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Nurse Staffing Plan

Facility: McKenzie-Willamette Medical Center
Received Date: May 14, 2024
Posting Date: May 14, 2024

DISCLAIMER: Oregon's hospital staffing law directs OHA to post hospital staffing plans received by OHA. OHA does not review or approve the staffing plans prior to posting. OHA does not endorse staffing plans nor can OHA provide advice or guidance about the application or enforcement of any staffing plan.

It is the hospital's responsibility to submit plans to OHA that are current, compliant with applicable laws, and address all units where services covered by the staffing plan are provided.

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

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: SCU (Department #12)	
Effective Date: January 2024	
Staffing Committee Representatives: Tina Nash / Scott Dolan	
Criteria-Description of Patient Population	Nursing care is provided for general medical and surgical patients, and stable adolescent patients (>40kg and 10yo and older). The age groups served are adolescent, adult, and geriatric. We also serve MIPs, SIPs, OBS and SOPs 30 Total rooms all private. These include 2 bariatric rooms with lifts as well as 2 negative pressure rooms Surgical patients including but not limited to: general surgery, gynecology, urology, trauma, neuro/spine surgery, dental and maxillofacial surgery, orthopedic surgery, vascular surgery, diagnostic procedures, ENT procedures, and cardiac surgery Medical patients including but not limited to: pneumonia, COPD, influenza, CHF, UTI, Sepsis, chest pain, stroke, pulmonary edema, weakness, electrolyte imbalances and acute renal failure.
Average Daily Census (ADC) annual average	23
Average Length of Stay (LOS) annual average	4.49
Specialized qualifications and competencies (include requirements for travel nurses)	**Charge Nurses:** BLS, Unit Specific Training/Experience Encouraged: ACLS, Telemetry Competency, Medical/Surgical certification **Registered Nurses**: BLS Encouraged: ACLS, Telemetry Competency, Nurse Practice Organization: Academy of Medical Surgical Nurses (AMSN). Med/Surg Certification available through AMSN and ANCC. **Travel Nurses**: BLS **Licensed Practical Nurses**: BLS **Certified Nursing Assistant II**: BLS **Certified Nursing Assistant I:** BLS

Abbreviation Key: Medical Inpatients (MIPs), Surgical Inpatients (SIPs), Observation Patients (OBS), Surgical outpatients (SOPs).

	Each nursing staff member will also receive annual skills training and review the necessary education provided through online learning, staff meetings and annual skills fairs. McKenzie-Willamette Medical Center currently fulfills their annual educational requirements and maintains the reviewed documentation through HealthStream. All float nurses will be required to maintain the minimum qualifications and competencies to work in the unit. Descriptions, qualifications, and competencies per staff provided in Appendix A
Total diagnoses for unit and Nurse Staff required to manage those diagnoses	Standard use of definition: "Diagnoses" refers to the medical diagnoses of the patient. Each diagnosis involves the medical care and interventions to manage various procedures and conditions encompassing the official diagnosis of that patient. Top ICD-10 diagnoses cared for by the unit are as follows: 1. Total Knee Replacement 2. Fusion of Spine 3. Total Hip Replacement 4. Osteoarthritis 5. Post Traumatic Fracture 6. Bilateral Knee Replacement 7. Rotator Cuff Repair 8. Bilateral Hip Replacement 9. Removal of Hardware 10. Revision of Knee See remaining list of diagnoses in Appendix D

Skill Mix and level of competency required to meet the healthcare needs of patients	See job description for each category in Appendix A: Charge Nurse, Floor RN, Travel RN, Break Nurse, LPN, CNA II, and CNA I. The standards and authorized duties to be performed for patient care by registered nurses, licensed nurse practitioners, and certified nursing assistants are described by the Oregon Board of Nursing Rules Chapter 851, in the following statues (links), respectively, RNs: 851-045-0060 LPNs: 851-045-0050 CNAs: 851-063-0010 and 851-063-0035
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	The unit's admissions, discharges, and transfers (ADT's) are tracked in the hospital's MedHost EHR system and reviewed annually. The times allotted for each are 60 minutes for admissions, 60 minutes for discharges, and 30 minutes for transfers. A nurse working on an ADT will not be given another ADT within the first's allotted time frame. Average ADT per shift per week: Days: 100.5 Eves: 24.88
Nationally Recognized Standards or Guidelines	• Academy of Medical-Surgical Nurses. (2020, December). Staffing standards for patient care. Retrieved from Staffing Standards for Patient Care • American Nurses Association. (2019) (3 ed.). Principles for nurse staffing. Retrieved from https://cdn2.hubspot.net/hubfs/4850206/PNS3E_ePDF.pdf • ONA's Center for Evidence-Based Practice and Research (CEBPR). Accessed May 2023. Retrieved from https://www.oregonrn.org/page/CEBPR
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.)	Standard use of definition: • Patient "Acuity" refers to the level of nursing skill required, for example medications, drains, tubes, IVs, wound care, etc. • Nursing "Intensity" refers to the level of patient need which makes giving nursing care more complicated, for example language barriers, cognitive barriers, etc.

What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	Patient acuity will be determined by the MedHost acuity tool within each shift and scored according to the anticipated needs of the patient for the following shift. The nursing workload intensity is also incorporated with questions to include in the total score. Reassessment of the acuity and intensity will be done by the primary nurse and communicated to the Charge RN as needed, and within 2 hours of the end of the shift to inform nurse-to-patient ratio adjustment and safe patient care for the current shift and to make appropriate, safe, and equitable assignments for the next shift. The average acuity of a singular patient on SCU (utilizing MWMC Acuity Tool) is: 3 The average acuity of a patient assignment on SCU (utilizing MWMC Acuity Tool) is: 11 The acuity of a patient team should not be >12. The staffing matrix illustrates a standard nurse-to-patient ratio on SCU (See appendix B). The ratio will be adjusted, if the acuity of the patient team and nursing intensity is determined to be unsafe. The primary care RN and Charge RN will jointly decide on the adjustment of patient ratio and duration of adjustment, using the MedHost Acuity Tool, to ensure safe patient care. Charge RN's will take into consideration appropriate patient load for nurses recently off new hire orientation. The Charge RN will determine the complexity of the patient's condition, assign the appropriate nurse, and escalate level of care, if necessary. Some factors that contribute to a higher nursing workload include: • Complexity of patient's condition, assessment and required nursing care. • Ample staffing support (see Primary Staffing Grid) for patient care. • Knowledge and skills required of nursing staff to assist in providing multi-disciplinary care. • Technology involved in patient care including but not limited to- bed alarms, Hoyer lift, telemetry, restraints central line/ PICC line, tube feedings, wound vacs, etc. • Degree of supervision required of nursing staff members. • Infection control-isolation, safety concerns, patient aggressiveness, and uncooperative and/or impulsive behavior. • The patient's mobility and associated fall risk. • Continuity of patient care.

<table>
<tr><td></td><td>Conditions that contribute to a higher level of acuity (include but are not limited to):
• Frequent VS or CBG monitoring
• Multiple IV medications/ frequent need
• Consistent CIWA score = 8
• Dementia/delirium- unsafe or unstable
• Complex wound care/ wound vacuum
• Complicated family /interpersonal interactions
• Bariatric patient
• High fall risk, with risk for injury
• Adolescent patients
• Suicide risk
• Requiring dialysis
• CBI/ Hand Irrigation
• Full Feeding assistance
• Epidural mgmt. <24hrs.
• Post-Op patients for the first 24 hrs.

See MedHost Acuity Tool 2023 in Appendix C attachment.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>What is the MINIMUM number of RNs, LPN and CNAs on specified shifts</td><td>Minimum Staffing Grid:
NSM = Nurse Staffing Member
1 patient = 2 NSM
2 patients = 2 NSM
3 patients = 2 NSM
4 patients = 2 NSM
5 patients = 2 NSM
6 patients = 2 NSM
7 patients = 2 NSM
8 patients = 2 NSM
9 patients = 2 NSM
10 patients = 3 NSM
11 patients = 3 NSM
12 patients = 3 NSM
13 patients = 3 NSM
14 patients = 3 NSM
15 patients = 4 NSM
16 patients = 4 NSM
17 patients = 4 NSM
18 patients = 4 NSM
19 patients = 4 NSM
20 patients = 5 NSM
21 patients = 5 NSM
22 patients = 5 NSM
23 patients = 5 NSM
24 patients = 5 NSM
25 patients = 6 NSM
26 patients = 6 NSM
27 patients = 6 NSM
28 patients = 6 NSM
29 patients = 6 NSM
30 patients = 7 NSM
CNAs will be utilized as support in addition to nursing staff when the Minimum Staffing Grid is used.</td></tr>
</table>

	Staffing grids will include two nurses when one patient is present, which includes the Charge RN. Daily staffing for the Surgical Care Unit is planned using the Primary Staffing Grid (see Appendix B). The Primary Staffing Grid is a guideline for staffing the unit with the appropriate number of nursing staff at varying census levels and will serve as the key grid by which the hospital will base the appropriate staffing needs for the shift. The Minimum Staffing Grid will not serve as the template for appropriate staffing and will require approval from the unit supervisor before it is applicable to the specified shift. Instances for use of the Minimum Staffing Grid includes but are not limited to: (a) A national emergency or state emergency declared under ORS 401.165 to 401.236 or 433.441 to 433.452 requiring the implementation of a facility disaster plan and crisis standards of care, as those terms are defined in section (7) OHA rules 333-510-0140; (b) Sudden and unforeseen adverse weather conditions; or (c) An infectious disease epidemic suffered by hospital staff." In conjunction with informing the unit supervisor, the Charge RN for the affected shift will be informed when the Staffing Minimum Grid will be used. With consideration of individual patient acuity and nursing care intensity, the Charge RN, in collaboration with the House Supervisor, will determine staffing for the oncoming shift and throughout the current shift to ensure that the number of staff and appropriate skill mix are available to ensure safe patient care. The Charge RN will track ADTs throughout the shift, and this data will be used to plan for adequate staff to care for expected ADT. The Primary Staffing Grid is provided in Appendix B. The unit may deviate from the established RN ratios (such as implementing more LPNs), if approved by the NSC, in pursuit of an innovative care model in which other clinical care staff may constitute up to 50% of the care team. These models must be approved by the NSC at least every 2 years.
Describe process for limiting admissions/diversions to another hospital etc.	**Diversion Avoidance Process:** SCU will remain open for admissions as long as there is capacity and capability to do so. Per OAR 33-510-0045(3)(g) a direct care RN may initiate the process for limiting admissions to SCU when, in their judgment, there is an inability to meet patient care needs and/or a risk of

	harm to existing patients. The direct care nurse will notify the SCU Charge nurse who will then alert the House Coordinator, the SCU Manager and/or the Administrator on-call. These individuals will collaborate with other departments to accommodate safe patient throughput and to prevent diversion whenever possible utilizing PC01-021: Managing patient Flow and Inpatient Capacity.
Describe non-direct care tasks including meals and breaks	Standard use of Definition: • "Meals" is defined as a thirty-minute, unpaid break given when a staff member is working more than six hours during which they should be relieved of all work duties (BOLI). • "Breaks" are defined as "one (1) paid fifteen (15) minute rest period for each four (4) hours of work during their shift" in our Bargaining Agreement. The unit will have meals and breaks coverage plan each shift. The break times will be tracked utilizing the facility's specified process: badging out for meals and back in at the completion of an uninterrupted meal at the clock or on the computer work station. During times of meals and rest breaks, nurses will transfer the care of the patient assignment to another designated, unencumbered nurse. The buddy system can be used for meals and breaks when the use of the buddy system does not result in the staffing grid/plan being exceeded. The Charge Nurse may take a patient assignment for the purpose of covering meals and breaks with approval from the staffing committee for units larger than 10 beds. Quarterly, the SCU Unit Practice Committee (UPC) will review and, if necessary, amend the plan for meals and breaks to ensure the provision of meals and breaks in accordance with HB 2697 and the Bargaining Agreement. During the day, unit management will be available for providing meal coverage.

Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	The CN will collaborate with the house supervisor to determine the needed staff for the oncoming shift to accommodate any and all changes to the census. When the census cannot be accommodated by the unit's available staff members, the house supervisor and/or hospital scheduler will utilize the float pool option. SCU utilizes float nurses and eligible staff from other units to float to SCU in order to provide appropriate staffing per for the patient needs of the unit. Each staff member floated to SCU must meet the minimum qualifications to practice on the unit.
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	A UPC meeting will be held at the end of December or beginning of January to gather and review the year's data. The following information and data will be collected and an annual review template will be completed to include: • Unsatisfactory patient outcomes • Missed meals and breaks • HCAHP results • Employee Survey results • Overtime hours: Mandatory/voluntary/end of shift overtime • Handwashing audits • Event reporting in RiskConnect • Staff injuries related to post-op bed utilization • Annual QI projects • SDRF's/Staffing situation when ratios aren't within ASPAN guidelines • Annual skills assessment and monthly education series • Staff turnover • Completion of call to patient's family member when patient transfers to inpatient unit

Appendix A
Job Descriptions, Skills, and Competencies

All staff will have Basic Life Support (BLS). RN's are encouraged to obtain competency in Advanced Cardiovascular Life Support (ACLS) and competency in Basic Electrocardiogram ECG interpretation.

Charge Nurse (CN): Coordinates and supervises patient care activities on the unit. Escalates unit concerns as necessary following appropriate chains of command. Manages patient flow and staffing, including safe staffing and equitable assignments using the MedHost Acuity Tool along with any concerns raised by the primary care nurse

Registered Nurse (RN): Plans, provides and documents direct bedside patient care, medication administration, patient/family teaching, and assignment of appropriate tasks to CNA2s with supervision.

Licensed Practical Nurse (LPN): Provides direct patient care under supervision of a Charge Nurse including appropriate medication administration, patient/family teaching and assignment of appropriate tasks to CNAs.

Certified Nursing Assistant (CNA2): Assists nurses with direct patient care including but not limited to: vital signs, safe patient handling, feeding, bathing, CBGs, and other appropriate assigned tasks from the nurse in accordance with the Oregon Board of Nursing.

CNA 1: Assists nurses with direct patient care including but not limited to: vital signs, safe patient handling, feeding, bathing, CBGs, and other appropriate assigned tasks from the nurse accordance with the Oregon Board of Nursing.

Appendix B
Primary Staffing Grid Guide Based on Census

Census ≤ 14

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	1*
13	1	4	1*
14	1	4	1*

All patients that will need to be placed on SCU by noon may be added to the am census and the unit may be staffed for that additional census at 0700. If that census is 30 or more, the staffing census will be established for 30. This allows for earlier discharges and improved throughput from PACU/ED. The above staffing grid incorporates nurse ratios of 1:4 and CNA ratios of 1:7 from 07-1900; 1:11 from 19-0700.

The Charge Nurse will work in collaboration with the House Coordinator and Nurse Manager to determine appropriateness of staffing based on patient variables, such as acuity.

