PUBLIC HEALTH DIVISION, Center for Health Protection
Health Care Regulation and Quality Improvement Section
Health Facility Licensing and Certification Program
Kate Brown, Governor

Survey & Certification Unit
800 NE Oregon Street, Suite 465
Portland, OR 97232
Voice: (971) 673-0540
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Nurse Staffing Report

Facility Name: Shriners Hospital for Children - Portland

Report Publication Date: October 6, 2017

Report Republication Date: May 11, 2018

DISCLAIMER: This report was provided to the hospital administrator and both co-chairs of the hospital-wide nurse staffing committee prior to publication.

The hospital submitted a Plan of Correction to address deficiencies cited in the report. The Plan of Correction has been approved by the Oregon Health Authority.

If you need this information in an alternate format,
please call our office at (971) 673-0540 or TTY 711.

Oregon Health Authority

Health Care Regulation and Quality Improvement
800 NE Oregon Street, Suite 465
Portland, Oregon 97232
971-673-0540
971-673-0556 (Fax)

July 11, 2017

Mr. Craig Patchin, Administrator
Shriners Hospital For Children-Portland
3101 SW Sam Jackson Park Road
Portland, OR 97239

RE: Nurse Staffing Survey

Dear Mr. Patchin:

On May 30, 2017 our office completed a nurse staffing survey at your facility. The survey revealed one or more violations of the Oregon Administrative Rules for Nurse Staffing Services.

Enclosed is the Report for that visit. You must complete and sign the Plan of Correction and return it to our office within **thirty (30) business days** of your receipt of this letter. Please keep a copy for your files. The Plan of Correction must include the following information for each deficiency cited:

1. A detailed description of how the hospital plans to correct the specific deficiency identified;
2. The procedure(s) for implementing the plan for the specific deficiency;
3. A timeline or date by which the hospital expects to implement the corrective actions;
4. The description of monitoring procedure(s) that the hospital will perform to prevent a recurrence of the specific deficiency identified; and
5. The title of the person who will be as responsible for implementing the corrective actions described.

Please note that the hospital administrator's signature and the date signed must be recorded on Page 1 of the Report/Plan of Correction form.

If you have any questions you may contact our office at (971) 673-0540.

Sincerely,

Annabelle Henry, for
Karyn Thrapp, RN, BSN
Patient Safety Surveyor
CMS Representative
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

Enclosures

CC: Nurse staffing committee Direct Care RN co-chair
Nurse staffing committee Nurse Manager co-chair

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	14-0073	A. BUILDING: _____ B. WING _____	05/30/2017

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E 000	Initial Comments This report reflects the findings of a full nurse staffing survey that was initiated onsite on 05/15/2017 and concluded with a telephone exit conference on 05/30/2017. The hospital was evaluated for compliance with the Oregon Administrative Rules for hospital Nursing Services Staffing set forth in OAR Chapter 333, Division 510. The deficiencies identified during the survey follow in this report. The following abbreviations, acronyms, and definitions may be used: AORN - Association of periOperative Registered Nurses ASPAN - American Society of PeriAnesthesia Nurses CMA - Certified Medical Assistant (not a NSM) CNA - Certified Nursing Assistant CNO - Chief Nursing Officer hr./ hrs. - hour/hours INPT - Inpatient unit MOT - Mandatory Overtime NSC - Nurse Staffing Committee NSM - Nursing Staff Member NSP - Nurse Staffing Plan PACU - Post-Anesthesia Recovery Unit OPC - Outpatient Clinic OR - Operating Room OT - Overtime RN - Registered Nurse SS - Surgical Services including pre-op, operative, and post-op	E 000		
E 602	OAR 333-510-0045 (2) Anti-Retaliation Notice (2) A hospital shall also post an anti-retaliation notice on the premises that:	E 602		

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E 602	Continued From page 1 (a) Summarizes the provisions of ORS 441.181, 441.183, 441.184 and 441.192; (b) Is clearly visible; and (c) Is posted where notices to employees and applicants for employment are customarily displayed. Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185 Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185 This Rule is not met as evidenced by: Based on observation and interview it was determined the hospital failed to ensure it posted the anti-retaliation notice in places where applicants for employment would be likely to view and read it. Findings include: 1. During tour of the hospital on 05/17/2017 beginning at 1700 there were no observations of the anti-retaliation notice posted where applicants for employment would be likely to view it. The notice was posted in areas only accessible to current hospital staff. 2. During interview with the Chief Nursing Officer on 05/30/2017 at 1615 he/she stated that applicants for employment generally apply online and do not come into the hospital to apply for jobs. He/she stated that the anti-retaliation notice was not posted electronically on the hospital's jobs website where applicants for employment would electronically apply for positions.	E 602		

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E 604	OAR 333-510-0045 (3) Nurse Staffing Documentation (3) A hospital shall keep and maintain all records necessary to demonstrate compliance with ORS 441.152 to 441.177. These records shall: (a) Be maintained for no fewer than three years; (b) Be promptly provided to the Authority upon request; and (c) Include, at minimum: (A) The staffing plan; (B) The hospital nurse staffing committee charter; (C) Staffing committee meeting minutes; (D) Documentation showing how all members of the staffing committee were selected; (E) All complaints filed with the staffing committee; (F) Personnel files for all nursing staff positions that include, at minimum, job descriptions, required licensure and specialized qualifications and competencies required for the individual ' s assigned nurse specialty or unit; (G) Documentation showing work schedules for nursing staff in each hospital nurse specialty or unit; (H) Documentation showing actual hours worked by all nursing staff; (I) Documentation showing all work schedule variances that resulted in the use of replacement nursing staff; (J) Documentation showing how many on-call hours, if any, required nursing staff to be on the hospital premises; (K) Documentation showing how many required meeting, education and training hours, if any, were required of nursing staff; (L) The hospital's mandatory overtime policy and procedure; (M) Documentation showing how many, if any, overtime hours were worked by nursing staff;	E 604		

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E 604	Continued From page 3 (N) Documentation of all waiver requests, if any, submitted to the Authority; (O) Documentation showing how many, if any, additional hours were worked due to emergency circumstances and the nature of those circumstances; (P) The list of on-call nursing staff used to obtain replacement nursing staff; (Q) Documentation showing how and when the hospital updates its list of on-call staff used to obtain replacement nursing staff and how the hospital determines eligibility to remain on the list; (R) Documentation showing the hospital's procedures for obtaining replacement nursing staff, including efforts made to obtain replacement staff; (S) Documentation showing the hospital's actual efforts to seek replacement staff when needed; (T) Documentation showing each actual instance in which the hospital implemented the policy described in OAR 333-510-0110(2)(g) to initiate limitations on admission or diversion of patients to another hospital; and (U) All staffing committee reports filed with the hospital administration following a review of the staffing plan. Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185 Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185 This Rule is not met as evidenced by: Based on interview, review of NSP, and review of NSM personnel records, it was determined that the hospital failed to maintain documentation showing: * Specialized qualifications and competencies for	E 604		

