofol sedation cases.)
3. Staff coverage for the GI Lab is maintained Monday through Friday to meet patient needs.
4. Weekend coverage is maintained by a RN / GI tech and/or surgery tech call rotation. This is posted monthly.
5. Breaks and meal breaks will be provided in accordance with state law.

Attachments

No Attachments

Approval Signatures

Approver	Date
Louise Dyjur: CNO St Mary Med Ctr	12/2021
David Stites: Dir Perioperative Svcs	12/2021
Cindy Moramarco: Mgr Clinical Outpatient PACU	12/2021

Applicability

WA - Providence St. Mary MC

Current Status: *Active* **PolicyStat ID:** *9105729*

Implementation:	*12/2020*
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Last Reviewed:	*06/2021*
Last Revised:	*06/2021*
Next Review:	*06/2024*
Owner:	*David Stites: Dir Perioperative Svcs*
Policy Area:	*Patient Care Services*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing Plan Cardiac Catherization Lab

Purpose:

The purpose of this policy is to establish guidelines to assure that adequate nursing personnel are available to render safe patient care in the intraoperative area at all times for a variety of patient acuity and patient populations served. The scope of service provided by the Cardiac Catheterization lab includes diagnostic, invasive, and therapeutic cardiac procedures, vascular procedures, and ancillary procedures. Except when specifically defined, staffing and assignment of nursing personnel will follow nursing administration policy 8720.4702. Hours of operation are from 0600 to 1630.

PROCEDURE

A. Basic staffing for one procedural lab will consist of 4 person care team per case consisting of either 2 RNs and 2 Radiology Techs or 1 RN and 3 Radiology Techs depending upon case type. A minimum of 1 RN will be present in the case when RN sedation is required. Ancillary procedures not requiring full team support will consist of 1 RN for sedation and 1 Radiology Tech (if needed for additional procedural care, monitoring, and/or documentation).

B. Staff members will be fully oriented and credentialed as competent when functioning independently in the procedural environment. RNs and Radiology Techs will meet all requirements within the job description prior to working independently within the procedural area.

C. A unit coordinator or charge nurse will be assigned on a daily basis. They will work in a team based collaborative approach to develop a plan to assure smooth efficient turnovers, lunch and break relief, a staffing plan for the next day, and respond to emergent/urgent needs within the Cath Lab and ancillary areas in which they support.

D. The care delivery components are pre operative, intraoperative and post operative. Refer to Perioperative policy 7020.1600 for explanation of each care delivery component.

E. The RN functions as the sedation nurse and/or circulator depending upon case type. These roles are not served simultaneously by only 1 RN. Primary responsibilities include, but are not limited to:

- Application of the nursing process in directing and coordinating all nursing activities related to the care and support of the patient to meet individualized patient needs.
- Creation and maintenance of a safe and comfortable environment for the patient through implementing and continual monitoring the principles of asepsis and safety.
- Provision of assistance to any member of the team in any manner. This requires knowledge of

instrumentation, equipment and supplies as well as available resources

- Identifies potential environmental danger or stressful situation and acts in an efficient, rational manner in emergency situations
- Maintains communication with team members, physicians, and other caregivers to ensure timely, efficient, and effective patient care.

F. The Radiological Technologist functions as the scrub person, monitor, and/or circulator depending upon case type. These roles are not served simultaneously by only 1 Radiology Tech. Primary responsibilities include, but are not limited to:

- Maintaining the integrity, safety and efficiency of the sterile field throughout the operation.
- Prepare and arrange instruments and supplies and assist the physician throughout the operation by providing the sterile instruments and supplies required.
- Monitor patient vital signs and record all necessary readings, pressures, assessments, and interventions to comprise a complete procedural log.
- Maintains communication with team members, physicians, and other caregivers to ensure timely, efficient, and effective patient care

G. Daily Assignments:

- Registered nurses and scrub techs are assigned to cases by either a designated unit coordinator or a member of OR management. Additional Staff needs will be provided on a case by case basis, dependent on operational needs of the department. Cases deemed complex or high in acuity may have additional staff assigned to include additional RN, ST, and or Anesthesiologists
- Factors taken into consideration when making assignments are:
  1. Technology to be utilized during case.
  2. The individual needs of the patient.
  3. Patient acuity
  4. Skills and ability of assigned nursing staff to fulfill requirements of patient and surgeon with little or limited supervision.
  5. Ongoing competency needs of staff.
  6. The safety needs of the patient in the intraoperative environment.

H. Evaluation of procedural limitations and the need to transfer a patient when unable to meet their needs will be the primary responsibility of the physician operator.

I. Staffing will be based upon Society for Cardiovascular Angiography and Interventions (SCAI) recommended staffing guidelines (2016, Naidu et al., *SCAI Expert Consensus Statement: 2016 Best Practices in the Cardiac Catheterization Laboratory*) at the minimum and will also take into account the needs of the patient, the needs of the department and the ability to safely provide the care needed for each individual patient.

