Astria Sunnyside Nurse Staffing Plan Submission

Cover Page

The following is the nurse staffing plan for Astria Sunnyside Hospital, submitted to the Washington State Department of Health in accordance with Revised Code of Washington 70.41.420.

Attestation Form

I, the undersigned with responsibility for Astria Sunnyside Hospital attest that the attached staffing plan and matrix was developed in accordance with RCW 70.41.420 for 2022 and includes all units covered under our hospital license under RCW 70.41. This plan was developed with consideration given to the following elements:

- ✓ 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.

Brian Gibbons CEO approved this staffing plan on December 15/21 (date)

This staffing plan was reviewed and approved by all committee members and adopted by the hospital on: 12/15/2021 (date)

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 – ICU Status
- Exhibit B – Medical Surgical & Telemetry Medical Status
- Exhibit C – Emergency Department
- Exhibit D – Cath Lab
- Exhibit E – Wound care
- Exhibit F – Oncology Department
- Exhibit G– Surgical Department
- Exhibit H– Family Birth Center
- Exhibit I – Home Health & Hospice

Nurse Staffing Plan Critical Elements

The following represents critical elements about the nurse staffing plan:

- ✓ 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.

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 - ICU

INTENSIVE CARE UNIT SERVICES

Combination of ICU / Intermediate / Med-Surg status

ICU					
	0700-1930		1900-0730		
Census	**RN**	**NAC**	**RN**	**NAC**	**TOTAL staff**
7	3	1	3	1	8
6	3	1	3	1	8
5	3	1	3	1	8
4	2	1	2	1	6
3	2	1	2	0	5
2	2	0	2	0	4
1	2	0	2	0	4
0	1	0	1	0	2

***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-mixed of hospital staff**

- ICU patient is 2:1 patient:nurse ratio
- Intermediate status patients is 3:1 patient:nurse ratio
- Tele monitoring should be taken into consideration with acuity when making staffing decision

Exhibit B

MEDICAL & SURGICAL SERVICES

Combination of Med-Surg / Peds/ Tele / Intermediate status

MEDSURG							
	0700-1930			1930-0700			
	RN	RN/LPN	NAC	RN	RN/LPN	NAC	TOTAL STAFF
0	-		-	-		-	-
1	2		0	2		0	4
2	2		0	2		0	4
3	2		0	2		0	4
4	2		0	2		0	4
5	2		0	2		0	4
6	2		0	2		0	4
7	2		1	2		0	5
8	2		1	2		1	6
9	2		1	2		1	6
10	2		1	2		1	6
11	3		1	3		1	8
12	3		1	3		1	8
13	3		2	3		2	10
14	3		2	3		2	10
15	3		2	3		2	10
16	3	1	2	3		2	11
17	3	1	2	3		2	11
18	3	1	2	3		2	12
19	3	1	2	3	1	2	12
20	3	1	2	3	1	2	12

***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-mixed of hospital staff**

- Medical/Surgical patient to nurse ratio is 5:1 days, 6:1 nocs, 4:1 total care both days and nocs
- Intermediate patients to nurse ratio is 3:1 days and nocs
- Pediatric patient to nurse ratio is 4:1 on day shift, and 5:1 on noc shif

Exhibit C – Emergency Department							
Role	**0700-1930**	**0900 -1730**	**1100-2330**	**1400-0230**	**1500-2330**	**1700-0530**	**1900-0730**
RN	2	1	1	1	0	1	2
NAC	1	0	0	0	1	0	1
***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.**							

* Consider patient acuity, review with Charge RN before making staffing adjustments when possible

* Before sending staff home on –call, confirm there aren't unmet needs elsewhere in house with the House Supervisor

* If the acuity/ census does not support all available resources/positions listed above, flex according to match the demands of the patient needs/ care level

Exhibit D – Cath Lab					
Role	**Mon & Friday**	**Tue - Wed**	**24/7 on call**		
RN	2	3	1	Rn's work 10 hour shifts ** x 3 RN's	
Cath Lab Tech	2 (3 On Mon)	3	2	Tech's work a mix of 8 hr shifts 3 weeks out of the month, with 1 week of 10 hour shifts- to give them a break from call	
***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.**					

* The days of the week the staff have off when working 10 hours shifts may change due to covering vacations and time off, as well as meeting physician and patient needs.

Exhibit E – Wound Care 0800-1630

Wound care visits	RN	HBO tech	LPN	Receptionist	
1-8 NO HBO	1	0	0	1	
9 or > with NO HBO	1	0	1	1	
1-8 W/HBO	1	1	0	1	
9 or > W/HBO	1	1	1	1	

***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 F – Oncology 0800 - 1700					
Clinic Visit	RN	NAC / MA	Receptionist		
1-6 with NO CHEMO	1	1	1		
7 or more with NO CHEMO	2	1	1		
1-6 W/CHEMO	2	1	1		
6 or more W/ CHEMO	3	1	1		
***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.**					

There must be at least 1 RN even if there are no pts in order to provide phone triage

If the receptionist is out sick will need additional RN to provide services at front desk

Must be 2 RNs if there is any chemotherapy infusing in order double check process of chemotherapy

SPECIAL CONSIDERATIONS IN STAFFING

- IF HAVE BLOOD TRANSFUSION
- IF BMBX SCHEDULED
- IF CHEMOTHERAPY PATIENT REQUIRES TEACHING
- IF PATIENT IS 1ST TIME TREATMENT