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E 604	Continued From page 4 NSMs as required by subsection (c)(F); and * Efforts to seek replacement staff (c)(S). Findings include: 1. Refer to the findings identified under Tag E630, OAR 333-510-0110(2)(a) that reflect the lack of documentation of competencies and other requirements for NSMs. 2. Refer to the findings identified under Tag E660, OAR 333-510-0125(3), that reflect the lack of documentation of attempts to obtain replacement staff on the SS unit.	E 604		
E 620	OAR 333-510-0105 (6) Nurse Staffing Committee Req. (6) The staffing committee must develop a written charter that documents the policies and procedures of the staffing committee. At minimum, the charter must include: (a) How meetings are scheduled; (b) How members are notified of meetings; (c) How agendas are determined; (d) How input from hospital nurse specialty or unit staff is submitted; (e) Who may participate in decision-making; (f) How decisions are made; and (g) How the staffing committee shall monitor, evaluate and modify the staffing plan over time. Stat. Auth.: ORS 413.042, 441.151 & 441.154 Stats. Implemented: ORS 441.154 This Rule is not met as evidenced by: Based on interview and review of the NSC charter	E 620		

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E 620	Continued From page 5 it was determined that the hospital failed to ensure the NSC charter was current, accurate, and included or clearly stipulated the following: * How members are notified of meetings; and * How agendas are determined. Findings include: 1. The "Shriners Hospital for Children - Portland Nurse Staffing Committee Charter," date as last revised 01/01/2016, was reviewed. a. The charter contained inaccurate and/or inconsistent information. For example * Under "Purpose" it referred to OAR 333-510-0045 as the source of the requirement for a nurse staffing committee; * Under "Responsibilities of the Membership in this Committee" it referred to the Committee Chair; * Under "Meeting Dates and Times" it referred to "either co-chair" and * Under "Responsibilities of the Membership in this Committee" it referred to primary members asking an "alternate" to attend, without specifying a selection process for alternates. b. The charter did not clearly stipulate how members are notified of meetings. In setting times for meetings it stated that the "Meeting is on the 1st Monday for the month from 3:00-4:00." The charter also stated that the the NSC "Must meet quarterly and at any time and place specified by either co-chair." c. The charter did not clearly stipulate how agendas were determined. There was no referrence to agendas or agenda items in the charter.	E 620		

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E 620	Continued From page 6 2. During interviews with the CNO and the Nurse Manager co-chair on 05/15/2017 at 1630 they acknowledged that there were required elements of the charter that were unmet.	E 620		
E 622	OAR 333-510-0105 (7) Nurse Staffing Committee Req. (7) Staffing committee meetings must be conducted as follows: (a) A meeting may not be conducted unless a quorum of staffing committee members is present; (b) Except as set forth in subsection (c) of this section, a meeting must be open to all hospital nursing staff as observers and to any other individual as either observer or presenter by invitation of either co-chair of the staffing committee; (c) Either co-chair of the staffing committee may temporarily exclude all non-members from a meeting during staffing committee deliberations and voting; and (d) Each staffing committee decision must be made by majority vote; however, if a quorum consists of an unequal number of hospital nurse managers and direct care staff, only an equal number of hospital nurse managers and direct care staff may vote. Stat. Auth.: ORS 413.042, 441.151 & 441.154 Stats. Implemented: ORS 441.154 This Rule is not met as evidenced by: Based on interview and review of NSC meeting minutes for the last 12 months it was determined	E 622		

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E 622	Continued From page 7 that the hospital failed to ensure that the NSC conducted business in accordance with this rule: * There was no assurance that an equal number of nurse managers and direct care staff had participated in voting. Findings include: 1. The NSC meeting minutes provided for the last 12 months were dated: 05/02/2016; 08/01/2016; 08/29/2016; 11/07/2016; and 03/06/2017. 2. NSC meeting minutes dated 08/01/2016 were reviewed. The attendance roster reflected seven individuals were present including four nurse manager members and three direct care members. The minutes reflect that "May meeting minutes...reviewed and approved ...All." There was no documentation to reflect how the approval was determined nor who in attendance participated in the decision to ensure that only an equal number of hospital nurse managers and direct care RNs voted. During interview with the CNO and Nurse Manager co-chair on 05/16/2017 at 1015 they confirmed that decisions were made by an unequal number of nurse managers and direct care staff. 3. NSC meeting minutes dated 08/29/2016 were reviewed. The attendance roster reflected seven individuals were present including four nurse manager members and three direct care members. The minutes reflect that "August 1st meeting minutes...reviewed and approved ...All." There was no documentation to reflect how the approval was determined nor who in attendance participated in the decision to ensure that only an equal number of hospital nurse managers and	E 622		

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E 622	Continued From page 8 direct care RNs voted. During interview with the CNO and Nurse Manager co-chair on 05/16/2017 at 1015 they confirmed that decisions were made by an unequal number of nurse managers and direct care staff. 4. NSC meeting minutes dated 03/06/2017 were reviewed. The attendance roster reflected seven individuals were present including four nurse manager members and three direct care members. The minutes reflect that "Review and Approval of Minutes ... Reviewed ... Approved ... 7/0" Documentation reflected that an unequal number of nurse managers and direct care RNs voted. During interview with the CNO and Nurse Manager co-chair on 05/16/2017 at 1015 they confirmed that decisions were made by an unequal number of nurse managers and direct care staff.	E 622		
E 628	OAR 333-510-0110 (1) Nurse Staffing Plan Req. (1) Each hospital shall implement a written hospital-wide staffing plan for nursing services that is developed and approved by the hospital nurse staffing committee established in accordance with ORS 441.154 and OAR chapter 333 division 510 rules. Stat. Auth.: ORS 413.042 & 441.155 Stats. Implemented: ORS 441.155 This Rule is not met as evidenced by:	E 628		

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E 628	Continued From page 9 Based on interview, review of NSC documentation, review of NSP documentation for 3 of 3 units (INPT, OPC, and SS), and NSC email vote documentation, it was determined that the hospital failed to implement a hospital-wide NSP developed and approved by the NSC in accordance with these rules: * The NSP did not reflect all elements required for consideration and inclusion in the NSP; and * There was no evidence to reflect that the current NSP had been approved by the NSC. Findings include: 1. Review of the current NSP for the INPT, OPC and SS units revealed there was no documentation to reflect that the NSP had been approved by the NSC. There were no approval dates recorded on the NSP. 2. Review of the NSC meeting minutes for the last 12 months revealed no documentation to reflect that the NSP for the INPT, OPC and SS specialties or units had been approved by the NSC. 3. During interview with the CNO and NSC nurse manager co-chair on 05/16/2017 beginning at 1150, it was confirmed that the NSP had not been approved by the NSC during a regular NSC meeting. They indicated that a vote was conducted by email. Review of these internal emails with the CNO and NSC nurse manager co-chair reflected that four nurse manager NSC members and three direct care staff NSC members voted to approve the NSP in March 2017 and May 2017. However, the emails also established that there were not an equal number of nurse manager members and direct care staff members required for decision-making.	E 628		