Census 15-22

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	3
16	1	4	3
17	1	5	3
18	1	5	3
19	1	5	3
20	1	5	3
21	1	6	3
22	1	6	3*

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	2
16	1	4	2
17	1	5	2
18	1	5	2
19	1	5	2
20	1	5	2
21	1	6	2
22	1	6	2

*Shaded area represents primary nursing or CNA with light assignment and additional duties

Census 23-28

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	3
16	1	4	3
17	1	5	3
18	1	5	3
19	1	5	3
20	1	5	3
21	1	6	3
22	1	6	4
23	1	6	4
24	1	6	4
25	1	7	4
26	1	7	4
27	1	7	4
28	1	7	4

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	2
16	1	4	2
17	1	5	2
18	1	5	2
19	1	5	2
20	1	5	2
21	1	6	2
22	1	6	2
23	1	6	3
24	1	6	3
25	1	7	3
26	1	7	3
27	1	7	3
28	1	7	3

McKenzie-Willamette MEDICAL CENTER

Census 28-30

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	3
16	1	4	3
17	1	5	3
18	1	5	3
19	1	5	3
20	1	5	3
21	1	6	3
22	1	6	4
23	1	6	4
24	1	6	4
25	1	7	4
26	1	7	4
27	1	7	4
28	1	7	4
29	1	8	4*
30	1	8	4*

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	2
16	1	4	2
17	1	5	2
18	1	5	2
19	1	5	2
20	1	5	2
21	1	6	2
22	1	6	2
23	1	6	3
24	1	6	3
25	1	7	3
26	1	7	3
27	1	7	3
28	1	7	3
29	1	8	3
30	1	8	3

*Shaded area represents primary nursing or CNA with light assignment and additional duties

McKenzie-Willamette MEDICAL CENTER

Appendix C
MedHost Acuity Tool 2023

Assessment/Vital Signs Frequency:

Q8 hr vital signs	0
Q4 hr VS and/or Neuro checks, Q8 hr Orthostatics	2
Q2 hr VS and/or Neuro checks, Q4 hr Orthostatics	3
Q1 hr VS and/or Neuro checks	5
Q30 hr VS and/or Neuro checks	7
Q15 hr VS and/or Neuro checks	9
Less than Q15 hr VS and/or Neuro checks	12
Total	

Mental Status

Alert and Oriented	0
Alert, calm, pleasant, cooperative but not oriented	1
Confused (not combative). Patient with sitter. Lethargic	2
Delirium or confused and calm, needs redirection q1 hour. Combative patient with sitter. Restraints	3
Obtunded. Heavily sedated	5
Restraints. Confused and restless and/or combative. Redirection less than q1 hour	7
Total	

Respiratory

Stable on RA at rest and with activity	0
Continuous pulse ox. Interventions Q8 hour, 02 by NC	1
Interventions Q4 hour, 02 by NRB or Oxymizer	2
Stable CPAP or BiPap, Interventions Q2 hr, 02 by high flow NC	3
Stable vent. Unstable BiPap. Interventions Q1 hr.	5
Unstable vent, titrating Q30 min	7
Unstable vent, titrating Q15 min	9
Unstable vent titrating less than Q15 min.	12
Total	

Telemetry

No Telemetry	0

Pain

No pain	0
Q8 hour interventions	1
Q4 hour interventions	2
Q2 hour interventions	3
Q1 hour interventions	5
Q30 min interventions	7
Q15 min interventions	9
Total	

Procedures

No procedures	0
Day before IP procedure or surgery	1
Hemodialysis, Peritoneal Dialysis, Established PICC-Central line	2
Day of routine IP pre or post procedure requiring nurse intervention(s)	3
Procedures requiring moderate sedation by RN	5
1-3 Emergency procedures	7
Greater than 3 emergency procedures	9
Total	

Admission/Discharge/Transfers

No ADT	0
Stable Transfer. Routine Discharge	1
Discharge to an outside facility	2
New Admission or post-op. Complex discharge	3
Complex post-op or admit. Transfer to a higher level	5
Unstable post-op, admission, or tranfer	7
Total	

Education

No education needed	0

Interventions Q8 hr. Tele	1
Interventions Q4 hr.	2
Interventions Q2 hr.	3
Interventions Q1 hr. Temp pacer backup	5
Interventions Q30 min. Temp pacer dependent	7
Interventions Q15 min.	9
Interventions less than Q15 min	12
Total	

Diagnostics

No lab or radiology tests	0
Interventions and/or tests Q8 hr.	1
Interventions and/or tests Q4 hr.	2
Interventions and/or tests Q2 hr.	4
Interventions and/or tests Q1 hr.	5
Interventions and/or tests Q30 min.	7
Interventions and/or tests Q15	9
Total	

Protocols

No Protocols	0
1 Protocol (eg. Heparin, K+ replacement). 1 Unit of blood products	1
2-3 of the protocols in column 1	2
2-4 of blood products, fluid bolus for BP, and 2-3 protocols	3
Alcohol withdrawal protocol, CIWA score ***	5
Greater than 4 protocols OR greater than 5 units of blood products	7
Greater than 4 protocols AND greater than 5 units of blood products	9
Total	

Medications

No meds	0
1-5 meds PO-IVPB-IVP	1
6-10 meds PO-IVPB-IVP	2
11-15 meds PO-IVPB-IVP	3

Standard education and reinforcement, no new diagnoses or meds	1
Some education needed	2
New diagnosis with educational needs	3
Extensive education needed	5
Complicated, extensive education with care coordination	7
Total	

Psych-Social-Family

Hourly rounding	0
Less than 2 interventions per shift	1
3-5 interventions per shift	2
6-9 interventions per shift	3
9-12 interventions per shift	5
Q1 interventions	7
Total	

Wound-Skin Care

No wounds, no skin breakdown risk, independent with turns	0
1-2 Qday-BID dressing change (simple wounds). Skin barrier, Wound vac no dressing change. Independent with turns.	1
Q2 hour turns. Heels floating	2
TID or complex dressing changes	3
Q1 hour turning and/or positioning. Greater than 5 simple wounds.	5
Greater than 5 complex wounds	7
Prone positioning	9
Total	

Ostomy/Continence

Ostomy, Continence and independent toileting	0
One person assists with toileting. Foley	1
Incontinent B-B 3-5 per shift and contained. Established ostomy. Rectal tube. Bowel prep.	2
Incontinent (or rectal tube leak) bowel bladder 5-8 times per shift. High-output or new ostomy	3

15+ meds. 1-3 drips requiring titration Q1 hr. IVP medications less than Q30 min.	5
1-3 IV drips requiring titration Q30 min or greater than 3 drips	7
1-3 IV drips requiring titration Q15 min	9
Greater than 3 drips requiring titration Q15 min.	12
Total	

Drains, I/O's

No drains, I/O's not monitored	0
I/O's greater than Q2 hrs. 1-2 drains (eg. JP, hemovac, perc.neph. NG-ND).	1
Continuous tube feed. Chest tube to water seal. Greater than 3 drains.	2
I/O's Q2 hrs. Chest tube to suction. CBI	3
Bolus tube feed. I/O's Q1 hr. Chest tube output greater than 100cc in 2 hours.	5
Greater than 500cc of blood or drainage in 1 hr. Greater than 2 chest tubes.	7
Active bleeding requiring in room management less than Q1 hour.	9
Total	

Acuity Score

1-10 points	1
11-20 points	2
21-30 points	3
31-40 points	4
41-50 points	5
51-60 points	6
61-70 points	7
71-80 points	8
81+ points	9
Final Acuity Score	

Uncontainable drainage (incontinent, wound drainage) requiring full bed changes 2-4 times per shift. Q1 hour toileting needs	5
Uncontrollable drainage requiring more than 4 full bed changes per shift.	7
Total	

ADL's

Independent with ADL's, able to obtain tools	0
Independent with ADL's, may need to have tools placed in reach	1
Stand by assist with ADL's, medication assist, crushed meds	2
One person assists with ADL's, total feed	3
Total care or feed. Two-person assist with ADL's	5
Total care and Total feed. Mechanical Lifts.	7
Total	

Isolation

No Isolation	1
Isolation	2
Total	

Safety/Fall

No Safety Issues	0
Low Fall Risk	1
Moderate Fall Risk. High or moderate risk Suicidal Ideations. Patient with Sitter.	2
High Fall Risk. Low or Moderate Risk Suicidal Ideations. Patient with Q15 min checks.	3
Total	

Appendix D

Total SCU Diagnoses

Diagnoses and %	
Total Knee Replacement	12%
Fusion of Spine	11%
Total Hip Replacement	9%
osteoarthritis	7%
post traumatic Fracture	6%
Bilat Knee Replacement	6%
Rotator Cuff Repair	5%
Bilat Hip Replacement	4%
Removal of hardware	4%
Revision of Knee	3%
Spinal Stenosis	3%
Other	3%
Revision of Hip	2%
Hernia Repair	2%
Spondylolysis	2%
Sepsis	2%

Diagnoses and %	
Appendicitis	2%
Resection of Gallbladder	2%
Cholelithiasis	2%
Intestinal Obstruction	2%
Lymphedema	1%
Adrenal Gland Disorder	1%
Drainage of Bladder	1%
Foreign Body Removal	1%
Rectal Prolapse	1%
Abdominal Fistula	1%
Cystocele	1%
Amputation	1%
Unstable Fracture	1%
Cancer	1%
Prostectomy	1%
Total	100%

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Short Stay Unit (SSU)/Pre-Admission Testing (PAT)	
Effective Date: April 2024	
Staffing Committee Representatives: Becky Brock and Deanne Miller	
Criteria-Description of Patient Population	**Nursing care is provided for the following groups of patients:** **<u>Short Stay Unit (SSU):</u>** Preoperative inpatients and same day procedural patients receiving anesthesia, procedural sedation, or local, ranging in age from six (6) months to geriatric, and are stable, non-critical prior to procedure; Stable inpatients who are scheduled for surgery (staging approximately one hour before surgery); Post-procedure patients (Phase II Recovery) requiring a short-term recovery prior to discharging from the hospital; Postop inpatients waiting for an inpatient bed to become available; Patients requiring series therapy (injections, transfusions, infusions) **<u>Pre-Admission Testing (PAT) Clinic:</u>** Patients requiring in-person preoperative RN and Anesthesia evaluations prior to day of procedure (this is done in rare circumstances) or patients requiring a preoperative telephone call by an RN prior to day of surgery with an anesthesia review of chart and possible call from anesthesia to patient. Chart review and medical record acquisition prior to or as soon as information is available, is obtained by the charge nurse (for day surgery, OPB surgery, AM surgery and for DI, EP and CVPR patients). Charge Nurse accesses charts from MWMC portal, EPIC, Heart Associates, OHVI, Shaw Heart, Prefontaine, St Charles, Good Sam and other cardiac centers as needed for EKGs, ECHOs, treadmills, pacemaker tracings and other heart testing. Pulmonary testing info obtained. VA (Roseburg, Portland and Eugene), nursing/rehab centers, clinics, offices and hospital records are obtained. These are passed on to RN who will be calling the patient. All patients require a preoperative telephone call by an RN prior to the day of procedure as well as a call to family members, rehab centers and care providers as needed to complete the interview.

	Patient status depicts the amount of paperwork and computer input. Status as follows, AM (spending at least one night), OPB (patient may spend the night) and day surgery (patient going home same day). -Extensive follow up after anesthesia review: pulmonary, cardiac and other specialty testing as needed or ordered. **SSU:** Located on the 2nd floor adjacent to the Endoscopy suite, Post Anesthesia Care Unit (PACU), Anesthesia workroom/office, the Main Operating Room (OR), and 2 waiting areas. 26 separate patient bays, 7 separate bathrooms; 1 separate bay/bathroom 2 negative pressure/isolation rooms with bathrooms 2 patient bays with ceiling lifts (up to 1,000 pounds) 1 nurse station, including patient nutrition area **PAT:** Located on the 1st floor by the main hospital entrance and registration 5 interview rooms, reception desk, area for telephone call and chart review purposes, outpatient lab station, patient bathroom with pass-thru into lab station and break room. **DIAGNOSES** (include, but are not limited to): --Surgical patients: spondylosis, spinal stenosis, neurogenic claudication, compression fracture, degenerative arthritis, traumatic arthritis, scoliosis, osteoarthritis, rotator cuff tear, bicep rupture/tear, bone spurs, Achilles rupture, patella fractures, meniscal tear, diverticular disease, kidney stones, cholecystitis, cholelithiasis, liver neoplasms, inguinal hernia, ventral hernia, breast cancer, benign prostatic hypertrophy, end stage renal disease, bladder cancer, kidney cancer, skin cancers, cervical cancers, renal calculi, bladder/prostate cancer, vaginal prolapse, uterine prolapse, rectocele, cystocele, ovarian cysts, vaginal bleeding, dysmenorrhea, endometriosis, uterine fibroids, desires sterilization, chronic sinusitis, adenotonsillitis, deviated nasal septum, bunions, hammer toes, venous stasis ulcers, antibiotic resistant infections, necrotic wounds, diabetic wounds. --Endoscopy patients: screening colonoscopy, personal/family history of polyps, personal/family history of colon cancer, diverticulitis, abdominal pain, anemia, melena, gastroesophageal reflux disease, esophageal varices, hematochezia, dysphagia, history of Barrett's esophagus

	--Series patients: post diagnosis outpatient antibiotic therapy, warfarin bridging pre/post-surgery or endoscopy, anemia, thrombocytopenia, bridging on to warfarin for deep vein thrombosis or pulmonary embolism, Crohn's disease, rheumatoid arthritis. **SPECIAL PATIENT NEEDS:** Patients from care facilities, non-English speaking, immunocompromised, hematological-compromised, mentally delayed – both children and adults, dementia, wheelchair-bound/Hoyer lift, morbidly obese/bariatric, blind, hearing impaired, wards of the state, complicated family/personal situations, complicated wounds, covid testing on admit, non-completed admission forms, especially for AM patients, difficult IV starts, patients having blocks, patients with multiple tubes on admit, patients with high anxiety and known home transportation issues.
Average Daily Census (ADC) annual average	**SSU** There is an average of 9 preoperative inpatients per day in the Short Stay Unit (SSU) requiring preoperative care possible postoperative care (OPB and AM). There is an average of 15 same day/endoscopy patients per day in SSU, requiring both preoperative and postoperative care. There is an average of 5 series patients daily. **PAT** Charge nurse gets between 30-40 pieces of chart information in 8-hour period. Charge nurse also answers phone calls, answers questions from anesthesia, answers questions from patients, managers and other medical related questions. There is an average of 11-day surgery patients called daily. There is an average of 8 AM/OPB patients called daily There are at least 9 attempts to call patients daily (including charting review). Average of 233-day surgery calls a month and 168 AM/OBP patients called a month. There is an average of 200 attempted phone calls monthly.
Average Length of Stay (LOS) annual average	**SSU** Together all patients require an average of 128 minutes (about 2 hours) each for preoperative care, and 65 minutes average for postoperative care for non-total joint patients. Those patients receiving preoperative nerve blocks require an average of 35 minutes more preoperative nursing care than those patients without nerve blocks. Postop time for total joint patients discharging the same day averages 123 minutes.