DETERMINATOIN FACTORS FOR ACUITY TO BE CONSIDERED

- Level of risk of medication/chemotherapy/immunotherapy
- Current condition of patient
- How many medication/chemotherapy agents will be given including pre-medications 7 added "cushion" for time to allow for line access & lab processing
- The more complex a treatment regimen is the more time is required is the more time required to eliminate the chance of error

Exhibit G– ACU / PACU 0600-2030					
Role	Mon – Friday 0600 -2030	Weekend/Holiday Call 0700-1200	24/7 on call		
RN/LPN - ACU	6	1	0		
RN - PACU	2	0	1		
***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.**					

PACU /ACU

- ACU

Pre anesthesia Phase:

Staffing is adjusted up or down depending on # of 0730 start time cases, volume of surgical cases, PAT's and recur patients.

Post anesthesia Phase 2:

Staffing should reflect patient acuity and complexity of care. In general, a 1:3 nurse-patient ratio allows for appropriate assessment, planning, implementing care, and evaluation for discharge as well as increasing efficiency and flow of patients through Phase 2 area.

- PACU

Staffing should reflect patient acuity and complexity of care. In general, a 1:2 nurse-patient ratio in Phase 1 allows for appropriate assessment, planning, implementing, and evaluation for discharge as well as increased efficiency and flow of patients through Phase 1 area.

** Please refer to the ASPAN's Practice Recommendation 1 Patient Classification/ Staffing Recommendations for specifics 2019- 2020*** A copy of this is kept in ACU and PACU

Exhibit G– Operating Room					
Role	Mon – Fri	Call from end of shift until 7pm Mon - Thur	24/7 on call		
RN Circulator	1RN per OR, plus 1 for breaks and lunches – if more than 2 cases in 1 room	1	1		
Scrub Tech	5	1	1		
***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.**					

Family Birth Center Staffing Guidelines – Exhibit H

There will be 2 labor trained RN's in the hospital at all times or what AWHONN guidelines dictate for management of the acuity of labor patients on the floor. Staff may be floated to other departments if there is no patients on the floor. There will be 2 RN's on the floor if there is any patients present.

There will be 1 NAC/scrub depending on patient acuity levels. The NAC may be floated to another department. Scrubs that are floated to another department may need to respond to a c-section quickly.

C-section staffing: C-sections require a minimum of 1 RN. If the C-section circulator trained RN and scrub trained NAC are available and census on floor allows they could staff the C-section also.

Labor and Delivery Care:

1:1	Initial Triage: (this ration may change to 1 nurse to 2-3 observations as maternal/fetal status is determined to be stable until patient disposition)
1:3	Antepartum testing: NST and observations
1:3	Antepartum patients in stable condition
1:1	Antepartum patients who are unstable
1:1	Continuous bedside attendance for women receiving magnesium sulfate for the first hour of administration. No more than one additional couplet or woman for a nurse caring for a woman receiving IV magnesium sulfate in a maintenance dose
1:2	Cervical ripening with pharmacologic agents
1:1	Laboring patients with medical or obstetrical complications during labor
1:1	Laboring patient receiving oxytocin
1:1	Laboring with minimal to no pain relief or medical interventions
1:1	Labor being monitored via intermittent auscultation
1:1	Regional anesthesia: continuous bedside nursing attendance during initiation until condition is stable
1:2	Premature labor patients being stabilized on tocolytics
1:1	Patients in second stage, fetal distress, postpartum hemorrhage
2:1	Birth; one nurse responsible for the mother and one nurse for the baby
1:1	Initial postpartum recovery for at least 2 hours
1:1	Ill patients with complications
1:1	Initial C-section recovery for at least 2 hours
1:1	Circulating for C-section delivery

Mother Baby Care

1:2	Immediate postoperative day who are recovering from Cesarean birth as part of the nurse ratio of one nurse to 3 mother baby couplets
1:3-4	Recently born infants and those requiring close observation
1:3	Stable mother baby couplets
1:5-6	Postpartum patients without complications (no more that 2 to 3 women ont eh immediate postpartum day who are recovering from cesarean birth as part of the nurse to patient ration of one nurse to 5 or 6 women without complications
1:3	Postpartum patients with complications, but in stable condition
1:5-6	Newborns needing only routine care

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 I – Home Health and Hospice 0800 – 1700 MONDAY-FRIDAY													
RN	NAC	Receptionist	Office Manager	Scheduler	Intake	Billing Medical Records	MSW	Chaplain	PT	PTA	OT	COTA	ST
8	2	1	2	1	1	1	1	1	2	3	1	1	1
***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.**													

There must be at least 1 RN manger to assist with telephone triage during business hours and 1 RN on call from 1630-0800

If the receptionist is out sick additional office staff will cover

SPECIAL CONSIDERATIONS IN STAFFING

- Mileage
- Travel time
- Weather
- Patient change of condition

DETERMINATOIN FACTORS FOR ACUITY TO BE CONSIDERED

- Patient Visit type Admission to services will be longer visit along with any assessment that involves oasis collection
- Patient acuity level someone with wound vac or new picc or port may be longer visit then a regular repeat visit
- Patient with multiple co morbity