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E 628	Continued From page 10 4. In NSM interviews completed between 05/15/2017 and 05/20/2017, 19 of 23 NSMs indicated that they had not participated in NSP development. 5. Refer to the findings identified under Tags E630, E632, E634, E636, E638, E640, E642, E644, and E646, OAR 333-510-0110(2)(a)-(h), that reflect the NSP did not reflect evidence that all required elements had been considered or included for the INPT, OPC and SS units.	E 628		
E 630	OAR 333-510-0110 (2)(a) Nurse Staffing Plan Req (2) The staffing plan: (a) Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients; Stat. Auth.: ORS 413.042 & 441.155 Stats. Implemented: ORS 441.155 This Rule is not met as evidenced by: Based on interview, review of NSP documentation for 3 of 3 units (INPT, OPC, and SS), review of documentation in 4 of 14 INPT, OPC and SS NSM personnel records (NSMs 11, 17, 18, and 19), and review of job descriptions it was determined that the hospital failed to ensure that a hospital-wide NSP was developed based	E 630		

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E 630	Continued From page 11 on the specialized qualifications and competencies of the nursing staff and was implemented to ensure all staff demonstrated the required competencies necessary to ensure that patients needs were met. Findings include: 1. Review of the INPT section of NSP dated "2017" reflected it did not specify required competencies or reference documents in which competencies were identified. The NSP reflected only NSMs were "expected to exceed competency requirements." * Review of personnel records for INPT RN NSM 11 reflected a lack of documentation of traction, cast removal, and venipuncture competencies as required by the RN job descrition. 2. Review of the SS section of NSP dated "2017" reflected that it did not specify all required competences or reference documents in which competencies were identified. The NSP reflected that NSMs were expected to "meet competency requirements ... including but not limited to the management of pain, post-operative nausea and vomiting, and thermoregulation..." However, there was a lack of specificity about the competencies needed by NSMs to ensure patient needs were met. * Review of personnel records for SS RN NSM 19 reflected a lack of documentation of cell saver, arterial line and tourniquet competences required by the RN PACU job description * In addition for NSM 19 the "Peri-operative ... Competency Tool" lacked documentation that competencies required by the tool were demonstrated. Those included, but were not limited to: blood administration, urinary bladder catheterization, chest tube care, and IV access.	E 630		

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E 630	Continued From page 12 There were a total of 28 competency items that did not reflect that the required competency had been demonstrated. 3. Similar findings were identified in the OPC section of NSP and personnel records for NSMs 17 and 18. 4. During interviews with the CNO and Unit Nurse Managers on 05/17/2017 beginning at 1310 and on 05/18/2017 beginning at 0945 they acknowledged and confirmed that competency documentation was not complete and that NSM job descriptions did not accurately reflect all competency requirements.	E 630		
E 632	OAR 333-510-0110 (2) (b) Nurse Staffing Plan Req. (2) The staffing plan: (b) Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit; This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 3 of 3 units (INPT, OPC and SS), it was determined that the hospital failed to implement a hospital-wide NSP that was developed based on measurements of unit activity that quantified the rate of admissions, discharges and transfers for each unit and the	E 632		

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SHRINERS HOSPITAL FOR CHILDREN-PORTL	3101 SW SAM JACKSON PARK ROAD PORTLAND, OR 97239

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E 632	Continued From page 13 time required for a direct care RN to complete those tasks. Findings include: 1. Review of the NSP dated "2017" revealed a lack of measurements of the rates of patient admissions, discharges and transfers and the times required for direct care RNs to complete those tasks. 2. During interviews with the CNO and Unit Nurse Managers on 05/16/2017 beginning at 1150 and on 05/17/2017 beginning at 1115 they confirmed that the NSP lacked the information identified in the finding above.	E 632		
E 634	OAR 333-510-0110 (2) (c) Nurse Staffing Plan Req. (2) The staffing plan: (c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses; This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 3 of 3 units (INPT, OPC and SS), it was determined that the hospital failed to implement a hospital-wide NSP that was developed based on total diagnoses for each unit and the nursing staff required to manage those diagnoses. Findings include:	E 634		

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E 634	Continued From page 14 1. Review of the NSP revealed a lack of information related to the total diagnoses for each unit and the nursing staff required to manage those diagnoses. * The NSP referenced only that the INPT "provides family-centered care to pediatric surgical patients (infants to young adults) that require inpatient care by a nurse during the immediate post-op period or for complex medical conditions related to their surgical intervention." * The NSP referenced only that the OPC "Provides quality family-centered care, which includes a multidisciplinary approach, to children with specialty healthcare conditions through evaluation of their needs, appropriate teaching and expert care in the ambulatory setting (local and outreach clinics)." 2. During interviews with the CNO and Unit Nurse Managers on 05/16/2017 beginning at 1150 and on 05/17/2017 beginning at 1115 they confirmed that the NSP lacked the information identified in the finding above.	E 634		
E 636	OAR 333-510-0110 (2) (d) Nurse Staffing Plan Req. (2) The staffing plan: (d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN);	E 636		

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E 636	Continued From page 15 This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 3 of 3 units (INPT, OPC and SS), it was determined that the hospital failed to implement a hospital-wide NSP that was developed to reflect for each unit consistency with current, nationally-recognized standards and guidelines established by professional nursing specialty organizations. Findings include: 1. Review of the NSP reflected that although it referenced professional nursing specialty organizations, there was a lack of documentation of the year or version of the standards and guidelines used. 2. During interviews with the CNO and Unit Nurse Managers on 05/16/2017 beginning at 1150 and on 05/17/2017 beginning at 1115 they confirmed that the NSP lacked the information identified in the finding above.	E 636		
E 638	OAR 333-510-0110 (2) (e) Nurse Staffing Plan Req. (2) The staffing plan: (e) Must recognize differences in patient acuity and nursing care intensity;	E 638		

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E 638	Continued From page 16 This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 2 of 3 units (OPC and SS), it was determined that the hospital failed to implement a hospital-wide NSP that recognized differences in patient acuity and nursing care intensity. Findings include: 1. Review of the NSP revealed no references to patient acuity or nursing intensity for the OPC and SS units. 2. During interviews with the CNO and Unit Nurse Managers on 05/16/2017 beginning at 1150 and on 05/17/2017 beginning at 1115 they confirmed that the NSP lacked the information identified in the finding above.	E 638		
E 640	OAR 333-510-0110 (2) (f) Nurse Staffing Plan Req. (2) The staffing plan: (f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts...	E 640		