	There is an average of 5 series patients per day in SSU, requiring an average of 49 minutes of care. There is an average of 0.73 cancellations per day (3.65 per week), following admission in SSU on the day of procedure. The average time for unscheduled patient transfers to an inpatient unit from the SSU is 60 minutes. **PAT** There is an average time of 3-5 min to get most patient chart records. Charge nurses can get an average of 40 charts completed in an 8-hour period. There is an average of 10 minutes preparing chart for interview. The average phone call for day surgery patient is 65 min. The average time of phone call for OPB/CVPR surgery patient is 90 min. Average time of phone call for AM surgery patient 155 min.
Specialized qualifications and competencies (include requirements for travel nurses)	**Qualifications and Competencies:** SSU RNs – BLS, ACLS, PALS, and one-time Moderate Sedation class with annual refresher required. PAT RNs – BLS required CNA IIs – BLS required All RN staff members are encouraged to achieve the Certified Ambulatory Peri Anesthesia Nurse or Medical/Surgical ANCC certification **Guidelines followed:** ASPAN Guidelines 2021-2022 Joint Commission Standards/National Patient Safety Goals 2021 Preoperative nursing and anesthesia patient instructions based on the American Society of Anesthesiologists Basic Standards for Peri Anesthesia Care – October 28, 2015 (most current version per Chief of Anesthesia) Licensed Independent Practitioner (LIP) discharge teaching instruction sheets for appropriate diagnosis, updated as needed Ongoing education related to technology changes and LIP preferences Annual staff evaluations Nurse Staffing Law, Senate Bill 469, 2016 **Annual Competencies:** Moderate sedation refresher Blood administration Glucometer POC

	Restraints **<u>Quality Measures:</u>** Handwashing Patient falls Transfusion Protocol compliance Medication errors/trends Event Reporting in Riskonnect Prevention of wrong patient, wrong procedure, wrong site surgery, through pre-procedure verification of documentation Staff injuries Education and communication with primary care provider completed for Endoscopy and series patients starting new medications Pain assessment/Reassessment Annual QI projects Employee satisfaction survey Mandatory and voluntary overtime Missed or late lunches SRDFs/Staffing situations when ratios aren't within ASPAN Guidelines
Skill Mix and level of competency required to meet the healthcare needs of patients	SSU RNs – BLS, ACLS, PALS, and onetime Moderate sedation class and annual refresher required. PAT RNs – BLS required CNA IIs – BLS required All RN staff members are encouraged to achieve the Certified Ambulatory Peri Anesthesia Nurse or Medical/Surgical ANCC certification Ongoing education related to technology changes and LIP preferences Annual staff evaluations Healthstream Competencies
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	**<u>SSU:</u>** Because we are a unit that closes, we are always in the process of discharge or transfer. Patients are escorted back to an SSU bed as RN and beds become available. Patients are prepared for surgery (checklists completed, IV, labs, EKG, anesthesia visit, surgeon visit, orders complete) and transferred to OR. Preparing a patient for surgery will take appx. 128 minutes on average, if needing a block will take 163 minutes on average.

	Patients arrive back to post-op SSU when beds and RN become available. Report is given by PACU /OR/ENDO RN to SSU post op RN. When patients arrive to postop SSU, they are given an assessment, full set of vital signs (q15 min), dressing checks, positioned for comfort (ice bags, pillows), and assessed for pain and nausea. This process takes about 12 min. average Post-op patients are reassessed Q15 min for change in status. Before discharge of patient, discharge teaching is completed by RN including new meds, continuing meds, diet changes, incision and dressing orders/care, info on type of surgery and expectations, signs and symptoms of infection, anesthesia info including not driving, signs and symptoms of anesthesia complications. This process takes about 20 minutes on average. Postop patients are there for 65 minutes on average. Total joint patients have added time for post-op care. Physical therapy evaluates patients for ability to function at home with walking, sitting, standing and climbing stairs as well as teaching (4-page TJ instruction sheet) -usually patient's coach is also at bedside to learn. Post-op RN completes teaching sheets, pain control info and usual discharge instruction sheets by surgeon and anesthesia. Average time for post-op total joint patients is 123 minutes. If a total joint patient fails to meet safety and standards, they will be transferred to Surgical Care Unit (SCU) for overnight stay with MD order. **SERIES:** Series patients are scheduled by the unit secretaries 7 days a week, usually from 0800-1200. Wheelchair bound patients are picked up by NSM at registration and taken up to SSU. Ambulatory patients come in through the SSU door after ringing the doorbell. Series patients are settled into a chair or bed (patient preference). Charts are looked at for orders. Routine vital signs done, IV infusions and IV site care completed, chart flow sheets completed, labs taken, and discharge paperwork completed. Ambulatory patients leave on their own and wheelchair bound patients are taken to Registration or to car as needed. **PAT:** RN obtains patient chart from first drawer in PAT office. These charts have already been processed by the charge nurse and have patient information already in chart. RN reviews chart to see what diagnosis patient has, looks at medication list, MD orders to get a summary of patient before telephone call (TC). TC done by RN. Information taken from patient about height, weight, allergies, medication list ("medication reconciliation" form) "Short Stay Unit Record" filled out, preop teaching done using "Procedure Information Sheet" including how and when to shower, medication to continue vs. stop (using "Medications from Anesthesia" sheet) and eating/drinking information. After patient call, chart is completed by adding pertinent information into CHP (computer) (height, weight, allergies, diagnosis info, smoking history, and pharmacy name). The chart is then arranged per anesthesia preference. If there is any outside information needed (i.e., ECHO, cardiology or pulmonary) this information is asked for by faxing outside sources a request

	form. If this is a day surgery patient, it takes an average of 65 minutes. If this is an OPB patient other work is included (enter meds in CHP, enter diagnosis in CHP add Flu vaccine in CHP). OPB patients take an average of 90 minutes. For an AM patient, most of work in in computer. Under the monopoly icon, the PAT section is filled out (with current and history of patient), interdisciplinary section filled out and Care Plan started. CHP filled out. AM patients average 155 minutes. These charts are then sent up to the anesthesia department on the second floor to be reviewed or called. Our anesthesia department are all MDs. Once charts are reviewed or called, they are brought back to the PAT department to be processed. If there are any MD orders, these will be processed. When charts are complete, they will be sent to SSU where charts will be put in chart backs and prepared for patient arrival.
Nationally Recognized Standards or Guidelines	Medical/Surgical ANCC certification ASPAN Guidelines Joint Commission Standards/National Patient Safety Goals 2021 Preoperative nursing and anesthesia patient instructions based on the American Society of Anesthesiologist Basic Standards for Peri Anesthesia Care- December 13, 2020 (most current version per Chief of Anesthesia). Licensed Independent Practitioner (LIP) discharge teaching instruction sheets for appropriate diagnosis, updated as needed. Ongoing education related to technology changes in LIP preferences. Nursing Staffing Law, Senate Bill 469, 2016.
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	Staffing in SSU is based on the American Society for Peri Anesthesia Nurses (ASPAN) Guidelines and adjusted as needed throughout the day to accommodate patient safety need and changes in status. PAT RNs complete an Acuity and Intensity Form after each patient phone call in which a number (acuity score) is assigned to each patient and added to Admission Nurse Worklist. This acuity score is used in SSU as a staffing tool to understand the underlying complications of patient for pre and postop. Staffing will be based on this acuity score.

	Series patient care on the weekends requires a minimum of two NSM. One RN is scheduled each weekend day. Other RNs, not normally scheduled on weekends are given a number and rotated through the list, covering a 0800-1200 call shift for one weekend day. If a CNA II volunteers to work, that person will be the second NSM. If no CNAs are available to act as the second NSM or the RN is not working that day, the call RN will work. If seven or more patients are scheduled that day, two RNs will be scheduled with CNA II help. These additional staff will be volunteers. CNA II are not required to work on weekends. Criteria for adjusting staff assignments may include, but are not limited to: arrival of pediatric patients with/without a parent, addition of series patients, additional PAT visit patients, add-on/delayed endoscopy or surgical procedure patients, relief charge or preceptor duties, pre-procedure telephone calls needing completion, ability to close department, absence of scheduled NSM support, need to temporarily hold patients due to increased inpatient census. Patient conditions that contribute to a higher level of acuity include, but are not limited to: known issues based on PAT visit/phone call, using the "Admission Nurse Worklist" and "SSU/PAT Intensity and Acuity Form" for continuity of care, change in mental status or vital signs, increased pain level compared to pain score on transfer from PACU, inability to void per provider orders, complicated family situation/interpersonal interactions.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	SSU staffing is comprised of Charge Nurses (CN), staff RNs, and Certified Nurse Assistant IIs (CNA IIs). PAT staffing is comprised of a CN and staff RNs Staffing is supported by the Nurse Manager, anesthesiologists, pharmacists and support services. Minimum staffing consists of at least one RN and another licensed nursing staff member when a patient is present in the unit. **Weekday minimum staffing breakdown (this is based on 26 patients all being on the unit at the same time. The max number of patients our unit can hold at one time is 26. It is extremely unlikely to have that many at once):** 1 Patient = 1 RN + 1 NSM 2 Patients = 1 RN + 1 NSM 3 Patients = 1 RN + 1 NSM 4 Patients = 2 RNs 5 Patients = 2 RNs 6 Patients = 2 RNs

	7 Patients = 3 RNs 8 Patients = 3 RNs 9 Patients = 3 RNs 10 Patients = 4 RNs 11 Patients = 4 RNs 12 Patients = 4 RNs 13 Patients = 5 RNs 14 Patients = 5 RNs 15 Patients = 5 RNs 16 Patients = 6 RNs 17 Patients = 6 RNs 18 Patients = 6 RNs 19 Patients = 7 RNs 20 Patients = 7 RNs 21 Patients = 7 RNs 22 Patients = 8 RNs 23 Patients = 8 RNs 24 Patients = 8 RNs 25 Patients = 9 RNs 26 Patients = 9 RNs **Ideal Staffing Numbers:** 1 Patient = 1 RN + 1 NSM 2 Patients = 1 RN + 1 NSM 3 Patients = 1 RN + 1 NSM 4 Patients = 2 RNs + 1 NSM 5 Patients = 2 RNs + 1 NSM 6 Patients = 2 RNs + 1 NSM 7 Patients = 3 RNs + 1 NSM 8 Patients = 3 RNs + 1 NSM 9 Patients = 3 RNs + 1 NSM 10 Patients = 4 RNs + 2 NSM 11 Patients = 4 RNs + 2 NSM 12 Patients = 4 RNs + 2 NSM 13 Patients = 5 RNs + 2 NSM 14 Patients = 5 RNs + 2 NSM 15 Patients = 5 RNs + 2 NSM 16 Patients = 6 RNs + 2 NSM

	17 Patients = 6 RNs + 2 NSM 18 Patients = 6 RNs + 2 NSM 19 Patients = 7 RNs + 2 NSM 20 Patients = 7 RNs + 2 NSM 21 Patients = 7 RNs + 3 NSM 22 Patients = 8 RNs + 3 NSM 23 Patients = 8 RNs + 3 NSM 24 Patients = 8 RNs + 3 NSM 25 Patients = 9 RNs + 3 NSM 26 Patients = 9 RNs + 3 NSM **Weekend Series Staffing:** Patients are required to have personal assistance to/from the unit, as the NSMs cannot leave the unit when there are only 2. On weekend days where we have only 6 series patients, only 3 patients at a time are on the unit: 3 Patients = 1 RN + 1 NSM On weekends where there are 7 or more patients, 2RNs are on site in order to have more than 3 patients on the unit at once. (4 patients = 2 RN [technically with 2 RNs, there could be 6 patients on the floor, as the minimum is 1 RN to 3 patients, but patients are scheduled in a staggered manner.) Staffing decisions are made one day ahead by CNs who evaluate PAT, OR, Endoscopy, DI, and series patient schedules for proposed census, timing, and patient complexity. If a NSM has requested an “off if possible” shift, it may be entered on the (paper) daily staffing sheet as a “Will Call”, or W/C. It is the responsibility of the NSM to call in to the CN two (2) hours before the scheduled start time. If scheduled earlier than 0830, calls to the CN will occur no earlier than 0630. If “will call” nursing staff member(s) are needed, they have up to two hours to report to work. Staff will contact CN 2 hours before scheduled start time if they need to call out ill. A “Staff Roster/ Work Early or Extension” sheet will be used to document additional staffing needs, which will be based on Nurse Staff Member (NSM) status and equal distribution of shifts as well as the Professional Agreement between Oregon Nurses Association or SEIU and McKenzie Willamette Medical Center. The staffing sheet is faxed to the House Coordinator (HC) each evening, Monday-Friday.

	If staffing adjustments need to be made during shift, the CNs of all areas communicate to adjust start times, secure additional trained staff, or low census staff accordingly. Trained SSU RNs may be assigned to PAT based on census or staffing need. Staff begin shifts between 0500 and 1300, working eight or ten hours per shift. This is based on the scheduled procedure/therapy time, anticipated return to SSU following procedure, number of patients to be called by PAT RNs, and the number of series patients. The House Coordinator will be notified when staff support is needed; staff can also be released to other patient units, to which they are currently oriented or as a constant observer, or low censused, based on patient volume and staff percentage. Projected staffing needs that differ from actual staffing needs for the department will be reviewed with management as soon as possible. Regular RN staff "start windows" (one hour before to one hour after start time) are utilized on a daily basis according to available staff, patient census and skill mix. An assignment time and location phone message is created each evening for staff to access in order to know their next day's assignment. PAT nurses begin shift at 0800 to 1830, M-F with staggered start times and end times.
Describe process for limiting admissions/diversions to another hospital etc.	**Diversion Avoidance Process:** SSU will remain open for admissions if there is capacity and capability to do so. Per OAR 33-510-0045(3)(g) a direct care RN may initiate the process for limiting admissions to SSU when, in their judgment, there is an inability to meet patient care needs or a risk of harm to patients exists. The direct care nurse will notify the SSU Charge nurse who will then alert the House Coordinator, the SSU Manager and/or the Administrator on-call. These individuals will collaborate with other departments to accommodate safe patient throughput and to prevent diversion whenever possible utilizing PC01-021: Managing patient Flow and Inpatient Capacity.