J. The staffing plan will be evaluated semi-annually at the staffing committee meetings and as needed. During evaluation, efforts will be made to determine if the staffing plan is appropriate based on the current patient population served. The plan will be adjusted as needed

K. The staffing plan will be evaluated semi-annually at the staffing committee meetings and as needed. During evaluation, efforts will be made to determine if the staffing plan is appropriate based on the current

patient population served. The plan will be adjusted as needed.

L. Staffing Plans are reviewed and revised annually using historical data and peer group comparisons.

M. The unit of service for OR is patient minutes and the annual budget is based on hours of surgery

Attachments

No Attachments

Approval Signatures

Approver	Date
Yvonne Strader: CNO St Mary Med Ctr	06/2021
David Stites: Mgr Clin Opr Rm/Card Surg Svcs	05/2021

Applicability

WA - Providence St. Mary MC

Current Status: *Active* | **PolicyStat ID:** *6595326*

Implementation:	12/1998
Effective:	11/2020
Last Reviewed:	11/2020
Last Revised:	12/2018
Next Review:	11/2023
Owner:	Rachel Manchester: Exec Dir Providence At Home
Policy Area:	Home Health
References:	
Applicability:	WA - Providence St. Mary MC

Scope of Service, Staffing Plan for Home Health, 7400.4702

POLICY

Department Directors and the Chief Nursing Officer develop department specific standards for the allocation of staff. These standards consider the scope of practice and type of patients served for each department, the method of care delivery utilized, as well as historical trends and strategic planning goals. Individual staffing assignments in home health are made by the Schedulers overseen by Clinical Managers. Staffing is determined by assessing patient care requirements, the skill mix and documented level of competency of the health care clinician and standards of practice. The number, qualifications and health status of staff (including management) are appropriate to the scope of care and services provided by the department.

PHILOSOPHY

The philosophy of the Home Health Department is based on the mission, values and beliefs of the community of people working together at Providence St. Mary Medical Center along with Home and Community Care and will be demonstrated through safe patient care and staff relationships.

SCOPE OF SERVICE

The Home Health Department provides acute, chronic, palliative and end of life care to patients of all ages. Statistics show that 78-80% of patients receiving service from Home Health are over the age of sixty-five. The percentage of adults served between ages eighteen to sixty-five is approximately 20 %. Approximately three percent are less than age seventeen. Regular hours of operation are 0800-1630 Monday through Friday. A registered nurse is available 24 hours/day and seven days a week. This nurse can be reached through the PSMMC switchboard after operating hours, weekends and holidays. Skilled services provided on an intermittent basis include nursing, physical, occupational and speech therapy, social service and personal care.

BASIC COMPETENCY

All staff working for the home health department will meet the basic qualifications as outlined in their job descriptions. General knowledge and experience with medical/surgical geriatric patients is required as a baseline to build upon. Clinical competency of staff is initially assessed and documented as part of orientation

for age group competencies, and updated as needed for safe patient care.

PROCEDURE

Staffing Plan:

Staffing is based on fluctuating needs of patient care services. Geographic location is a variable due to travel time involved. A general eight hour work day for staff consists of the number of visits as follows (on average):

- RN 4-6 visits
- HHA 5-7 visits
- PT 4-6 visits
- OT 4-6 visits
- SLP varies
- MSW 3-4 visits

Staffing is, therefore, based on the number of daily visits anticipated considering variables such as geographic location, weather conditions, admission verses follow up visits and type and amount of service objectives to be rendered per visit. Most professional staff maintain their own caseload of patients to assure continuity of care and maintain a weekly schedule of visits. The Clinical Manager and Schedulers review each days schedule and assigns staff and visits as needed, based on patient need, skill level required and competency of staff available. The Clinical Manager oversees their team staffing and consults with the Unit Coordinator/ Triage RN as needed. New admissions are delegated to appropriate staff based on competency and work schedules. Per diem and cross-trained staff are available to cover higher than normal fluctuations of visits or medical leaves. The Clinical Managers are also available to provide direct patient care visits if needed. All disciplines are generally based in the home health department. Occasionally, an "agency" or traveler may be engaged by contract for patient care.

The Clinical Managers, or a similarly qualified individual is responsible for pre-scheduling teams and staffing minimally on a monthly basis, utilizing department and industry standards, minimum staffing guidelines, pertinent Human Resource policies and contractual obligations. The Clinical Managers and Director are accountable for ongoing review, analysis, and follow-up of staffing needs and productivity issues and trends.

Support Services:

Support services may include but is not limited to Pharmacy, Dietary, Respiratory Therapy, Outpatient Rehabilitation, Materials Management, Chaplaincy and Social Services.

Attachments

No Attachments

Approval Signatures

Approver	Date
Yvonne Strader: CNO St Mary Med Ctr	11/2020
Ann Halstrom: Dir Home Health	10/2020

Approver	Date
Rachel Manchester: Dir Quality/Nursing - HH	10/2019

Applicability

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Effective:	*12/2021*
Last Reviewed:	*12/2021*
Last Revised:	*12/2021*
Next Review:	*12/2024*
Owner:	*Natasha Delano: Dir Cancer Center*
Policy Area:	*Medical Oncology*
References:	
Applicability:	*WA - Providence St. Mary MC*

Staffing Plan, 7152.4007

POLICY

To establish guidelines to assure sufficient number of qualified nursing personnel to provide safe, high quality nursing care to Outpatient Oncology patients in the Cancer Center.