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E 640	Continued From page 17 This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 2 of 3 units (OPC and SS), it was determined that the hospital failed to implement a hospital-wide NSP that established minimum numbers of nursing staff required on specified shifts. Findings include: 1. Review of the NSP revealed that it did not clearly establish the number of NSMs required for shifts in the OPC unit. * NSP stated "each clinic will have at least one RN or one CMA assigned." A CMA as used in the OPC is a Certified Medical Assistant and is not a NSM as defined in these rules. * NSP stated "Minimum Staffing: One RN will staff the OPC minimally during normal business hours." 2. Review of NSP for SS unit revealed that it did not clearly establish the number of NSMs required for shifts in the SS unit. * NSP stated "Two competent staff, one of who [sic] is an RN competent to provide Phase I post-anesthesia nursing, are present whenever a patient is receiving phase one level of care." * NSP stated "1900-last patient out - RN call team, comprised of a minimum of two competent staff, one of whom is competent to deliver Phase I care." * NSP does not define "competent staff" or otherwise indicate whether "competent staff" are all NSMs. 3. During interviews with the CNO and Unit Nurse Managers on 05/16/2017 beginning at 1150 and on 05/17/2017 beginning at 1115 they confirmed	E 640		

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E 640	Continued From page 18 that the NSP lacked the information identified in the finding above.	E 640		
E 642	OAR 333-510-0110 (2)(f) Nurse Staffing Plan Requirements (2) The staffing plan: (f) Must provide that no fewer than one registered nurse and one other nursing staff member is on duty in a unit when a patient is present; This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 1 of 3 units (OPC), it was determined that the hospital failed to implement a hospital-wide NSP that ensured no fewer than one RN and one other NSM be on duty in a unit when a patient is present. Findings include: 1. Review of the NSP dated "2017" for OPC reflects "Minimum Staffing: one RN will staff the OPC minimally during normal business hours." 2. During interviews with the CNO and OPC Nurse Manager on 05/17/2017 beginning at 1115 the nurse manager stated that on Fridays the OPC is generally staffed with only one RN and no	E 642		

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E 642	Continued From page 19 other NSM.	E 642		
E 644	OAR 333-510-0110 (2) (g) Nurse Staffing Plan Req. (2) The staffing plan: (g) Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgment of a direct care registered nurse or a nurse manager, there is an inability to meet patient care needs or a risk of harm to patients; This Rule is not met as evidenced by: Based on interview and review of NSP documentation for 2 of 3 units (INPT and SS) and review of Nurse Staffing Policies and Procedures, it was determined that the hospital failed to implement a hospital-wide NSP that included a formal process for evaluating and initiating limitations on admission or diversion that allowed for any direct care RN or nurse manager to initiate the process. Findings include: 1. Review of the NSP dated "2017" reflected that for INPT unit "planned elective admissions may be cancelled ... if those projected admissions are not able to be safely staffed." There was no documentation to provide that a direct care RN could initiate that process. 2. Review of the NSP dated "2017" for SS unit reflected "planned elective admissions may be cancelled ... if those projected admissions are not	E 644		

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E 644	Continued From page 20 able to be safely staffed." There was no documentation to provide that a direct care RN could initiate that process. 3. Review of Policy and Procedure titled "Plan for Patient Care Services" dated "4/2016" reflected "In the event of a lack of staffing" services may be cancelled. There was no provision for a direct care RN or nurse manager to initiate that process. It was not clear how the process would be initialized and who could initiate it. 4. In NSM interviews completed between 05/15/2017 and 05/20/2017, 15 of 23 NSMs indicated they did not know the hospital's or unit's policy for evaluating and initiating limitations on admissions or divert status. 5. In NSM interviews completed between 05/15/2017 and 05/20/2017, 18 of 23 NSMs indicated that they didn't know what their role was or that they had no role in the process of evaluating and initiating limitations on admission or diversion.	E 644		
E 646	OAR 333-510-0110 (2) (h) Nurse Staffing Plan Req. (2) The staffing plan: (h) Must consider tasks not related to providing direct care, including meal breaks and rest breaks; This Rule is not met as evidenced by: Based on interview, review of NSP documentation for 3 of 3 units (INPT, OPC and	E 646		

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E 646	Continued From page 21 SS), review of documentation in 1 of 6 INPT NSM timekeeping records (NSM 10), and review of the INPT Overtime Log, it was determined that the hospital failed to implement a hospital-wide NSP that was developed to consider for each unit meal breaks, rest breaks, and other tasks not related to direct patient care. The NSP did not provide for additional NSMs to maintain the staffing ratios required in the NSP during these breaks, creating the possibility that the units did not meet minimum staffing required for the duration of NSM breaks. Findings include: 1. Review of the NSP dated "2017" revealed no consideration of NSM meal breaks, rest breaks, and other tasks not related to direct patient care. The NSP "Staffing plan requirements" which listed considerations in formulating the NSP did not list consideration of meal breaks, rest breaks, or other tasks not related to direct patient care. 2. Review of NSM timekeeping records with the CNO and Unit Nurse Manager reflected that INPT NSM 10 missed a meal break on 02/11/2017; 3. Review of the INPT unit Overtime Log for January 2017 through 05/18/2017 reflected INPT NSMs did not take meal breaks on approximately 21 occasions. For example, on 04/01/2017 NSM 13 wrote in the log "2 RNs - unable to leave unit for break." 4. In NSM interviews completed between 05/15/2017 and 05/20/2017, 13 of 23 NSMs indicated that in the past year they had experienced one or more occasions where they missed breaks and meals because there was not sufficient staff to cover that time.	E 646		

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E 646	Continued From page 22 5. In NSM interviews completed between 05/15/2017 and 05/20/2017, 13 of 23 NSMs indicated that in the past year there were occassions where NSMs covered each others' assignments in addition to their own so that NSMs could take meal and rest breaks. 6. During interviews with the CNO and Unit Nurse Managers on 05/16/2017 beginning at 1150 and on 05/17/2017 beginning at 1115 they confirmed that the NSP lacked the information identified in the finding above.	E 646		
E 660	OAR 333-510-0125 (3) Replacement Nurse Staffing Req. (3) When a hospital learns about the need for replacement nursing staff, the hospital must make every reasonable effort to obtain adequate voluntary replacement nursing staff for unfilled hours or shifts before requiring a nursing staff member to work overtime and these efforts must be documented. Reasonable efforts include, but are not limited to: (a) The hospital seeking replacement nursing staff at the time the vacancy is known; and (b) The hospital contacting all available resources on its list of on-call nursing staff as described in this rule. Stat. Auth.: ORS 413.042, 441.155 & 441.166 Stats. Implemented: ORS 441.155 & 441.166 Hist.: PH 22-2016, f. & cert. ef. 7-1-16	E 660		