Describe non-direct care tasks including meals and breaks	**Meal and rest breaks:** Rest/meal breaks will follow the Professional Agreements between MWMC and the ONA and SEIU. The provision of a meal/rest breaks is done on a rotation basis among nurses using a free nurse and/or the charge nurse, manager, or other nurses who have a partial team of patients. The covering nurse shall have no more than three (3) preoperative patients, or three (3) postoperative patients total when covering for breaks. Rounding every half hour must be current and report given before going on break. The necessity to request additional staff to complete timely breaks is decided by the Charge RN after review with direct patient care RNs. The CN will utilize the chain of command for rest/meal break support as needed. The daily staffing sheet shall reflect who has received their rest/mealtimes. Staff will enter actual times in the break/meal column respectively, and one initial for all breaks for the day. This is not mandatory for record keeping but rather a tracking mechanism for the CN to ensure all staff are receiving timely breaks. On-call staff (series) will notify HC if rest/meal breaks are needed. Involuntarily missed/late meals will be communicated to the CN and management as soon as possible. CNA II breaks and lunches will be the same as RN. PAT nurses write break and lunch times on daily staffing sheet. Staggered break times or break nurses are not required because PAT is not a patient care area. **Non-direct care in SSU:** Stocking blanket warmer with IV bags and blankets Emptying trash Emptying linens Making beds Ped and Adult code cart check offs Stocking series carts, IV carts and CNA II carts CBG machines uploaded and QCd Thermometers checked and dispensed Chart backs cleaned and ready for use

	Patient charts completed and ready for patient admission (orders, H&P, labs, EKG etc.) Scheduling infusions Completing charges and stats E-Fax orders completed and printed Answering phones and doorbell Ordering EKG, labs, breathing treatments etc. Calculating and entering charges Verifying surgery schedules Verifying pre-op documents for next day (work one day ahead) Faxing orders to pharmacy Ordering daily supplies Sending infusion orders and patient info to insurance verification Restocking/printing chart forms Building Block packets Printing forms from Imprint Running HCGs Delivering specimens to lab Returning wheelchairs to SSU or lobby Creating patient magnets Moving beds and chairs as needed Taking patient belongings to necessary postop floors Updating/maintaining white board Post-op calls Communicating needs to other floors Inventorying Pyxis Drawing meds SBAR for meals/breaks Making coffee Maintaining discharge papers/instructions Checking for phones (17) Checking vein viewer Checking INR kit readiness Checking O2 tanks of gurneys Tidying break room Stocking nurses station kitchen Checking Hoyer slings Organizing Equipment room Restocking gloves/Emesis bags/Sani-wipes

	Stocking site markers Stocking patient cupboards Checking restrooms for cleanliness Filling patient bed bag kits Documenting warmer temps Transporting charts between SSU, PAT and Anesthesia as needed Compiling charts 3 days in advance
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	The day before, the charge nurse of both SSU and PAT will make appropriate staffing plans based on surgery and series schedule. If there is a lack of staff, resource nurses are asked if they can work or nurses that are off that day are contacted for extra work. This also works for sick calls and changes in census. There are usually five RN's and one unit secretary that work in PAT. If there are sick calls, work is absorbed by RNs that are working that day. SSU RNs who are cross trained will be floated to PAT if SSU staffing allows. If there are multiple next-day charts to complete, PAT resource RNs are called to ask if they can work. SSU nurses are asked if they can work, though they need to be oriented to PAT.
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	UPC meeting will be held at end of December or early January to gather the data that was obtained during the year. A template will be completed by UPC that includes: Patient Outcomes Non-OT staffing Complaints (SRDF) MHPPD to # of patient served in a 24-hour period Aggregate Mandatory OT worked Aggregate Voluntary OT worked % of shifts for which staffing differed from NS plan Other considerations Report of unit engaging in pattern of mandatory or non-emergency OT

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Cath Lab	
Effective Date: 10\1\2023	
Staffing Committee Representatives: DeLaina Shahan RN	
Criteria-Description of Patient Population	Procedural unit providing services for Cardiology, Vascular, Interventional Radiology, and Electrophysiology procedures to the adult population.
Average Daily Census (ADC) annual average	The average daily census varies with an annual average of 2000 cases, average 10 cases/day which includes add-on cases in addition to scheduled cases. This average is based on 4 10hr work days/wk with some of these cases falling on call days.
Average Length of Stay (LOS) annual average	N/A Procedural Area
Specialized qualifications and competencies (include requirements for travel nurses)	1. Oregon Nursing License for RNs 2. Oregon Radiology License for RTRs 3. BLS 4. ACLS 5. Moderate Sedation Competency for RNs 6. Critical Care Competencies for RNs (see Staff Development) 7. Annual hospital required education for RNs and RTRs (see Staff Development) 8. Device pocket closure check off for RTRs 9. Sheath pull competency 10. Completion of the Clinical Orientation Guidelines for Cath Lab Staff
Skill Mix and level of competency required to meet the healthcare needs of patients	Minimum staffing includes 4 personnel per case consisting of: 1. 1 Cath Lab RN whose sole role is to provide procedural sedation and monitoring of the patient. 2. 1 Radiology Technologist Registered (RTR), who are considered “Nurse Staff Members” under waiver filed with OHA, to assist the MD table side with procedure 3. 2 Cath Lab RNs or RTRs to monitor, document, and circulate the case 4. Hybrid Cases: 1 CVOR RN, 1 CVOR CST, 1 Anesthesia Tech, 1 RTR Cath Lab, 1 Cath Lab staff (RN or RTR) 5. EP Cases: 4 staff members, mix of RTR’s and RN’s similar to cath lab

	6. Staffing levels are consistent for all rooms. *In cases where there is an Anesthesiologist present, the minimum staffing is 3 personnel. See section above for competencies. *Staffing guidelines are as recommended by The Society for Cardiovascular Angiography and Interventions (SCAI) Expert Consensus Statement: Best Practices in the Cardiac Catherization Laboratory (2021)
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	NA Procedural Area
Nationally Recognized Standards or Guidelines	1. American Association of Critical Care Nurses (AACN) Scope and Standards for Acute and Critical Care Nursing Practice (2015) 2. The Association of Radiologic and Imaging Nursing (ARIN): Clinical Practice Guideline Moderate Sedation and Analgesia (2009) 3. The Society for Cardiovascular Angiography and Interventions (SCAI) Expert Consensus Statement: Best Practices in the Cardiac Catheterization Laboratory (2021) 4. Oregon Nurse Practice Act (2022) 5. The American Registry of Radiologic Technologist (ARRT): The Practice Standards for Medical Imaging and Radiation Therapy (2017) 6. Medical Imaging Practitioners and Limited X-Ray Machine Operators Oregon Revised Statutes (2022) 7. Heart Rhythm Society Expert Consensus Statement on Electrophysiology Laboratory Standards: Process, Protocols, Equipment, Personnel, and Safety (2020)
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.)	Assignments are adjusted throughout the shift as patient census, patient condition, and staff availability/skill mix change. The manager or lead also assesses throughout each shift whether patient care needs are being met or if patient safety is at risk and adjustments are made accordingly. If the direct care RN determines that patient care needs are not being met or patient safety is at risk, the RN will use the chain of command to ensure appropriate patient care. Acuity varies by diagnosis and patient condition making the CCL a dynamic and diverse

What is the process of changing the overall acuity and intensity of the unit and who can make that change?	procedural unit. The combination of Mallampati score, American Society of Anesthesiology (ASA) physical status classification and Stop-Bang score aid in determining acuity beforehand.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	A minimum of 2 RNs and 2 RTRs are required to operate one room unless an anesthesiologist is present. The minimum staff for a call shift is 2 RNs and 2 RTRs.
Describe process for limiting admissions/diversions to another hospital etc.	If no cath labs are operable or can be adequately staffed, the chain of command will be notified so that measures can be taken to ensure patient safety.
Describe non-direct care tasks including meals and breaks	1. Other case roles such as: monitoring, documenting, and circulating cases. 2. Quality control of equipment such as: Defibrillators, Hemochrons, room temperatures, room humidity, Glucometer 3. Monthly audits of breaks and lunches 4. Monthly audits of cases as required by the hospital Quality and Risk department 5. Room turnover and cleaning 6. Room restocking 7. Checking supplies for outdates 8. Providing breaks and lunches to all staff staying within the CL NSP Guides
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	In case of problematic staffing issues, the nurse has a chain of command to follow: Team Leader > Manager > Director of CV Services or House Coordinator > CNO/Admin on Call. Staffing issues are dealt with collaboratively between those listed above in the chain of command and staff. Additional staff may be obtained from the following: 1. Regular cath lab staff not scheduled 2. Resource cath lab staff 3. CVPR nurses who have been cross trained to the Cath Lab
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address?	SRDF's Mandatory OT hours Riskonnects: untoward patient outcomes, staff injuries Door to balloon time average YTD Average daily productivity YTD
ATTACH UNIT STAFFING GUIDES	

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Critical Care Unit (CCU)	
Effective Date: August 2nd, 2023	
Staffing Committee Representatives: Jennifer Cave (Primary), Suzanne Salgado (Secondary)	
Criteria-Description of Patient Population	CCU is an adult Critical Care Unit specializing in the care of the critically ill adult. Patient population includes but is not limited to patients experiencing neurological, cardiac, pulmonary, renal, metabolic and infectious conditions with hemodynamic instability, and those who are in their post-operative period. Population also includes, acute medical, surgical, or telemetry level patients awaiting transfer to an appropriate acute care unit. Care is provided 24 hours per day, 7 days a week. Specialized care in the CCU is described in the "Patient Population and Care Environment" section, and includes the following but is not limited to: Hemodynamic Monitoring and Management of Vasoactive Drips Antiarrhythmic Drips Anticoagulation Drips IABP Impella Temporary Pacemaker Management Hypothermia/Targeted Temperature Management Ventilator Support Chest Tube Management Pericardiocentesis PA Catheter Management EKOS CRRT Cheetah Fluid Management System TEEs & Cardioversions

	Admission of pre-procedure or pre-op patients. Moderate Sedation management. Recovery of post-op patients. Recovery of post cath lab patients with and without sheath pulls. Patient education related to all listed disease conditions, pre and post procedure education, and DC teaching. Our unit includes 16 private inpatient rooms numbered 265-280. 272 & 273 rooms are designed to care for bariatric patients, are equipped with ceiling lifts and have showers in the rooms. 274 is designed as a negative air flow room. Two shower rooms are located at the South end of the unit across from 272. All rooms are equipped with cardiac monitoring, (rooms 273-280 can monitor two more pressure lines than 265-272), and have dialysis capability. The CVOR, Hybrid and Cath lab units are located adjacent to our unit. The consultation room, two store rooms, dirty utility, staff break room and 3 office spaces are located within the CCU. The unit has a locked entrance. Our family waiting room is located outside of the CCU. Our patients are admitted to the CCU via MWMC ED, direct transfer from surrounding area hospitals and directly from local physician offices or urgent care clinics. Our patient population includes the following but is not limited to: **Open Heart Surgeries (OHS)** Post–Op Open Heart Surgical patients up to discharge from hospital **Vascular Surgeries** including Abdominal Aortic Aneurysm Repair, Carotid Endarterectomy, Femoral-Popliteal Bypass, Peripheral angiograms, TCARs and peripheral vascular disease **Thoracic Surgeries** including Video Assisted Thoracotomy (VAT), lobectomy, and pneumonectomy **Other Patient Populations:** TAVR Acute Coronary Syndrome w/Chest Pain Acute Myocardial Infarction/STEMI

	Cardiac Arrest/Cardiogenic Shock Cardiac Arrhythmias/Conduction Disorders Pre and Post Cardiac Angiography-diagnostic and intervention Hypertensive Crisis Pulmonary Edema Pulmonary Embolus COPD Pneumonia Endocarditis Heart Failure CVA AKI Acute Respiratory Failure Drug/ETOH Withdrawal Sepsis Acute Renal Failure Poisoning and Toxic Effects of Drugs DKA Attempted Suicide/Suicidal Ideation Severe gastrointestinal bleeding CNS infections Seizures Unstable post-surgical patients Electrolyte and Metabolic Disorders Multiple System Organ Failure Life Threatening Infections Complex high risk antepartum and post-partum patients Major abdominal surgery Severe delirium Difficult social or psychiatric patients who are stable but require a higher level of observation are frequently housed in the CCU. Limited outpatient procedures are provided.

	Outpatient procedures include but not limited to*:* ▪ TEE ▪ Cardioversion Other services provided by CCU include: Remote telemetry monitoring and interpretation of SCU tele patients.
Average Daily Census (ADC) annual average	Average Monthly Census for 2022: 383.7 patients Average Daily Census for 2022: 12.6 patients
Average Length of Stay (LOS) annual average	The average length of stay in CCU is 3.7 days
Specialized qualifications and competencies (include requirements for travel nurses)	Required competencies for CCU RNs will be documented in HealthStream and will be completed per the Critical Care Professional Development Plan and Calendar as maintained by the hospital education department. Plan attached to this staffing plan. Specialized Competency Levels for CCU RNs include: • C-1: C1 RNs are able to competently care for our most critical CCU patients. C1 RNs have completed all necessary education requirements and have passed a BKAT or ECCO Module Exam through our critical care educator. • C-2: C2 RNs are actively working towards obtaining their C1 status which should be completed within one year of hire or transfer into the unit. C2 RNs may care for stable CCU patients independently and for unstable patients with back-up support from a C1 RN. • Advanced competencies include CRRT, IABP, Impella Support, and immediate post-OHS care. RNs who have been deemed competent to care for these patients have undergone additional training with our Critical Care Educator and have had their competencies documented in their HealthStream record.

	Nurses floating to CCU from another unit: ● Intermediate RNs may care for intermediate level patients per the Intermediate Patient Placement Guidelines. Medical or Surgical RNs may care for the med/surg patients in the CCU per the Patient Placement Guidelines. ● Nurses floated to CCU from another unit will be assigned a patient care team that has the lowest acuity on the floor and/or a lesser number of patients per the 2021 ONA contract. Travel Nurses working in the CCU will have and maintain competency in the following for the duration of their contract: ● Basic and Advanced Life Support (BLS and ACLS) ● General Nursing Orientation New Hire Skills Completion checklist for CCU RNs (competency attached) Charge nurses use their expert judgment in addition to considering the acuity and intensity of the patient in order to make appropriate patient assignments.
Skill Mix and level of competency required to meet the healthcare needs of patients	Each shift CCU will be staffed with RNs with the following skill mix in order to adequately meet the needs of the patients. Any one nurse may have more than one skill code assigned to them. Overall number of staff based on minimum and goal staffing guides: ● A C1 RN in addition to the Charge RN who is also a C1 RN. ● A post-OHS RN ● An RN who is IABP and Impella competent ● An RN who is CRRT competent
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	Annual 2022 Data: ● Average Daily Admits: 2.9 ● Average Time to Complete an Admission: 60 minutes ● Average Daily Discharges: 2.2 ● Average Time to Complete a Discharge: 45 minutes

	● Average Daily Transfers: 1.7 ● Average Time to Complete a Transfer: 25 minutes ADT %: 42%
Nationally Recognized Standards or Guidelines	CCU follows guidelines set forth by American Association of Critical Care Nursing (AACN), American Heart Association (AHA), all McKenzie-Willamette policies and procedures, and per the nursing guidelines listed on facility intranet.
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	**Staffing for acuity and nurse intensity** Patient care is provided following the American Association of Critical Care Nurses (AACN) Scope & Standards for Acute and Critical Care Nursing Practice and AACN's Synergy Model 2015 2nd edition. Daily shift assignments are based on patient acuity, patient intensity and skill level of nurses in order to provide safe patient care and accommodate the needs of the patients and their families. **Advanced Acuity Levels:** **Recovery level** patients include but are not limited to: immediate recovery period following open-heart, vascular, and/or thoracic surgery. These patients will be 2:1 or 1:1 nurse to patient ratio for a minimum of the first post-surgical hour or until phase I recovery requirements are met for surgeries other than OHS. **Advanced Critical Acuity 1:1** IABP therapy, Impella therapy, CRRT, hemodynamically unstable patients requiring continuous nursing interventions. Special consideration 1:1 patients include those patients who have an LIP ordered constant observer which is provided by a qualified staff member. **Critical Acuity 1:2** patients include but are not limited to: See Patient Placement Guidelines under Critical Care category **Intermediate acuity 1:3** See Patient Guidelines under Intermediate Care category.