PROCEDURE

1. Staffing is based on daily unit census, patient acuity, and qualifications of available staff.
2. **Assignments**
   Registered nurse (RN) assignments in the infusion suite are coordinated by the Charge RN who considers patient need, technical and clinical skills required and competencies of available staff.
3. **Workload and Hours of Operation**
   See Cancer Center Philosophy/Scope of Service Policy 7155.0100
4. **Base Staffing**
   A. Infusion Suite
      1. A minimum of two Oncology Nursing Society (ONS) chemotherapy/biotherapy certified RNs will be present whenever chemotherapy patients are scheduled for treatment.

   B. Medical and Radiation Oncology
      1. A nurse or medical assistant (MA) will be present for each physician on-site.
      2. One triage nurse will be scheduled at all times during normal clinic hours.
5. **Scheduling**
   Scheduling is done at least monthly and updated as unit census and patient acuity fluctuate. Scheduling will maintain the base staffing and include acuity assignments for each day the clinic is open. The Cancer Center clinic manager provides scheduling oversight.
6. **Contingency Staffing**
   A. Low census reduction in staffing is accomplished according to the USNU RN Nursing Contract and is based on need as determined by the Acuity Matrix. All efforts will be made to cross-train Medical Oncology RNs for the Radiation Oncology unit in the Cancer Center so that they are also a resource to Radiation Oncology as the daily RN staffing calculation allows.

B. High census coverage is accomplished by supplementing staff with Medical Oncology oriented and trained per-diem RNs on staff or from the Float Pool as available. All efforts will be made to cross-train RNs from the Radiation Oncology unit in the Cancer Center so that they are also a resource to Medical Oncology as the radiation therapy patient census allows.

7. **Schedules**
The Cancer Center clinical schedule is maintained by the clinic manager in coordination with the Charge RN and is located in Teams using the Shifts application.

8. **Chemotherapy Staffing Matrix**

Level I: less than 30 minutes. Nursing time: 20 minutes. **1 Acuity Point** Includes but not limited to: • Laboratory tests • Nurse assessment • IV access and/or removal • Central line access • Dressing changes • Coordination of care • Arranging blood transfusions • Laboratory-only port draw (performed by nurse) • Ambulatory infusion pump paperwork • Discontinuing ambulatory pump	**Level II: 30-90 minutes. Nursing time: 45 minutes.** **2 Acuity Points** Includes but not limited to: • Port, line troubleshooting • Hydration with or without assessment • Administration of IV medication including pain, antibiotic & antiemetics • Phlebotomy • Platelet transfusion • Patient needing assistance (fall risk)
Level III: 1-2 hours. Nursing time: 60 minutes **3 Acuity Points** Includes but not limited to: • Chemotherapy lasting 1-2 hrs • Patient tx with symptom management or multiple needs • Patient and family education (cycle 1, day 1 chemotherapy)	**Level IV: 2-4 hours. Nursing time: 90 minutes** **4 Acuity Points** Includes but not limited to: • Chemotherapy lasting 4 hrs with multiple drugs • Blood products requiring frequent monitoring • Tx with high potential for allergic reaction • Patient needing fever/neutropenia work-up (with fluids, antibiotics, possible admission) • First tx on clinical trial requiring frequent monitoring
Level V: more than 4 hours. Nursing time: 180 minutes **5 Acuity Points** Includes but not limited to: • Complex chemotherapy lasting greater than 4 hours • Patient needing complex symptom management/possible admission • Intraperitoneal chemotherapy	**Daily Staffing Calculation** 1. Enter acuity from table 2. Add avg daily acuity for add-ons 10 3. Add 5 points for chemo order entry/scheduling 4. Add 2 points for NP or Pt Educ 5. Add items 1-4 for total acuity points 6. Divide by 18 (ideal acuity points/RN) 7. Result = number of RNs needed

In order to cover high-volume morning and chemo order entry activities, each day will begin with all available RNs on duty. To meet the calculated staffing level as determined by the Daily Staffing Calculation above, the appropriate number of RNs will take low-census time off in the afternoon.

9. **Patient Assignment**

The Charge RN will make assignments by examining Individual skills of available nurses and the patient's level of complexity. Continuity of care is an important consideration when making assignments.

Float nurses should be assigned to acuity level 1 when possible. To ensure treatment accuracy and patient safety, a two-RN check will be performed by chemotherapy/biotherapy trained nurses when performing post-chemo order entry and prior to administration of chemotherapy or biotherapy at patient chairside .

Attachments

No Attachments

Approval Signatures

Approver	Date
Mary Crawford: Exec Dir Operations	12/2021
Louise Dyjur: CNO St Mary Med Ctr	12/2021
Oliver Batson: Physician Medical Oncology	12/2021
Natasha Delano: Dir Cancer Center	12/2021

Applicability

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