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E 660	Continued From page 23 This Rule is not met as evidenced by: Based on interview, and review of the SS unit work schedules and daily assignment documentation it was determined that the hospital failed to ensure that replacement staff was obtained for an unfilled shift in the SS unit. Findings include: 1. Review of the SS unit staffing documentation for 03/15/2017 reflected a NSM sick call for that date was received prior to the beginning of the surgical services operations for that date. There was no documentation to reflect efforts to obtain replacement staff and the documentation reflected the unfilled shift remained unfilled. 2. During interview with the SS unit Nurse Managers on 05/16/2017 beginning at 1500 he/she stated that there were no systems for documentation of attempts to find replacement staff in that unit. The manager stated that they had never documented those efforts.	E 660		
E 665	OAR 333-510-0130 (1)- (7) Nurse Staffing Member Overtime (1) For purposes of this rule "require" means to make compulsory as a condition of employment whether as a result of a previously scheduled shift or hours actually worked during time spent on call or on standby. (2) A hospital may not require a nursing staff member to work: (a) Beyond the agreed-upon and prearranged shift, regardless of the length of the shift; (b) More than 48 hours in any hospital-defined	E 665		

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E 665	Continued From page 24 work week; (c) More than 12 hours in a 24-hour period; (d) During the 10-hour period immediately following the 12th hour worked during a 24-hour period. This work period begins when the nursing staff member begins a shift; or (e) During the 10-hour period immediately following any agreed-upon and prearranged shift in which the nurse worked more than 12 hours in a 24-hour period. (3) Time spent by the nursing staff member in required meetings or receiving education or training shall be included as hours worked for the purpose of section (2) of this rule. (4) Time spent on call or on standby when the nursing staff member is required to be at the hospital shall be included as hours worked for the purpose of section (2) of this rule. (5) Time spent on call or on standby when the nursing staff member is not required to be at the hospital may not be included as hours worked for the purpose of section (2) of this rule. (6) Nothing in this rule precludes a nursing staff member from volunteering to work overtime. (7) A hospital may require an additional hour of work beyond the hours authorized in section (2) of this rule if: (a) A staff vacancy for the next shift becomes known at the end of the current shift; or (b) There is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another nursing staff member. This Rule is not met as evidenced by: Based on interview and review of timekeeping documentation for 4 of 18 SS and OPC NSMs	E 665		

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E 665	Continued From page 25 (NSMs 1, 2, 16 and 17), it was determined that the hospital failed to ensure that NSMs were not required to work: * Beyond the agreed-upon and prearranged shift; * More than 12 hours in a 24-hr. period; and * During the 10-hour period immediately following the 12th hour worked during a 24-hr. period. Findings include: 1. Review of SS NSM 1's timekeeping record for the week of 02/05/2017 at 0000 through 02/11/2017 at 2359 reflected he/she regularly worked an 8 hour shift. It reflected that he/she worked 8.75 hours on 02/06/2017; 11 hours on 02/07/2017; 10.5 hours on 02/08/2017; and 8.75 hours on 02/09/2017. There was no documentation to indicate whether the time worked in excess of 8 hours each day was voluntary or MOT. 2. Review of SS NSM 2's timekeeping record for the week of 03/12/2017 at 0000 through 03/18/2017 at 2359 reflected he/she regularly worked an 8 hour shift. It reflected that on 03/16/2017 he/she worked from 1100 to 1930 and on 03/17/2017 he/she returned to work from 0515 to 1615. During the 24 hour period beginning on 03/16/2017 at 1100 he/she had worked his/her 12th hour on 03/17/2017 at 0915. There was no documentation to indicate whether the time worked in excess of 12 hours in a 24 hour period was voluntary or MOT or that the NSM had declined the 10-hour rest period immediately following the 12th hour he/she worked. 3. Review of SS NSM 16's timekeeping record for the week of 03/12/2017 at 0000 through 03/18/2017 at 2359 reflected he/she regularly worked an 8 hour shift. It reflected that he/she	E 665		

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E 665	Continued From page 26 worked 9 hours on 03/13/2017. There was no documentation to indicate whether the time worked in excess of 8 hours each day was voluntary or MOT. 4. Similar findings were identified in the timekeeping record for OPC NSM 17. 5. During an interview with the SS Nurse Manager on 05/17/2017 beginning at 0930 the manager confirmed that there was no documentation to indicate whether the OT worked by NSMs 1 and 2 was voluntary or MOT. During an interview with the OPC Nurse Manager on 05/17/2017 beginning at 1200 the manager confirmed that there was no documentation to indicate whether the OT worked by NSMs 16 and 17 was voluntary or MOT.	E 665		

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May 8, 2018

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3101 SW Sam Jackson Park Road
Portland, OR 97239

RE: POC Determination Letter for Nursing Staffing Survey – POC Sufficient

Dear Ms. Reid, Ms. Wecker, and Ms. Scott:

This letter provides notification that your plan of correction (POC), in response to deficiencies cited during the nurse staffing survey completed on May 30, 2017 has been received, reviewed, and accepted by the Public Health Division, Oregon Health Authority, Health Care Regulation and Quality Improvement.

In accordance with the requirements of Oregon Administrative Rule 333-501-0035(7) the hospital must implement the corrections within 45 business days after receiving the Oregon Health Authority's determination that the POC is sufficient. Surveyors will conduct a revisit to verify that the POC has been implemented within 60 business days.

Thank you for your attention to this matter. If you have any questions, please contact our office at mailbox.hclc@state.or.us.

Sincerely,

Nurse Staffing Survey Team
Oregon Health Authority
Public Health Division
Health Care Regulation and Quality Improvement

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY 711

Shriners Hospital for Children - Portland
Nurse Staffing Survey Response Plan of Correction
March, 2018

Legend:

- IPU = Inpatient Unit
- OPC = Outpatient Clinic
- SS = Surgical Services
- Departments = IPU, OPC, SS

1. **Regulation#/Topic: OAR 333-510-0045(2) E 602/ Anti-Retaliation Notice**
   A. Deficiency?
      a. No notice posted where applicants can see it (on-line)
   B. What happened?
      a. It wasn't clear to us that the anti-retaliation notice needed to be available to applicants in all forms of application.
   C. How are we correcting it?
      a. Human Resources (HR) is now posting the Anti-Retaliation document in both the HR department (if an applicant comes in to fill out an application) and within our on-line job postings/applications. HR was directed to attach the link to an Anti-Retaliation Notice with a link to ORS 441.181-441.192 (attached) on every nursing position posted by Shriners Hospital for Children-Portland.
      b. A paper copy is also posted in human resources for any walk in applicant.
   D. Who is responsible?
      a. Nurse Executive
   E. When will it be corrected?
      a. 45 days after OHA approval of our Plan of correction.
   F. How are we monitoring it?
      a. On the first Monday of each month the Nurse Executive will check all nursing job postings for the anti-retaliation notice and email each patient care manager to verify that their anti-retaliation notices are posted in their designated staffing areas monthly. It will be reported and recorded in our nurse staffing committee. We are currently compliant.