	On occasion, CCU provides care for a M/S tele or non-tele patient. These patients are 1:4 nurse/patient ratio depending upon intensity of the nursing care provided. A 4 patient medical team requires a resource RN on the floor. See Patient Placement Guidelines under Med/Surg. **Acuity/Intensity Tool** CCU determines acuity and intensity based on the McKenzie Willamette Medical Center Acuity/Intensity Tool. Two patient teams should not have an acuity >12. Three patient teams should not have an acuity >11. Conditions that can contribute to higher intensity include (but not limited to): Aggressiveness and/or dementia Delirium Incontinence Frequent wound care Hourly blood sugars High fall risk with risk of injury Total feeder or total care Frequent toileting assist 2 person assist to transfer The CCU will assist the house by sending an RN to in-house Rapid Response's, Code Blue's, Stroke Alerts and (add Code Copper?), Code Ruby's per PC04-038 Cardiopulmonary Emergency Code Response and PC04-043 Rapid Response Team policies. The house coordinator will provide in unit back up to the CCU staff when the charge nurse attendance at the events listed above creates a potentially unsafe situation on the unit. Appropriateness of admissions to the CCU is guided by the Hospital Policy CC01-004: Admission and Discharge Criteria CCU and the patient placement guidelines.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts?	Each shift shall be staffed with a 12-hour CCU Charge Nurse (CN) who does not take a patient team except transitionally. A CNA 2 or other clinical staff member can be requested as a sitter instead of an RN. Core staffing is a mix of C-1 OHS, C-1 and C2 trained nurses. When there are more than 4 full teams or when

<table>
<tr><td></td><td>acuity/intensity deems it necessary per charge RN, a resource RN will be available to assist with code/RRT responses, to facilitate rapid movement of post-Code Blue or decompensating patients to CCU from the ED or other nursing unit, assist with ADLs, procedures and meal and rest break coverage. High nursing care intensity patients are determined by primary RN and verified by charge nurse. Charge nurse will determine if high intensity of unit warrants an additional NSM to be added.</td></tr>
<tr><td>CCU Minimum Staffing</td><td>
<table>
<tr><th>Number of patients</th><th>Advanced ICU with 1:1 ratio</th><th>Critical/ICU with 1:2</th><th>Intermediate/PCU with 1:3 ratio</th><th>Med/Surg overflow with 1:4 ratio</th></tr>
<tr><td>1</td><td>2</td><td>2</td><td>2</td><td>2</td></tr>
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12	13	7	5	4
13	14	8	6	5
14	15	8	6	5
15	16	9	6	5
16	17	9	7	5

CCU direct care nursing staff is supported by the CCU Assistant Manager, CCU Nurse Manager, Staffing office, House Coordinator, the CCU Medical Director and colleagues, Hospitalists, Intensivists, respiratory care, physical therapy, occupational therapy, PICC RNs, pharmacists, dieticians, care managers, cardiac rehab, environmental services, Cath Lab and CVOR staff as needed. Census and acuity fluctuations due to admissions, discharges, transfers in and/or out of the unit, and procedures are managed by utilizing any other qualified RNs as available. Low census and standby will follow Professional Agreement between Oregon Nurses Association and McKenzie Willamette Medical Center.

The CN is responsible to evaluate the current census, patient acuity levels, staff available, skill code, and anticipated activity in the CCU for that shift and the next shift. Anticipated activities include admissions, discharges, transfers in or out of the unit, procedures and surgeries. The CN will make appropriate assignments based on this information. Throughout the shift the CN will delegate additional responsibilities as patient needs warrant. The CN will assure that the appropriate RN skill level matches the patient's acuity needs in order to maintain unit flow/throughput.

Regularly scheduled CCU nurses may be floated to other departments per ONA contract. If there is a critical patient that is admitted or transferred into the unit and the current CCU staff members working are not able to accommodate such an admit or transfer the nurse that was floated off of the unit will be relieved to return to the unit within 30 minutes of the need arising. The nurse may

	be relieved by the Director, Manager, Charge RN, house supervisor, or any other qualified NSM of the unit that the CCU nurse floated to. In the case when additional staff is needed, a collaborative effort between Department Manager, staff, staffing office, and the house coordinator is made. Additional staff may be obtained from the following options: -Regular CCU RN's who have prearranged extra work or standby status. -PCU RN's who have prearranged extra work or standby status. -Resource CCU and PCU RN's -Float Med/Surg Tele RN's -Nurse Managers -Per diem Nurse Staffing Agencies and Travel RN's -Off Duty regularly scheduled CCU staff. SRDF's are a tool used by nursing staff and the hospital to document incidences of problematic staffing which allows for timely follow up and review of each occurrence. Staff is encouraged to report staffing concerns using the SRDF process.
Describe process for limiting admissions/diversions to another hospital etc.	CCU will remain open for admissions as long as there is capacity and capability. Per OAR 333-510-0045(3)(g) a direct care registered nurse may initiate the process for limiting admissions to CCU when, in their judgment, there is an inability to meet patient care needs or a risk of harm to patients exists. The direct care nurse will notify the CCU charge nurse who will then notify the House Coordinator, CCU Nurse Manager, or the Administrator On-Call. These individuals will collaborate with other departments to accommodate safe patient throughput and to prevent critical care diversion whenever possible utilizing PC01-021: Managing Patient Flow and Inpatient Capacity.
Describe non-direct care tasks including meals and breaks	**Meal and rest breaks** Meal and rest breaks will follow Professional agreement between MWMC and ONA. The provision of meal and rest breaks is done on a rotation basis among nurses using the charge nurse, the

	scheduled resource/break nurse, or a nurse with a partial patient team that would not be covering teams outside the staffing plan guides.
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	**Minimum staffing** In the event that the CCU has no patients in the unit, we will maintain the monitoring of telemetry patients on SCU. CCU will maintain a CN in house to cover RRTs, Code Blues, Code Ruby's, or other emergent patient need or transfer. ~~and a~~ Two direct care nurses will be on call should patients need to be admitted or transferred into the unit. At least one on call direct care nurse need to hold a C-1 status.
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of	2022 Data: • CCU Harm Events- ○ CAUTI: 1 occurrence ○ CLABSI: 1 occurrence ○ Falls: 12 occurrences ○ C.Diff: 9 occurrences ○ VAPS: 1 occurrence • SRDFs Filed- ○ 11 ○ Percentage of shifts outside of staffing plan based on SRDFs-1.5% • Hours per Patient Day- ○ Productive Hours-18.27 ○ Productive & Non-Productive Hours-20.79 • Mandatory OT Hours- ○ 0 (none) • Voluntary OT Hours- ○ 18,323.5 hours for 2022 ○ Average of 1526.9 hours per month Average of 381.7 hours per week

voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan Did the nurse staffing committee ask for additional information	
Attached: CCU Staffing Guides, Critical Care 2023 Professional Development Plan and Calendar, and General Nursing Orientation New Hire Skills Completion Checklist for CCU RNs	

CCU Staffing Guides

Number of patients	Advanced ICU with 1:1 ratio	Critical/ICU with 1:2	Intermediate/PCU with 1:3 ratio	Med/Surg overflow with 1:4 ratio
1	2	2	2	2
2	3	2	2	2
3	4	3	2	2
4	5	3	3	2
5	7	4	3	3
6	8	4	3	3
7	9	6	4	3
8	10	6	4	3
9	11	7	4	4
10	12	7	5	4
11	13	8	5	4
12	14	8	6	4
13	15	9	7	5
14	16	9	7	5
15	17	10	7	5
16	18	10	8	5

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: CVPR	
Effective Date: 10/01/2023	
Staffing Committee Representatives: Paul Stone RN	
Criteria-Description of Patient Population	A Blended Prep and recovery unit focused on a primarily ambulatory outpatient adult population including Cardiovascular Service Line (CVSL) and Interventional Radiology/Diagnostic Imaging (IR/DI). Additionally, IP/OP Vascular Access placement, IP/OP Stress Testing, IP/OP CVSL PAT testing
Average Daily Census (ADC) annual average	~13.5 Daily encounters in 2022
Average Length of Stay (LOS) annual average	2022 Data ALOS EP: 7.3hrs Cardiac: 6.6 hrs Vascular: 3.8 hrs
Specialized qualifications and competencies (include requirements for travel nurses)	1. Oregon Nursing License for RNs 2. BLS 3. ACLS 4. Moderate Sedation Competency for RNs 5. Critical Care Competencies for RNs (see Staff Development) 6. Annual hospital required education for RNs 7. Sheath pull competency 8. Completion of the Clinical Orientation Guidelines for CVPR Staff 9. Vascular Access specialized training and competencies VA-BC Accreditation
Skill Mix and level of competency required to meet the healthcare needs of patients	CVPR is staffed with all RN's with completed CVPR competencies at a minimum per assignment. VA is staffed with VA trained RN's.
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	N/A Outpatient and procedural area

Nationally Recognized Standards or Guidelines	1. American Society of PeriAnesthesia Nurses (ASPAN) (2023-2024) 2. The American College of Cardiology (ACC) 3. The Association of Radiologic and Imagining Nursing (ARIN) 4. Oregon Nurse Practice Act (2022) 5. Infusion Nurses Society (INS) (2021) 6. Centers for Disease Control (CDC)
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	Assignments are adjusted throughout the shift as patient acuity and nursing intensity change. CVPR addresses many different patient populations and needs and requires an adaptive team approach to adequately address these populations. Skill mix is accounted for in each assignment. The Charge RN or lead also assess throughout the shift whether patient care needs are being met or if patient safety is at risk and adjustments are made accordingly. If the direct care RN determines that patient care needs are not being met or patient safety is at risk, the RN will use the chain of command to ensure appropriate patient care.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	Shifts: 0500-1730 0730-2000 All shifts are staffed the same Minimum RNs available for patient care is 2 when a patient is present Sheath Pulls, Moderate Sedation, and any other appropriate patient will be a 1-1 ratio All other assignments will be at a 1-3 ratio subject to acuity and intensity
Describe process for limiting admissions/diversions to another hospital etc.	Designated Chain of command will be followed for any deviations from normal operation.
Describe non-direct care tasks including meals and breaks	Meal and rest breaks will follow Professional agreement between MWMC and ONA. The provision of meal and rest breaks is done on a rotation basis among nurses using the charge nurse or a nurse with a partial patient team that would not be covering teams outside the staffing plan guides. Non-Direct care Tasks: Quality: Glucometer and ACT QA Monthly audits

	Chart preps Patient TPC's pre procedure and post discharge Supply management Policies, Protocols, Discharge Teaching Instructions-updates
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	CVPR will utilize Charge RN or Resource personnel to remain within staffing guides. In the event current staff are unable to stay within guides Charge RN or Lead will utilize the chain of command to generate needed staff
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? Potential Reportable data: • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	SRDF's Mandatory OT Hours Percentage of shifts for which staffing differed from the Nurse Staffing Plan-via SRDF's Riskonnects: unexpected patient outcomes, staff injuries
ATTACH UNIT STAFFING GUIDES	

McKenzie-Willamette Medical Center Nurse Staffing Plan	
Department: Emergency Department (ED)	
Effective Date: October 17, 2023	
Staffing Committee Representatives: J. Crow Bolt (Primary), Tanya Richardson (Alternate)	
Criteria-Description of Patient Population	The Emergency Department patient population ranges from infant to geriatric with a wide variety of urgent and emergent care needs. Care is provided 24 hours per day, 7 days per week. The ED is a state-designated Level III Trauma Center accredited by the Joint Commission. The ED's primary diagnoses for 2023 are Abdominal Pain, Chest Pain, Respiratory Illness, Abscess, Cellulitis, Contusion, Laceration, Headache and Back Pain. The ED includes 20 Basic Exam Rooms, 3 Triage Bays, 5 Pivot Pod Rooms, 8 Fast Track Rooms, 3 Resuscitation Bays/Major Exam Rooms, 1 Behavioral Health Safe Room and 1 decontamination room. The 3 Major Exam Rooms and Bed 32 can be operated as negative air flow rooms. Bed 23 is equipped with a Hoyer ceiling lift. Bed 32 has a shower. All Basic Exam Rooms and Major Exam Rooms are equipped with cardiac monitoring. Our consultation room, 2 storerooms, 3 medication rooms, 2 dirty utility rooms, staff break room and 2 office spaces are located within the ED. The unit has 6 access-controlled entrances, including one for EMS. Our patients arrive through the lobby, ambulance transport, or visitor or outpatient RRT. Our patient population includes adults and pediatric patients with a wide variety of socioeconomic backgrounds. Medical and behavioral conditions of this population include, but are not limited to, the following: Acute and chronic cardiovascular disease, including myocardial infarction and hypertension; acute and chronic respiratory conditions, including asthma and COPD; acute and chronic neurological conditions, including stroke and altered mental status; acute and chronic mental health emergencies, including suicidal ideation and schizophrenia; acute and chronic endocrinological conditions, including diabetes; acute and chronic musculoskeletal conditions, including fractures and sprains/strains; acute and chronic gastroenterological conditions, including bowel obstruction and appendicitis; acute and chronic obstetric conditions, including miscarriage; acute and chronic renal disease, including renal injury and failure; acute and chronic liver disease, including liver injury and failure; modified and full trauma; and substance abuse, overdose and withdrawal.

	When the inpatient units are full, admitted patients may be boarded in the ED using modified inpatient practices, including primary care, paper charting and outside specialty.
Average Daily Census (ADC) annual average	Average Daily Census for 2023 YTD: 136 patients. Average Daily Census for 2022: 127 patients.
Average Length of Stay (LOS) annual average	Average Length of Stay for 2023 YTD: • Hospitalization: 649 minutes • Discharge: 177 minutes • Transfer: 472 Average Length of Stay for 2022: • Hospitalization: 1,034 minutes • Discharge: 192 minutes • Transfer: 563 minutes
Specialized qualifications and competencies (include requirements for travel nurses)	Required competencies for ED RNs are documented in HealthStream and by the ED Educator. • **Required upon hire:** BLS • **Required before completion of orientation:** ACLS, PALS • **Required within 6 months of hire:** TNCC, NIHSS, Moderate Sedation Course • **Traveler requirements:** BLS, ACLS, PALS, and TNCC. • **Optional competencies and certifications**: BSN, SANE, CEN/CCRN • **Triage**: Successful passage of the ESI triage test after completion of the HealthStream triage course within 1 year of floor orientation. New grad RNs may require more ED experience for triage competency and may be extended to 2 years following floor orientation before orienting to triage, at the discretion of the ED manager. **Criteria for E1 Status:** The E1 RN must be competent to provide independent care of all ED patients in all levels of acuity; possess critical thinking skills; maintain proficiency with all ED procedures and equipment at such a level as to be a resource; and be able to provide assistance to other staff and providers. The E1 must possess organizational skills to be able to prioritize and sustain appropriate patient care load as assigned while being a resource for the department; be proficient in triage assessment and management; and demonstrate the ability

	to flex their own patient care loads and assist others to flex their patient care loads based on department patient acuity levels and staffing skill sets. Charge nurses must be at E1 status. **Criteria for E2 Status:** The E2 RN must be competent to provide independent care for stable ED patients. They must be able to provide care to unstable and/or critical patients with minimal guidance from the ED Charge RN, preceptor or ED physician. E2 must actively acquire measurable critical thinking skills and proficiency with all ED procedures and equipment.
Skill Mix and level of competency required to meet the healthcare needs of patients	Each shift, the ED will be staffed with RNs with at least one E1 RN in addition to the Charge RN. Overall number of staff is based on minimum and goal staffing guides.
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	• **Average Daily Admits, 2023 YTD:** 16 (15 in 2022) • **Average Time to Complete an Admission, 2023 YTD:** 434 (817 in 2022) • **Average Daily Discharges, 2023 YTD:** 114 (103 in 2022) • **Average Time to Complete a Discharge:** 60 minutes • **Average Daily Transfers, 2023 YTD:** <1 • **Average Time to Complete a Transfer, 2023 YTD:** 30 minutes
Nationally Recognized Standards or Guidelines	The ED follows guidelines set forth by the Emergency Nurses Association (ENA) and the Association of the American College of Emergency Physicians (ACEP). Triage acuity is determined in accordance with ENA ESI Implementation Guidelines: Revised 2020 https://www.ena.org/docs/default-source/education-document-library/esi-implementation-handbook-2020.pdf? sfvrsn=fdc327df_2