2. **Regulation#/Topic: OAR 333-510-0110(2)(a) E 604/Nurse Staffing Documentation**
   A. Deficiency?
      a. Lack of documentation of staff's specialized qualifications/ competencies
   B. What happened?
      a. We have always had competencies, which were referred to in the NSP in the past; but we did not think we needed to include all of the competencies documents in the NSP.
      b. The initial orientation competencies were not well organized; our previous Nurse Educator kept most of them in her office, which made it difficult for the managers to have visibility of what was outstanding. We had several competency files that were not complete.
      c. Our annual competencies were also poorly organized and tracked by our previous Nurse Educator.

C. How are we correcting it?
   a. All of the competency documents are now in the NSP (attached).
   b. We developed Staffing Matrices for each department to identify staff that are competent in select skills for the purpose of making assignments (see NSP).
   c. Monthly, we audit all staff's competency documents to complete all competencies that had not been verified.
   d. A new process has been developed to manage new-hire competencies, including bi-monthly meetings between manager, preceptor, and new hire until orientation is complete. Any competencies not completed by the end of the orientation period due to lack of opportunity will be flagged and followed-up with employee monthly and documented until all competencies are completed.
   e. Our new Nurse Educator has revised our annual competency program. Annual competencies are determined by position and department. Competencies common to all departments are organized and recorded by the Nurse Educator; they are posted in an on-line spreadsheet.

D. Who is responsible?
   a. The managers of IPU, OPC and SS are responsible for developing their department's initial orientation program and competencies and to ensure that the employee's competencies are completed by the end of their orientation, or have a plan to complete the infrequently seen competencies prior to allowing the employee to independently perform those skills.
   b. The managers of IPU, OPC and SS are responsible to work with the Nurse Educator regarding the development of "common" annual competencies and to ensure that their staff have completed them by the end of each year. The Nurse Educator is responsible for posting the completed "common'' competencies.
   c. The managers of IPU, OPC and SS are responsible for developing their department's annual competencies and ensuring that their employees complete them by the end of the year.

E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.

F. How are we monitoring it?
   a. The IPU, OPC and SS managers follow a new process that has been developed to manage new-hire competencies, including bi-monthly meetings between manager, preceptor, and new hire until orientation is complete. Any competencies not completed by the end of the orientation period due to lack of opportunity will be flagged and followed-up with employee monthly and documented until all competencies are completed. This will also be reported in the end-of-the-year annual report.
   b. The Nurse Executive will review the completion of nursing staff's annual competencies and hold managers accountable for the completions. This will also be reported in the end-of-the-year annual report.

3. Regulation#/Topic: OAR 333-510-0125(3) E 604/Nurse Staffing Documentation

A. Deficiency?
   a. Lack of documentation of attempts to obtain replacement staff on the SS Unit

B. What happened?
   a. SS Manager did not understand that he needed to keep a written log of attempts to replace staff

C. How are we correcting it?

a. We now have a "Nurse Staffing Plan Absence Tracking" log in the NSP and the charge nurse will document absences and attempts for replacement.

D. Who is responsible?
   a. SS Manager
E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.
F. How are we monitoring it?
   a. SS manager will monitor use of tools by the charge nurses monthly.

4. Regulation#/Topic: OAR 333-510-0105(7) E 622/Nurse Staffing Committee Requirements

A. Deficiency?
   a. An unequal number of nurse managers and direct care staff participated in voting
B. What happened?
   a. When we had had voting in the past, we always had an unanimous vote, so it didn't occur to us that we needed to sit someone out if we didn't have equal numbers of staff/managers.
C. How are we correcting it?
   a. We have revised our Nurse Staffing Committee Agenda to 'force' us to identify who is present and who will be voting to ensure an equal number of staff and managers will be voting. We will establish the quorum and voting staff at the beginning of each meeting.
D. Who is responsible?
   a. Nurse Staffing Committee Co-Chairs
E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.
F. How are we monitoring it?
   a. It will be prompted in the agenda and reflected in the meeting minutes

5. Regulation#/Topic: OAR 333-510-0110(1) E 628/Nurse Staffing Plan Requirements

A. Deficiency?
   a. The hospital failed to implement a hospital-wide NSP developed and approved by the Nurse Staffing Committee
   b. 19 of 23 nurse staff members indicated that they had not participated in the NSP development
B. What happened?
   a. We made some changes to the Staffing Plan in March 2017, and sent it out to the members to review and vote on-line. We did not get votes returned in a timely manner and when OHA arrived in May 2017, we had just completed the approval process prior to their arrival.
   b. We were not aware that each individual staff member needed to participate in the development of the NSP.
C. How are we correcting it?
   a. The nurse staffing plan will be reviewed by the nurse staffing committee quarterly and revise it as needed; the revised document will be approved after all revisions but no less than every 12 months.
      i. The nurse staffing committee will approve all revisions within 30 days of the revision. If we do not have a quorum at the regularly scheduled nurse staff meeting, then another meeting will be called to approve the nurse staffing plan.

b. After the NSP is revised the IPU, OPC and SS managers will send the NSP to their department for review and approval, rejection or recommended changes. Staff will be asked to sign a "Staffing Plan Acknowledgement Form". All recommendations will be taken to the NSC for review; and will be denied or accepted and incorporated into the NSP. Simple majority is needed to approve or reject the NSP at the department level.
c. Nurse staffing plan must be approved prior to implementation.

D. Who is responsible?
a. This is the responsibility of the DPCS-NE who may delegate to the Nurse Staffing Committee Co-Chairs
b. IPU, OPC and SS managers are responsible for sending the draft NSP to staff and asking them to provide feedback and/or sign the Acknowledgement Form.

E. When will it be corrected?
a. 45 days after OHA approval of our Plan of correction.

F. How are we monitoring it?
a. A review of the NSP will be reflected in the NSC minutes at least quarterly.

6. Regulation#/Topic: OAR 333-510-0110(2)(b) E 632/Nurse Staffing Plan Requirements

A. Deficiency?
a. The hospital failed to implement a hospital-wide NSP that was developed based on measurements of unit activity that quantified the rate of admissions, discharges and transfers for each unit and the time required for direct care RN to complete those tasks

B. What happened?
a. We did not realize that we needed to include in the NSP specific times for admissions, discharges and transfers in the various nursing departments. The IPU Acuity Tool did not specifically account for admissions, discharges and transfers.

C. How are we correcting it?
a. The NSP was revised to include the following for the nursing departments; in addition, the IPU acuity tool was revised to include admission/ DC/Transfer activities.
i. IPU: "Patient acuity using the acuity tool which includes admission, discharge and transfer activities. The department requires the following average allocations of nursing time:
a) An admission requires an average of 45 minutes of RN time for each patient.
b) A discharge or transfer requires one hour for each patient."
ii. SS: "Daily staffing needs for each area of the department are based on a dynamic surgical schedule with a fluctuating case volume of one to 12 patients and one to three OR rooms, with average of five cases a day. Cases are typically scheduled to run from 0730 to 1700, M-F, but may run significantly later depending on the length of the case. Staffing of the Surgical Admission/Discharge area begins as early as 0500, and may run until 1800 or later. The Post Anesthesia Recovery Unit (PACU) may be staffed as early as 0700 and provides services until the last surgical patient of the day is discharged or transferred. Shift assignments and staffing vary daily by case volume and patient need. The department is not scheduled to run during nights, weekends and holidays.
a) The department provides care for an average daily census of five patients, requiring the following average allocations of nursing time:
(i) The Admission/Recovery Area requires an average of 45 minutes of RN time for each patient admission, and one hour for each patient discharge.

(ii) The OR requires from one to twelve hours of both scrub and circulator time for each patient. Cases last an average of 2.6 hours, with an additional 30 minutes each for set-up and clean-up time per case.

(iii) The PACU typically requires a range of 15 to 75 minutes of RN Phase I care for each patient, with an average of 45 minutes. Inpatients require an average of an additional 30 minutes of Phase II care."

D. Who is responsible?
   a. Department managers
E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.
F. How are we monitoring it?
   a. IPU, OPC and SS Department managers will monitor changes in patient volumes including admissions, discharges and transfers quarterly and will evaluate for trends that impact staffing and the data will be reviewed and recorded in the NSC meeting minutes.

7. **Regulation#/Topic: OAR 333-510-00110(2)c E 634/Nurse Staffing Plan Requirements**

A. Deficiency?
   a. The NSP revealed a lack of information related to the total diagnoses for each unit and the nursing staff required to manage those diagnoses.
B. What happened?
   a. We did not think we had to list every common diagnoses that we treated at SHC in the NSP. We also did not think we needed to include the actual competencies in the NSP to indicate the staffing requirements to manage the diagnoses.
C. How are we correcting it?
   a. Revised the NSP to include most common diagnoses seen in each clinical area.
   b. Each department developed or revised tools to determine recommended staffing levels based on the volume, patient diagnosis, patient acuity, staff mix and staff skills. These tools are used by Managers/Supervisors/Charge nurses when determining daily staffing.
   c. For Surgical services, the OR utilizes a Case Acuity tool and the OR Staffing Tool to address diagnoses and patient acuity, along with the OR Skills Matrix to ensure properly trained nursing staff to care for these diagnoses. For PACU, as well as Pre/Post units, the Surgical Admission-Discharge Area/PACU Case Acuity and Staffing Tool are used. Additionally, the Surgical Admission-Discharge Area Skills Matrix and the PACU skills are used. The SS Scope of Service document also defines the nursing services provided by these units.
   d. For the IPU, a skills matrix, as well as Staffing Guidelines and the Inpatient Acuity Staffing tool are used to address diagnoses and patient acuity. The IPU Scope of Service document also defines the nursing services provided by these units.
   e. For the OPC, a Skills Matrix and Staffing Matrix are used to determine adequate daily staffing and to ensure properly trained nursing staff are available to care for diagnoses treated. The OPC Scope of Service document also defines the nursing services provided by these units.
D. Who is responsible?
   a. Department managers
E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.
F. How are we monitoring it?

a. Quarterly review in the NSC meetings; reflected in the minutes.

8. **Regulation#/Topic: OAR 333-510-0110(2)(e) E 638/Nurse Staffing Plan Requirements**
   A. Deficiency?
      a. The hospital failed to implement a hospital-wide NSP that recognized differences in patient acuity and nursing care intensity; NSP revealed no reference to patient acuity or nursing intensity for the OPC and SS Units.
   B. What happened?
      a. It was not understood that the OPC and SS needed an acuity/nursing intensity tool as they typically were staffing based on the numbers of patients and staff skill requirements.
   C. How are we correcting it?
      a. OPC and SS Managers developed tools to stratify pt./procedures types by acuity and intensity. The NSP was updated to include the use of these tools daily in the staffing/assignment decision-making; and guidance was given in the NSP, regarding managing unforeseen changes in volume, acuity or intensity.
      b. For Surgical services, the OR utilizes a Case Acuity tool and the OR Staffing Tool to address diagnoses and patient acuity, along with the OR Skills Matrix to ensure properly trained nursing staff to care for these diagnoses. For PACU, as well as Pre/Post units, the Surgical Admission-Discharge Area/PACU Case Acuity and Staffing Tool are used. Additionally, the Surgical Admission-Discharge Area Skills Matrix and the PACU skills Matrix are used. The SS Scope of Service document also defines the nursing services provided by these units.
      c. For the OPC, a Skills Matrix and Staffing Matrix are used to determine adequate daily staffing and to ensure properly trained nursing staff are available to care for diagnoses treated. The OPC Scope of Service document also defines the nursing services provided by these units.
   D. Who is responsible?
      a. OPC and SS managers
   E. When will it be corrected?
      a. 45 days after OHA approval of our Plan of correction.
   F. How are we monitoring it?
      a. Will update at annual NSP review

9. **Regulation#/Topic: OAR 333-510-0110(2)(f) E 640/Nurse Staffing Plan Requirements**
   A. Deficiency?
      a. OPC and SS failed to establish minimum NSM required for shifts
      b. OPC did not clearly establish the number of NSM required for shifts; CMAs were used in the staffing - they are not considered NSMs
      c. SS did not clearly establish the number of NSMs required for shifts in SS units - spoke of competent staff, but not define in NSP
   B. What happened?
      a. We were compliant with minimum staffing in those areas, but did not put it in writing as a part of the NSP.
      b. We were not aware that Medical Assistants could not be considered nurse staff without the approval of a waiver. Also, we did not think that having 1 nurse in clinic with one MD was not adequate for safe patient care in a hospital with multiple other nursing staff available for emergencies.

c. Again, were compliant with standards of staffing in the OR, but did not put it in writing in the NSP.

C. How are we correcting it?
   a. OPC and SS managers developed minimum staffing requirements and this was added to the NSP. OPC does not staff by shifts – they staff by the number of clinics and the number and acuity of patients in those clinics. OR does not staff by shifts – they staff by the number of ORs running and the acuity/intensity of the patient(s) being cared for.
      i. "The OPC minimum NSM required is 2 RNs during business hours, one of which can be the Nurse Manager".
      ii. "SS minimum NSM required is 2 RNS (cross-trained to Pre-OP, OR and PACU)". The department Manager/Nurse Supervisor/Charge Nurse may substitute for a staff nurse if needed.
         a) OR Minimum Staffing with one patient:
            (i) One RN and one additional nursing staff member for pre-operative preparation. RN may then assist in the OR or PACU
            (ii) Two RNs, or one RN and one Surgical Technologist to assist with the surgical procedure. RN may then assist in PACU.
            (iii)Two PACU-trained RNs for patient recovery, one of whom is competent to provide Phase I Level recovery care – second RN may be PALS-certified OR nurse with PACU orientation.
   b. The OPC manager developed staffing tools to assist in making assignments based on volumes and acuity. OPC staffing levels are based on the number of clinics running, patient volumes, and patient acuity and will be adjusted accordingly." A Skills Matrix and Staffing Matrix are used to determine adequate daily staffing and to ensure properly trained nursing staff are available to care for diagnoses treated. The OPC Scope of Service document also defines the nursing services provided by these units.
      a) SHC has submitted a Waiver which was approved Dec. 2017 to include medical assistants and surgical technologists in the definition of nursing staff.
   c. Updated the SS NSP to remove "competent" and replace with "completion of required competencies."