How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	ED patients receive an ESI acuity level by assessing condition and utilizing standards established by ENA's Emergency Severity Research Team. An RN assigns an ESI level of 1-5, consistent with recommendations from the ENA and ACEP. ENA ESI Implementation Guidelines: Revised 2020 https://www.ena.org/docs/default-source/education-document-library/esi-implementation-handbook-2020.pdf?sfvrsn=fdc327df_2 The assigned ESI level will guide the initial determination of patient acuity and nursing care intensity required to provide safe and effective care. As there is no measure of acuity and intensity for ED patients widely validated in the USA, changes to acuity and intensity – and related nurse-to-patient ratios – will be determined by collaboration between staff nurses and the charge nurse in relation to patient's trajectory and progress throughout their encounter. This includes imaging and lab results, planned disposition and clinical status. Nurse-to-patient ratios based on chief complaint and intervention in the ED include: • **2:1** ◦ Initial (FULL) Trauma ◦ Initial Critical/Unstable Patient ◦ Initial Stroke ◦ Initial TPA Stroke ◦ Initial STEMI • **1:1** ◦ Forensic Cases ◦ TPA Stroke Patients ◦ Procedural Sedation ◦ Intubated (Initially) ◦ Initial Modified Trauma • **1:2**

	◦ Unstable Cardiac Patient ◦ Sepsis patient (initially) • **<u>1:3</u>** ◦ Mix of ESI 2-5 Patients • **<u>1:4</u>** ◦ Mix of ESI Level 4-5 Patients (see "Fast Track Guidelines") ◦ Pivot Pod Mix of ESI 2-5 (ESI 2 and 3 patients are transiently cared for in Pivot Pod. See "Pivot Pod Guidelines.") • **<u>1:5 (preferably with assigned tech)</u>** ◦ Mix of ESI Level 4-5 Patients (see "Fast Track Guidelines") ◦ Pivot Pod Mix of ESI 2-5 (w/ assigned tech)(ESI 2 and 3 patients are transiently cared for in Pivot Pod. See "Pivot Pod Guidelines.") **Boarding Patients:** The ED tracks acuity and intensity of boarding inpatients using the same tool established hospital-wide. Boarding inpatients are defined as patients who have had admission orders for at least four hours. Acuity and intensity are determined when the inpatient transitions into boarding, and subsequently with any major change in patient condition. Acuity and intensity scores are communicated to the charge nurse who utilizes them to determine boarding patient assignments. In the instance that patients are being boarded in the Emergency Department, the following nurse-to-patient ratio will be followed: • **1:3 –** Intermediate-level patients • **1:3 –** Blended team intermediate-level patients, and pediatrics • **1:4 –** Medical overflow patients • For critical care admissions, the ED Charge RN will consult with CCU Charge RN for appropriate nurse-to-patient ratio, but never to exceed 1:2. Attempts will be made to cohort patients, so that an ED RN will have only boarded patients, not a mix of ED and boarded patients (when volume allows.)

	If RN has 4 boarded patients, the call lights will be sent to the ED Tech phone. It is the expectation that anyone can assist with the needs of the patient. ENA Position Statement on Crowding, Boarding, and Patient Throughput https://www.ena.org/ docs/default-source/resource-library/practice-resources/position-statements/ crowdingboardingandpatientthroughput
What is the MINIMUM number of RNs and CNAs on specified shifts	Emergency Nurses Association (ENA) Guidelines and Position Statements are reviewed when determining and updating Emergency Department staffing guidelines. ENA Staffing Guidelines: Revised 2018 https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/staffingandproductivityemergencydepartment Department staffing increases and decreases based on average rate of presentation to the ED and admission pattern. The Charge RN has the authority to flex staffing based on presentation and acuity of patients presenting to the ED lobby and EMS arrivals. • Peak census occurs between the hours of 1100-2300. • Average admission and percentage to inpatient status from ED arrivals for 2022 and 2023 YTD is 12%. ◦ **0000-0800:** 3.20 patients (12.5% of admits) ◦ **0800-1600:** 4.47 patients (17.4% of admits)

- **1600-0000:** 18 patients (70.1% of admits)

The ED is staffed by RNs and Techs (EMT-I/EMT-P) who provide care to the ED patient population.

Assignments are adjusted throughout the shift as patient census, acuity level, and staff availability/skill mix change. The Charge RN also assesses throughout each shift whether patient care needs are being met or if patient safety is at risk and makes adjustments accordingly.

Start Time	Core Staffing RNs	Minimum # of RNs (Including Charge)	Core Staffing Ancillary Staff	Minimum # of Ancillary Staff	Minimum # of E1 RNs (Including Charge)	Core Break Nurses	Minimum Break Nurses
00:00	10	4	3	1	2	2	1
02:00	8	4	2	1	2	1	1
08:00	9	6	2	1	4	0	0
12:00	13	8	3	1	4	2	1
16:00	14	8	4	1	4	2	1
22:00	14	7	4	1	3	2	1

Fast Track: RN only = 4 patients, RN + Tech = 5 pts. This assumes all ESI 4-5. If taking an ESI 3, reduce total Fast Track patients by 1.

ED Charge RN may request additional staff to assist with patient care when needed. Charge RN evaluates:

	• Department census • Patient acuity • Anticipated activity (procedures, admissions/discharges) • Number of staff scheduled and potential for adjustment to staffing • Staff skill mix, competency level • Overall skill mix of department
Describe process for limiting admissions/diversions to another hospital etc.	**Diversion Avoidance Process:** Emergency Department staffing decisions, including the decision to go on divert, are addressed collaboratively with the ED RN, ED Charge Nurse, ED Physicians, ED Management, House Supervisor, and the Administrator On-Call (AOC). In case of staffing or patient care issues that are problematic, the nurse has a chain of command to follow. See Organization Capacity Management Plan (OCMP).
Describe non-direct care tasks including meals and breaks	**Meal and rest breaks** Rest/meal breaks will follow the Professional Agreement between MWMC and the ONA and Oregon Nurse Staffing Laws. Dedicated Nurse Staff Member will be used to ensure meal/rest break coverage. Another assigned nurse (float) can provide break coverage, particularly for Triage, Charge, Pivot Pod, and Fast Track RNs. The Charge RN will utilize the chain of command (Charge RN>House Supervisor>Department Manager) for rest/meal break support as needed. Nursing staff is to report to Charge Nurse if they have not been able to take a break within 6 hours of shift start. Lunch will be tracked, and rest breaks attested to, in Kronos units, with exceptions noted in the Kronos Book at Nurses' Station A. Standard use of Definition: • "Meals" refers to a thirty-minute, unpaid meal period during a NSM's work shift, in which they shall be relieved of all work duties (BOLI and Professional Agreement.) • "Breaks" refers to a paid, 15 minute rest period for each 4 hours of work during a NSM's shift. With Charge Nurse approval, 2 rest periods may be combined for a 30 minute rest period or 1 rest period may be combined with an unpaid 30 minute meal period for a combined total of 45 minutes (BOLI and Professional Agreement.)

Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	Open shifts are posted to Shift Select. Overtime pay, Incentive pay, shift trades, and other incentives may be used. Open shifts are texted out by the Staffing Office or ED leadership. Agency travel nurses may be utilized. (See attached Qualification and Certifications for Travel Nurses in the ED.) If the ED is boarding inpatients, nurses from other units may be floated to the ED to care for those patients. Charge Nurse may flex down staff, upon evaluation of: • Department census • Patient acuity • Anticipated activity (procedures, admissions/discharges) • Number of staff scheduled and potential for adjustment to staffing • Staff skill mix, competency level • Overall skill mix of the department • Assessment of oncoming and departing staff

How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address?
• Patient Outcome Data
• Complaints regarding staffing (SRDF)
• Hours per patient day (HPPD)
• Number of mandatory overtime hours worked by nursing staff
• Number of voluntary hours worked by nursing staff
• Percentage of shifts for which staffing differed from the nurse staffing plan
• Did the nurse staffing committee ask for additional information
	2023 YTD Data:
	• ED Harm Events
	  ○ CAUTI: 0
	  ○ CLABSI: 0
	  ○ Falls: 12
	  ○ C. Diff: 0
	  ○ VAPS: 0
	• Hours per Unit of Service: 2.32
	  ○ Productive Hours: 303
	  ○ Productive and Non-Productive Hours: 44
	• Mandatory OT Hours: 0
	• Voluntary OT
	  ○ Productivity: 107.3%
	  ○ OT: 9%
	
	2022 Data:
	• ED Harm Events

	○ CAUTI: 0 ○ CLABSI: 0 ○ Falls: 26 ○ C. Diff: 0 ○ VAPS: 0 • SRDFs Filed: ○ 4 • Hours per Unit of Service: 2.32 ○ Productive Hours: 303 ○ Productive and Non-Productive Hours: 44 • Mandatory OT Hours: 0
ATTACHED: ED 2023 Professional Development Plan and Calendar, General Nursing Orientation New Hire Skills Completion Checklist for ED RNs, Qualification and Certifications for Travel Nurses in the ED, Fast Track Guidelines, and Pivot Pod Guidelines.	

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Endoscopy	
Effective Date: December 6, 2023	
Staffing Committee Representatives: None	
Criteria-Description of Patient Population	The endoscopy department serves adult and geriatric individuals receiving endoscopic procedures including, but not limited to: • Colonoscopy • Flexible Sigmoidoscopy • Rectal Endoscopic Ultrasound • EGD • Push Enteroscopy • Esophageal Endoscopic Ultrasound (EUS) • Fine Needle Aspiration through Endoscopic Ultrasound (FNA) • Endoscopic retrograde cholangiopancreatography (ERCP) • Bronchoscopy • Endoscopic Bronchial Ultrasound with Fine Needle Aspiration (EBUS) • Bravo pH capsule placement • Fecal transplant Diagnoses: Gastroesophageal reflux disease, Cirrhosis, Esophageal varices screening/surveillance, Dysphagia, History of Barrett's esophagus, Suspected upper GI Bleed, Hematemesis, Foreign body removal, Abnormal imaging (CT, US, MRI, etc.), Anemia, Screening colonoscopy, History of colon polyps, Personal/family history of colon cancer, Diverticulitis, Diverticulosis, Abdominal pain, Abnormal imaging (CT, US, MRI, etc.), Melena, Hematochezia, Surveillance of previous condition or diagnosis, Biliary and pancreatic duct dysfunction.
Average Daily Census (ADC) annual average	Endoscopy has an average daily census of 6 patients per weekday, not including inpatient call procedures during the weekend.

Average Length of Stay (LOS) annual average	Each procedure is an average of 45 minutes.
Specialized qualifications and competencies (include requirements for travel nurses)	Endoscopy staff members have up to date Qualifications and Competencies: • All nurses including potential traveling nurses hold Oregon Nursing License, BLS, ACLS, Moderate Sedation course and yearly refresher • All Endo Technicians hold CNA 2 license, BLS • All staff members attend endoscopic technique and equipment in-services provided by various medical equipment representatives Quality Measures: • Scope reprocessing standards and tracking • 100% Staff attendance of annual endoscopy skills and check off • Audits for time out prior to start of procedure • Audits for completion of procedure records • Staff injuries • Tracking of scope withdrawal time from cecum during colonoscopies • Yearly training for all staff by endoscope manufacturer on proper scope cleaning and handling • Employee Surveys • Variances of the staffing plan • Bronchoscopy scope processing accuracy between respiratory therapy and endoscopy • Specimen Tracking • Tracking of daily activities such as meal/rest breaks and mandatory overtime • Radiation exposure of staff (ERCP) • Handwashing Annual Competencies: • Blood administration • Glucometer POC • Restraints

Skill Mix and level of competency required to meet the healthcare needs of patients	All nurses hold Oregon Nursing License, BLS, ACLS, Moderate Sedation course and yearly refresher All Endo Technicians hold CNA 2 license, BLS Both RNs and Technicians remain up to date on • LIP preferences • Annual staff evaluations • HealthStream Competencies
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	Admitting outpatient pre-operative patients takes 30-90 minutes depending on patient acuity. Endoscopy continuously transfers patients between procedure and recovery rooms with varying transfer times depending on location and patient acuity. On average it takes 3 minutes to transport each outpatient to the procedure room. On average it takes 25 minutes to transport each inpatient to the procedure room or staging department. On average it takes 3 minutes to transport each endoscopy patient from the procedure room to PACU or SSU for recovery. In the event of a food impaction, the endoscopy RN will discharge patients post procedure if there is an LIP order. This discharge process takes an average of 1 hour once they are recovered.
Nationally Recognized Standards or Guidelines	Standards of Practice and guidelines: • SGNA (Society of Gastroenterology Nurses and Associates) Guidelines • ASGE (American Society for Gastrointestinal Endoscopy) Guidelines • AORN (Association of Peri-Operative Registered Nurses) Guidelines • JC (Joint Commission) Standards/National Patient Safety Goals 2022 • Anesthesiologists Basic Standards for Peri Anesthesia Care – October 28, 2015 (most current version per Chief of Anesthesia) • Annual Staff Evaluations • Nurse Staffing Law, Senate Bill 469, 2016
How will patient acuity and nursing intensity be accounted for in assignments? Include how often	On the day before, the charge RN gives special consideration to the next day's schedule to determine the volume of patients, acuity of expected patient population, types of procedures,

the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	and types of anesthesia or sedation. After assessing this information staff assignments are made for the next day. Assignments are adjusted throughout the shift by the charge RN as patient census, patient condition, and staff availability change. The charge RN also assesses throughout each shift on an hourly basis whether patient care needs are being met or if patient safety is at risk and adjustments are made accordingly. Patient conditions that contribute to a higher level of acuity include but are not limited to known issues based on pre-procedure phone call, inadequate colonoscopy prep day of procedure, the health status and mobility level of patient, interpreter services, disability services, isolation status, etc. If the direct care RN determines that the patient care needs are not being met or patient safety is at risk, the RN will use the chain of command to ensure appropriate patient care. Chain of command is as follows: RN>>>Charge RN>>>Manager>>>Director, Perioperative Services>>>Chief Nursing Officer. Acuity varies by diagnosis and patient condition making the Endoscopy Unit a diverse procedural unit. The combination of Mallampati score, American Society of Anesthesiology (ASA) physical status classification and Stop-Bang score aid in determining acuity beforehand.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	When a patient is present in the endoscopy unit or Operating Room at least one RN and one nurse staff member (NSM) will be present. -Or- one MD and one NSM. This is consistent during “on call” hours. Patients are admitted and staged in the Short Stay Unit where additional NSMs oversee their care.
Describe process for limiting admissions/diversions to another hospital etc.	Patient population is primarily outpatients who go home the same day. If a patient comes through the ED, the admission decision is generally made after the procedure takes place if the patient is stable. The GI MD along with the hospitalist determines the course of action. If the hospital does not have a GI MD on call, patients are transferred to the nearest location with available GI services.