D. Who is responsible?
   a. OPC and SS managers

E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.

F. How are we monitoring it?
   a. The OPC and SS Mgrs. will review minimal staffing requirements when we review the NSP.
   b. Renew the waiver by 1/1/2021.

10. Regulation #/Topic: OAR 333-510-0110 (2) (g) E 644/Nurse Staffing Plan Requirements

A. Deficiency?
   a. Hospital failed to include a formal process for evaluating and initiating limitations on admission or diversion that allowed for any direct care RN or nurse manager to initiate the process
   b. In the "Plan for Patient Care Services" it did not include a provision for an RN or nurse manager to initiate the process to cancel services for short staffing

c. 15 or 23 staff did not know the process or their role in evaluating and initiating limits on admissions or diversion

B. What happened?
   a. Our description of how a staff member could initiate a process to limit the admissions, clinic visits or surgeries, if they believed that staffing was not adequate for safe patient care, was not detailed enough.
   b. While the staffing plan was available in the departments, we had no requirement for the staff to read the plan.

C. How are we correcting it?
   a. We added more specific language regarding using their "Chain of Command, starting with their manager."
      1. The staff requesting to limit admissions or surgeries will also be asked to submit a safety report.
   b. We added language to the plan that stated that the manager may also initiate the process to limit admissions or surgeries
   c. When the NSP has been approved by the NSC, the department managers will provide a copy of the plan to be reviewed by the individual department staff; the staff will be required to sign a form acknowledging that they reviewed the NSP. This acknowledgement will serve as evidence that they are aware that an RN may initiate a process to limit admissions, clinic visits or surgeries (depending on department) and that they do this by using their Chain of Command, starting with their manager.

D. Who is responsible?
   a. The department managers are responsible for working with their staff to develop the annual NSP. The NSC approves the NSP.

E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.

F. How are we monitoring it?
   a. All staff acknowledge understanding of the NSP with each revision.(This includes language regarding initiating limitations on admissions).
   b. We monitor all request to limit admissions by having the patient care staff member submit a patient safety event form, which the manager of the department will respond to in a timely manner. All such safety reports will be reviewed in quarterly NSC meetings to identify any trends requiring action.

11. Regulation#/Topic: OAR 333-510-0110(2)(g) E 646/Nurse Staffing Plan Requirements

A. Deficiency?
   a. NSP revealed no consideration of NSM meals breaks, rest breaks and other tasks not related to direct patient care
   b. Review of records indicated that staff frequently missed meal breaks
   c. 13 of 23 staff indicated that they covered each other's assignments in addition to their own so that NSMs could take meal and rest breaks

B. What happened?
   a. We were under the impression that staff could use the buddy-system and relieve each other for breaks/meals/meetings.
   b. Staff were responsible for coordinating their break/meal times with their buddy, there was no process to enforce that staff took their breaks.

C. How are we correcting it?
   a. The staffing plans were revised to include more specific language
      i. IPU: Meals, Breaks and Non Patient Care Activities:
         a) A person without a patient care assignment (The Supervisor/Relief Shift Supervisor, Resource nurse, and Manager) is responsible to relieve staff for rest/ meal breaks and non-patient care activities;
         b) IPU staff may relieve each other for meals and breaks only if the number of patients at that time are equivalent to one patient care staff assignment.
      ii. OPC: Meals, Breaks and Non Patient Care Activities:
         a) The Charge Nurse (and Manager if necessary) is responsible to relieve staff for rest/ meal breaks and non-patient care activities as needed.
         b) OPC staff may relieve each other for meals and breaks only if the number of patients at that time are equivalent to one patient care staff assignment.
         c) Staff will also be relieved of patient care duties by the Charge Nurse (and Manager if necessary) to attend meetings/education events.
      iii. SS: Meals, Breaks and Non Patient Care Activities:
         a) Float Nurses are scheduled as necessary to provide rest and meal breaks if the flow of activity does not provide sufficient time between patient care activities.
         b) Activity in the OR may be suspended between cases to allow staff to take meals and breaks.
         c) Staff will be relieved of patient care duties to attend meetings/education events.
         d) The Charge Nurse (and Manager if necessary) is responsible to relieve staff for rest/meal breaks or meetings/educational events as needed.
   b. Each department has defined the process for relieving staff for meals and breaks in the staffing plan.
   c. A new form was developed to track staff's break/meals.
D. Who is responsible?
   a. The department managers.
E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.
F. How are we monitoring it?
   a. We will report the percentage of missed rest or meal breaks in each department at the Quarterly Nurse Staffing Committee Meetings.

12. Regulation#/Topic: OAR 333-510-0130(1-7) E 665/Nurse Staffing Member Overtime

A. Deficiency?
   a. There was no indication that the overtime of SS and OPC NSMs was voluntary or not
   b. There was no indication that the overtime in excess of 12 hrs. in a 24 hr. period was voluntary or that the NSM had declined the 10-hr rest period immediately following the 12th hr. worked
B. What happened?
   a. In the last year, there was only one instance when a nurse was required to work mandatory overtime. The managers note it on a spreadsheet we keep. But there were many other instances of overtime and no documentation that identified these hours as 'non-mandatory' – we were not aware that we had to track all individual's overtime as voluntary or mandatory.

b. We were not aware that we had to keep track of each instance of whether or not they requested/declined the10-hr. rest period when a staff member worked more than 12 hrs.

C. How are we correcting it?
   a. We now have a complex log that includes columns for staff to indicate all overtime, whether it was voluntary or mandatory; if they work > 12hrs if they requested and were given a 10 hr. rest period.
   b. The NSP for Surgical Services now has clear language about the job duty requirement of on-call shifts to cover OR cases that may go beyond the normally scheduled day. These on-call shifts are scheduled at least a month in advance and the shifts are assigned based on the individual's requested days not to be on-call.

D. Who is responsible?
   a. The department managers are responsible for tracking these issues.

E. When will it be corrected?
   a. 45 days after OHA approval of our Plan of correction.

F. How are we monitoring it?
   a. The managers will collect this data monthly on the NSP Dashboard
   b. The data will be reported quarterly at the NSC.