Describe non-direct care tasks including meals and breaks	Non-direct care tasks include • Pre-operative phone calls • Pre-operative chart reviews and documentation • Pre-operative chart assembly • Daily staffing • Daily statistic logging • Calculating and entering charges • Materials inventory • Material outdates • Stocking materials • Equipment sanitization • Scope processing and cleaning both after each case and weekly washes • Maintaining and verifying scope function • Procedural room set up and take down • Equipment transferring to OR and inpatient floors • Pyxis inventory • Crash cart check • Emptying trash and linens • Making gurneys • Setting up pre-procedure rooms in Short Stay Unit • Endoscopy room temperature checks Breaks are compliant with ONA standards and consist of a 30-minute lunch break and two additional 15 min breaks during the scheduled 8-hour shifts. Meal breaks are taken between cases and/or covered by additional endoscopy nursing staff depending on patient census. The daily staffing sheet shall reflect who has received their rest/mealtimes, to be completed by each staff member by either their initials or the charge nurse's initials. The Kronos time keeping system logs lunch breaks as well. Involuntarily missed/late meals will be communicated to the charge nurse and management as soon as possible.

Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	Scheduling is performed by the charge RN the day before based on the next day's procedure schedule and the number of pre-operative phone calls that need to be made. Endoscopy charge RN will replace sick calls by reaching out to staff members who are not scheduled. Charge RN will also utilize help from Short Stay Unit if a need exists and Short Stay is able to accommodate. Routine low census and standby will follow professional agreement between ONA/SEIU and McKenzie-Willamette Medical Center and staffing percentage.
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	UPC meeting will be held in January to address the following: patient outcomes, any SRDFs, HPPD, mandatory overtime, voluntary hours worked, any variances between staffing and outlined staffing plan and any other additional information.

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Medical Care Unit	
Effective Date: November 2023	
Staffing Committee Representatives: Bernadette Bax and Miranda Perrigan	
Criteria-Description of Patient Population	The Medical Care Unit (MCU) provides nursing care 24 hours a day, 7 days a week for general medical inpatients and observation status of the adult and geriatric populations. The Medical Care Unit has the capacity to care for up to 32 patients at a singular time in 32 total patient beds that are composed of 12 private rooms and 10 double rooms. **Primary Diagnosis seen on MCU include, but are not limited to:** ● Neurological: o CVA, TIA, Seizure, Altered Mental Status, Dementia, Encephalopathy, Epilepsy ● Cardiovascular: o Telemetry monitoring, Chest pain, NSTEMI, DVT, Heart Failure, Heart Disease, Hypertension ● Respiratory: o PE, Influenza, Pneumonia, Chest Tube Management, COVID19, Respiratory Failure, COPD. ● Gastrointestinal: o Bowel Obstruction, Gastrointestinal Bleed, Nasogastric tubes, PEG, and duodenal feeding tube, fecal incontinence tube management, Ileus, Appendicitis, Diarrhea, Diverticulitis, Crohn's Disease, Gastroparesis, Pancreatitis ● Renal: o UTI, and Chronic Kidney Injury, Nephrostomy tube management, Dialysis, Kidney Stones, Pyelonephritis, Acute Kidney Failure ● Palliative/Hospice care ● ETOH and drug withdrawal ● Fluid, nutrition, and electrolyte imbalances, Dehydration ● Sepsis ● Limited post-operative care, acute or chronic wounds ● Acute or chronic pain control ● Various psychiatric conditions ● Cellulitis and Wounds ● Muscular Dystrophy ● Cancer

Average Daily Census (ADC) annual average	The Average Daily Census is 25 patients.
Average Length of Stay (LOS) annual average	The Average Length of Stay is 3.72 days.
Specialized qualifications and competencies (include requirements for travel nurses)	**Charge Nurses:** BLS, Unit Specific Training/Experience Encouraged to obtain: ACLS, Telemetry Competency, ANCC Medical/Surgical Certification **Registered Nurses**: BLS Encouraged: ACLS, Telemetry Competency, ANCC Medical/Surgical Certification **Travel Nurses**: BLS **Licensed Practical Nurses**: BLS **Certified Nursing Assistant II**: BLS **Certified Nursing Assistant I:** BLS Each nursing staff member will receive annual skills training and review the necessary education provided through online learning, staff meetings and annual skills fairs. McKenzie-Willamette Medical Center currently fulfills their annual educational requirements and maintains the reviewed documentation through HealthStream. All float nurses and travel nurses will be required to maintain the minimum qualifications and competencies to work in the unit. An orientation packet is completed by all RN/LPN/CNAII/CNAI with their preceptor. This is submitted to and filed with the Human Resources Department. The current list of skills and certifications of each Nurse Staffing Member will be maintained and tracked by Human Resources, Clinical Educators, and Unit Manager.
Skill Mix and level of competency required to meet the healthcare needs of patients	**Skill Mix:** With the approval of the Nurse Staffing Committee this unit can deviate from the direct care registered nurse to patient ratios in pursuit of innovative care models that allow other clinical care staff to constitute up to 50 percent of the registered nurses needed to comply with the applicable nurse to patient ratio.

	Level of Required Competency: All RNs/LPNs/CNAII/CNAI- BLS All RN staff members are encouraged to obtain the Medical-Surgical Nursing ANCC Certification. **Considerations are made using**: AMSN Guidelines Nurse Staffing Law Oregon Administrative Rule
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	The Admission, Discharge, and Transfer (ADT) rate on the Medical Care Unit is 50%. The average time it takes to complete a: Admission: 60 minutes Discharge: 120 minutes Transfer: 30 minutes
Nationally Recognized Standards or Guidelines	Joint Commission Standards and National Patient Safety Goals
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	Standard use of definition: • "Acuity" refers to the level of nursing skill required, for example medications, drains, tubes, IVs, wound care, etc. • "Intensity" refers to the level of patient need which makes giving nursing care more complicated, for example language barriers, cognitive barriers, etc. Nurse to patient ratios will be based on patient acuity and intensity and shall be based on a Licensed Independent Practitioners classification of the patient as indicated in the patients' medical records and may be: 1:3 ONE NURSE TO THREE PATIENTS 1:4 ONE NURSE TO FOUR PATIENTS 1:5 ONE NURSE TO FIVE PATIENTS

	The average acuity of a singular patient on MCU (utilizing MWMC Acuity Tool) is: 3 The average acuity of a patient assignment on MCU (utilizing MWMC Acuity Tool) is: 11 The acuity goal of a patient assignment on MCU is: 12 The acuity and intensity of patients will be determined using the Nursing Acuity and Intensity tool in the EMR once a shift (0400 for night shift and 1600 for day shift) and with any change in patient condition. These scores will be communicated to the charge nurse who will use the scores to determine the appropriateness of nurse/patient assignments. The charge nurse will provide continuous monitoring of overall acuity and intensity of the unit by monitoring patient condition, staff management of patient assignments, number of staff and patients on the unit at any given time and make any changes necessary. The charge nurse will communicate nursing intensity and acuity to the house coordinator, other unit charge nurses, unit manager, unit director, and administrator on call as necessary. Acuity and Intensity Tool can be referred to in Appendix A
What is the MINIMUM number of RNs, LPNs, and CNAs on specified shifts	NSM= Nurse Staff Member 1 patient= 2 NSM 2 patients= 2 NSM 3 patients= 2 NSM 4 patients= 2 NSM 5 patients= 2 NSM 6 patients= 2 NSM 7 patients= 2 NSM 8 patients= 2 NSM 9 patients= 2 NSM 10 patients= 2 NSM 11 patients= 3 NSM 12 patients= 3 NSM 13 patients= 3 NSM 14 patients= 3 NSM 15 patients= 3 NSM 16 patients= 4 NSM 17 patients= 4 NSM

	18 patients= 4 NSM 19 patients= 4 NSM 20 patients= 5 NSM 21 patients= 5 NSM 22 patients= 5 NSM 23 patients= 5 NSM 24 patients= 5 NSM 25 patients= 6 NSM 26 patients= 6 NSM 27 patients= 6 NSM 28 patients= 6 NSM 29 patients= 6 NSM 30 patients= 7 NSM 31 patients= 7 NSM 32 patients= 7 NSM
Describe process for limiting admissions/diversions to another hospital etc.	The diversion of patients is handled on a case-by-case basis and is avoided when possible. Any employee may ask his/her supervisor, charge nurse, manager, director, House Supervisor, or administrator on call to evaluate the need to limit admissions or go on diversion if he/she believes there is an inability to meet patient care need or a risk of harm to patients. If the unit has no beds available due to maximum capacity of beds or available staffing, the Charge RN contacts the manager during the day, supervisor at night to determine a plan. Collaboration with other departments occurs as well to accommodate safe Nurse to patient ratios.
Describe non-direct care tasks including meals and breaks	<u>Meals and Breaks:</u> Breaks are defined as the following: --One unpaid meal period consisting of one 30-minute meal break for shifts of 6 hours or more and one paid 15-minute rest period during each 4 hours of work. (One 12-hour shift will consist of three fifteen-minute breaks and one 30-minute break.) *If possible, the Charge RN may allow a nurse to combine a meal break with one 15-minute rest break, dependent upon unit needs.*

	--A “Meal/Rest Break” is defined as “time away from patient care, with no interruptions that are related to nursing or the nurses’ assignment.” The NSM shall be able to physically step away from the unit/floor if desired. • A Dedicated NSM with appropriate skill codes/qualifications shall be available to provide breaks to each scheduled NSM on the unit. • The NSM will report off to the dedicated NSM for breaks. • The buddy system can be used for meals and breaks when the use of the buddy system does not result in the staffing grid/plan being exceeded. • The Charge Nurse may take a patient assignment for the purpose of covering meals and breaks with approval from the staffing committee for units larger than 10 beds. • In the event of interruptions, the break period(s) is/are eliminated and accounting for the missing break must be reflected/documented in Kronos and reported to the charge RN. Premium pay will then be paid per the ONA and SEIU CBAs until a full break can be accommodated. • NSM are responsible for documenting breaks by utilizing the Kronos time clock to punch in and out for meal breaks. If a NSM is not able to take a meal or rest break, they will utilize their chain of command (Meal/Break Nurse, Assigned Buddy, Charge Nurse, House Supervisor, and Unit Manager) prior to the missed break, so there is opportunity for it to be provided. • The meal and rest break plan will be maintained by the Unit’s Practice Committee (UPC) for review each quarter to review the frequency of missed meals and breaks.
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	Predicted staffing needs are sent out weekly forecasting staffing needs based off current staffing and the average daily census. Able and willing staff fill these staffing needs. When additional staff are needed due to call outs or an increase in patient census, the charge RN notifies the House Coordinator and/or staffing office. The staffing office then follows their process for filling staffing needs (i.e., floating other qualified and oriented staff from other units or recruiting additional staff to come in). If unable to fill staffing needs, Manager of unit is notified, and every effort made to find additional staff are completed. A low census and standby will follow the professional agreement between ONA/SEIU and McKenzie-Willamette Medical Center and will consider staffing percentages and skill mix.

How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff. • Number of voluntary hours worked by nursing staff. • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	MCU's Unit Practice Council will meet 8-12 times a year (roughly, once a month) to review the following data for the month prior. At the first of a new year UPC will utilize data previously reviewed and make a report including: • SRDFs • Missed Meals and Breaks • Average ADT results • Overtime hours • Audits • Event reporting in Riskonnect • Annual QI projects • Annual Skill Assessments • Staff Turnover Quality Measures and Patient Outcomes: • Patient Identifiers • Blood Transfusion Verification • Reporting of critical results • Medication Reconciliation on Admit/Transfer/Discharge • Hand Hygiene • Glucometer Care • Medication labeling (if applicable for sterile procedure) • Restraints • Crash Carts • Patient Education • Care Planning • Pain Assessment /Reassessments • HCAHPS/SRDF Data • Annual Quality Evaluation for this Staffing Plan. If necessary, may review more often. If necessary, more often than annually.

Appendix A

McKenzie-Willamette Medical Center Acuity and Intensity Tool

MedHost Acuity Tool 2023

Assessment/Vital Signs Frequency:

Q8 hr vital signs	0
Q4 hr VS and/or Neuro checks, Q8 hr Orthostatics	2
Q2 hr VS and/or Neuro checks, Q4 hr Orthostatics	3
Q1 hr VS and/or Neuro checks	5
Q30 hr VS and/or Neuro checks	7
Q15 hr VS and/or Neuro checks	9
Less than Q15 hr VS and/or Neuro checks	12
Total	

Pain

No pain	0
Q8 hour interventions	1
Q4 hour interventions	2
Q2 hour interventions	3
Q1 hour interventions	5
Q30 min interventions	7
Q15 min interventions	9
Total	

Mental Status

Alert and Oriented	0
Alert, calm, pleasant, cooperative but not oriented	1
Confused (not combative). Patient with sitter. Lethargic	2
Delirium or confused and calm, needs redirection q1 hour. Combative patient with sitter. Restraints	3
Obtunded. Heavily sedated	5
Restraints. Confused and restless and/or combative. Redirection less than q1 hour	7
Total	

Procedures

No procedures	0
Day before IP procedure or surgery	1
Hemodialysis, Peritoneal Dialysis, Established PICC-Central line	2
Day of routine IP pre or post procedure requiring nurse intervention(s)	3
Procedures requiring moderate sedation by RN	5
1-3 Emergency procedures	7
Greater than 3 emergency procedures	9
Total	

Respiratory

Stable on RA at rest and with activity	0
Continuous pulse ox. Interventions Q8 hour, 02 by NC	1
Interventions Q4 hour, 02 by NRB or Oxymizer	2
Stable CPAP or BiPap, Interventions Q2 hr, 02 by high flow NC	3
Stable vent. Unstable BiPap. Interventions Q1 hr.	5

Admission/Discharge/Transfers

No ADT	0
Stable Transfer. Routine Discharge	1
Discharge to an outside facility	2
New Admission or post-op. Complex discharge	3

Unstable vent, titrating Q30 min	7
Unstable vent, titrating Q15 min	9
Unstable vent titrating less than Q15 min.	12
Total	

Telemetry

No Telemetry	0
Interventions Q8 hr. Tele	1
Interventions Q4 hr.	2
Interventions Q2 hr.	3
Interventions Q1 hr. Temp pacer backup	5
Interventions Q30 min. Temp pacer dependent	7
Interventions Q15 min.	9
Interventions less than Q15 min	12
Total	

Diagnostics

No lab or radiology tests	0
Interventions and/or tests Q8 hr.	1
Interventions and/or tests Q4 hr.	2
Interventions and/or tests Q2 hr.	4
Interventions and/or tests Q1 hr.	5
Interventions and/or tests Q30 min.	7
Interventions and/or tests Q15	9
Total	

Protocols

No Protocols	0
1 Protocol (eg. Heparin, K+ replacement). 1 Unit of blood products	1
2-3 of the protocols in column 1	2
2-4 of blood products, fluid bolus for BP, and 2-3 protocols	3
Alcohol withdrawal protocol, CIWA score ***	5
Greater than 4 protocols OR greater than 5 units of blood products	7
Greater than 4 protocols AND greater than 5 units of blood products	9

Complex post-op or admit. Transfer to a higher level	5
Unstable post-op, admission, or tranfer	7
Total	

Education

No education needed	0
Standard education and reinforcement, no new diagnoses or meds	1
Some education needed	2
New diagnosis with educational needs	3
Extensive education needed	5
Complicated, extensive education with care coordination	7
Total	

Psych-Social-Family

Hourly rounding	0
Less than 2 interventions per shift	1
3-5 interventions per shift	2
6-9 interventions per shift	3
9-12 interventions per shift	5
Q1 interventions	7
Total	

Wound-Skin Care

No wounds, no skin breakdown risk, independent with turns	0
1-2 Qday-BID dressing change (simple wounds). Skin barrier, Wound vac no dressing change. Independent with turns.	1
Q2 hour turns. Heels floating	2
TID or complex dressing changes	3
Q1 hour turning and/or positioning. Greater than 5 simple wounds.	5
Greater than 5 complex wounds	7
Prone positioning	9
Total	

Ostomy/Continence

Total	

Medications

No meds	0
1-5 meds PO-IVPB-IVP	1
6-10 meds PO-IVPB-IVP	2
11-15 meds PO-IVPB-IVP	3
15+ meds. 1-3 drips requiring titration Q1 hr. IVP medications less than Q30 min.	5
1-3 IV drips requiring titration Q30 min or greater than 3 drips	7
1-3 IV drips requiring titration Q15 min	9
Greater than 3 drips requiring titration Q15 min.	12
Total	

Drains, I/O's

No drains, I/O's not monitored	0
I/O's greater than Q2 hrs. 1-2 drains (eg. JP, hemovac, perc.neph. NG-ND).	1
Continuous tube feed. Chest tube to water seal. Greater than 3 drains.	2
I/O's Q2 hrs. Chest tube to suction. CBI	3
Bolus tube feed. I/O's Q1 hr. Chest tube output greater than 100cc in 2 hours.	5
Greater than 500cc of blood or drainage in 1 hr. Greater than 2 chest tubes.	7
Active bleeding requiring in room management less than Q1 hour.	9
Total	

Acuity Score

1-10 points	1
11-20 points	2
21-30 points	3
31-40 points	4
41-50 points	5
51-60 points	6
61-70 points	7

Ostomy, Continence and independent toileting	0
One person assists with toileting. Foley	1
Incontinent B-B 3-5 per shift and contained. Established ostomy. Rectal tube. Bowel prep.	2
Incontinent (or rectal tube leak) bowel bladder 5-8 times per shift. High-output or new ostomy	3
Uncontainable drainage (incontinent, wound drainage) requiring full bed changes 2-4 times per shift. Q1 hour toileting needs	5
Uncontrollable drainage requiring more than 4 full bed changes per shift.	7
Total	

ADL's

Independent with ADL's, able to obtain tools	0
Independent with ADL's, may need to have tools placed in reach	1
Stand by assist with ADL's, medication assist, crushed meds	2
One person assists with ADL's, total feed	3
Total care or feed. Two-person assist with ADL's	5
Total care and Total feed. Mechanical Lifts.	7
Total	

Isolation

No Isolation	1
Isolation	2
Total	

Safety/Fall

No Safety Issues	0
Low Fall Risk	1
Moderate Fall Risk. High or moderate risk Suicidal Ideations. Patient with Sitter.	2
High Fall Risk. Low or Moderate Risk Suicidal Ideations. Patient with Q15 min checks.	3
Total	

71-80 points	8
81+ points	9
Final Acuity Score	

Appendix B: Unit Goal Staffing Guides Based on Census

Census ≤14

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	1*
13	1	4	1*
14	1	4	1*

*Shaded areas represent
primary nursing or CNA with light assignment and additional duties

Census 15-22

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	3
16	1	4	3
17	1	5	3
18	1	5	3
19	1	5	3
20	1	5	3
21	1	6	3
22	1	6	3*

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	2
16	1	4	2
17	1	5	2
18	1	5	2
19	1	5	2
20	1	5	2
21	1	6	2
22	1	6	2

Census 23-28

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	3
16	1	4	3
17	1	5	3
18	1	5	3
19	1	5	3
20	1	5	3
21	1	6	3
22	1	6	4
23	1	6	4
24	1	6	4
25	1	7	4
26	1	7	4
27	1	7	4
28	1	7	4

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	2
16	1	4	2
17	1	5	2
18	1	5	2
19	1	5	2
20	1	5	2
21	1	6	2
22	1	6	2
23	1	6	3
24	1	6	3
25	1	7	3
26	1	7	3
27	1	7	3
28	1	7	3

Census 29-32

Census 0700-1900	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	2
9	1	3	2
10	1	3	2
11	1	3	2
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	3
16	1	4	3
17	1	5	3
18	1	5	3
19	1	5	3
20	1	5	3
21	1	6	3
22	1	6	4
23	1	6	4
24	1	6	4
25	1	7	4
26	1	7	4
27	1	7	4

28	1	7	4
29	1	8	4*
30	1	8	4*
31	1	8	4*
32	1	8	4*

Census 1900-0700	CN	RN/LPN	CNA
1	1	1	0
2	1	1	0
3	1	1	0
4	1	1	0
5	1	2	0
6	1	2	0
7	1	2	1
8	1	2	1
9	1	3	1
10	1	3	1
11	1	3	1
12	1	3	2
13	1	4	2
14	1	4	2
15	1	4	2
16	1	4	2
17	1	5	2
18	1	5	2
19	1	5	2
20	1	5	2
21	1	6	2
22	1	6	2
23	1	6	3
24	1	6	3
25	1	7	3
26	1	7	3
27	1	7	3
28	1	7	3
29	1	8	3
30	1	8	3
31	1	8	3
32	1	8	3

*Shaded areas represent
primary nursing or CNA with light assignment and additional duties

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Operating Room & Cardiovascular Operating Room	
Effective Date: November 2023	
Staffing Committee Representatives: Stephen Lyddane (Primary); Secondary (Vacant)	
Criteria-Description of Patient Population	The Operating Room (OR) provides surgical services to the pediatric, adolescent, adult and geriatric population. Cardiovascular Operating Room (CVOR) provides surgical services to the adult and geriatric population Primary Services Provided: • Nursing Scope as defined by the American Nurse Association, Oregon Board of Nursing, and the Association of Perioperative Registered Nurses • Ongoing patient assessment and critical decision making • Pre-and Postoperative education • Patient Advocacy • Circulation and scrubbing of all surgeries <u>Patient Diagnosis (</u>included, but are not limited to): -Surgical patients: spondylosis, spinal stenosis, neurogenic claudication, compression fracture, degenerative arthritis, traumatic arthritis, scoliosis, osteoarthritis, rotator cuff tear, bicep rupture/tear, bone spurs, Achilles rupture, patellar fractures, meniscal tear, diverticular disease, kidney stones, cholecystitis, cholelithiasis, liver neoplasms, inguinal hernia, ventral hernia, breast cancer, benign prostatic hypertrophy, end stage renal disease, bladder cancer, kidney cancer, skin cancer, cervical cancer, renal calculi, bladder/prostate cancer, vaginal prolapse, uterine prolapse, rectocele, cystocele, ovarian cysts, vaginal bleeding, dysmenorrhea, endometriosis, uterine fibroids, desires sterilization, chronic sinusitis, adeno-tonsillitis, deviated nasal septum, bunions, hammer toes, venous statis ulcers, antibiotic resistant infections, necrotic wounds, aortic aneurysm, peripheral vascular

	disease, and cardiovascular surgeries.
Average Daily Census (ADC) Annual Average	N/A
Average Length of Stay (LOS) Annual Average	N/A
Specialized qualifications and competencies (Include requirements for travel staff)	All RN staff members are encouraged to obtain and maintain Certified Nurse Perioperative (CNOR) Credential. Charge RN: RN, ACLS, BLS RN: RN, ACLS, BLS CNA2: BLS OR RN staff will also be encouraged to obtain PALS Travel RNs will have and maintain certification and licensure per OR/CVOR Education plan calendar and certification requirements. Joint Commission Standard/National Patient Safety Goals 2023 AORN Guidelines 2023 Nurse staffing law, Senate Bill 469 Oregon Administrative Rule (OAR) 333-510-0130(2) Annual Staff Evaluations Required competencies for OR/CVOR RNs will be documented in HealthStream and will be completed per the Operating Room Professional Development Plan and Calendar as maintained by the hospital education department. Plan attached to this staffing plan.

Skill Mix and level of competency required to meet the healthcare needs of the patients	All nurses in the OR/CVOR Staff are oriented and trained upon hire to the unit to demonstrate competency in the direct care of the aggregate patient population served. This is documented in the individual nursing staff members orientation packet and kept on file
Activity Measure include rate of admissions, discharges, transfers, and time required to complete tasks:	Average Turnover time On Time Start
Nationally Recognized Standards or Guidelines	AORN 2023 Guidelines Joint Commission Standards/National Safety Goals 2023
How will patient acuity and nursing intensity be accounted for assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change	RNs in a circulating role will be 1:1 for all surgical procedures. RNs in a scrub role will be 1:1 for all surgical procedures.
What is the minimum number of RNs on specified unit?	<u>Weekday RN (Circulating Role) Minimum staffing:</u> 1 patient: 2 RNs and 0 CNAs 2 patients: 3 RNs and 0 CNAs 3 patients: 4 RNs and 0 CNAs 4 patients: 5 RNs and 0 CNAs 5 patients: 6 RNs and 0 CNAs 6 patients: 7 RNs and 0 CNAs 7 patients: 8 RNs and 0 CNAs 8 patients: 9 RNs and 0 CNAs 9 patients: 10 RNs and 0 CNAs <u>On-call staffing minimums:</u> 2 staff members:

	• 1 staff member in circulating role • 1 staff member in the scrub role.
Describe process for limiting admissions/diversions to another hospital etc.	Communicate needs of OR/CVOR up the chain of command, i.e Charge RN, House Coordinator, Unit Manager, Unit Director, Administrator on call.
Describe non-direct care tasks including meals and breaks	<u>Meal & rest breaks:</u> Rest breaks will follow the Professional Agreement between MWMC and the ONA/SEIU. Charge RN will utilize the chain of command for rest/meal breaks support as needed. On call staff will notify the house coordinator if rest/meal breaks are needed. Involuntary missed/late meals will be communicated to the charge nurse and management as soon as possible. Meal & Rest break times are posted at a designated location and assigned daily by the Charge RN. <u>Non-direct patient care in Main OR/CVOR: (</u>Included but not limited to) • Unit preparation for first start cases • Stocking blankets and IV fluids in warmer • Stocking OR/CVOR Rooms when not in use • Regular expiration outdates check • Turning over room in-between cases • Opening OR/CVOR rooms for cases • Crash Cart Checkoff • Pyxis Checkoff • CBG QC • Ongoing communication with other departments

Describe how the unit utilizes replacement staff for sick calls, changes in census, etc?	The day before, the charge RN will make appropriate staffing assignments based on staff availability and surgery schedule. Low census will follow the professional agreement between MWMC and SEIU/ONA.
How will the unit and staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Date • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary overtime house worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan. • Did the nurse staffing committee ask for additional information	The first UPC meeting of the year will work towards obtaining data from the previous year. A report will be made including but not limited to: • Unexpected patient outcomes • SRDFs • SSIs • Employee survey results • Overtime hours: Mandatory/voluntary/end of shift overtime • Event Reporting in Riskconnect • Staff injuries • Staff turnover
Please see attached Unit Staffing Guides	

OR Staffing Guideline

1 patient: 2 RNs and 2 CNA

2 patients: 4 RNs and 2 CNA

3 patients: 5 RNs and 2 CNA

4 patients: 6 RNs and 2 CNA

5 patients: 8 RNs and 2 CNA

6 patients: 9 RNs and 2 CNA

7 patients: 11 RNs and 2 CNA

8 patients: 12 RNs and 2 CNA

9 patients: 14 RNs and 2 CNA

CVOR Staffing Guideline

1 patient: 2 RNs

2 patients: 4 RNs

3 patients: 5 RNs

4 patients: 6 RNs

- AORN Guidelines 2023

- Joint Commission Standards/National Patient Safety Goal 2023

Preoperative nursing and anesthesia patient instructions based on the American Society of Anesthesiologist Basic Standards for Peri Anesthesia Care-October 28, 2015 (most current version per Chief of Anesthesia)

- Ongoing education related to technology changes and LIP preferences
- Annual staff evaluations
- Nurse Staffing Law, Senate Bill 469, 2016
- An orientation packet is completed by all employees in OR with preceptor and OR educator.

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: PACU	
Effective Date: MAY 2023	
Staffing Committee Representatives: CHELSEA HOPKINS AND KELLY MONIZ	
Criteria-Description of Patient Population	The post Anesthesia care unit (PACU) serves non-critical pediatric, adolescent, adult and geriatric patients receiving general or regional anesthesia and other patients as determined by the department of Anesthesia (e.g. Moderate Sedation and Deep Sedation). Patients on airborne precautions or Covid + patients will be recovered in the Operating Room or CCU without the assistance of PACU staff Critical Care Unit patients will recover in CCU without the assistance of PACU staff during regular shifts as well as call shifts (Weekdays from 19 to 07 and weekends- Saturday and Sunday- 07 to 07). **DIAGNOSES (include, but are not limited to):** -Surgical patients: spondylosis, spinal stenosis, neurogenic claudication, compression fracture, degenerative arthritis, traumatic arthritis, scoliosis, osteoarthritis, rotator cuff tear, bicep rupture/tear, bone spurs, Achilles rupture, patella fractures, meniscal tear, diverticular disease, kidney stones, cholecystitis, cholelithiasis, liver neoplasms, inguinal hernia, ventral hernia, breast cancer, benign prostatic hypertrophy, end stage renal disease, bladder cancer, kidney cancer, skin cancers, cervical cancers, renal calculi, bladder/prostate cancer, vaginal prolapse, uterine prolapse, rectocele, cystocele, ovarian cysts, vaginal bleeding, dysmenorrhea, endometriosis, uterine fibroids, desires sterilization, chronic sinusitis, adenotonsillitis, deviated nasal septum, bunions, hammer toes, venous stasis ulcers, antibiotic resistant infections, necrotic wounds, diabetic wounds. --Endoscopy patients: screening colonoscopy, personal/family history of polyps, personal/family history of colon cancer, diverticulitis, abdominal pain, anemia, melena, gastroesophageal reflux disease, esophageal varices, hematochezia, dysphagia, history of Barrett's esophagus **Primary Services Provide**d: • Cardiovascular monitoring • Airway assessment, intervention, and continuous monitoring • IV therapy\ medication administration • Patient education • Nausea prevention and control • Psychosocial care and support • Coordination of patient care with support services • Initial postoperative care • Ventilator support

	• Initiation and titration of vasoactive/ antiarrhythmic IV drugs • Invasive hemodynamic monitoring • Promotion of normothermia • Promotion of comfort • Glucose monitoring • Assist with block patients • Post-partum recovery with general anesthesia • MRI under general anesthesia • CT ablation under general anesthesia
Average Daily Census (ADC) annual average	The average of 590 total patients per month. The average Daily census is 26
Average Length of Stay (LOS) annual average	Average episode of care from arrival to transfer is 78 minutes Average time from arrival to ready for transfer is 38 minuets
Specialized qualifications and competencies (include requirements for travel nurses)	All RN staff members are encouraged to achieve the CPAN certification. ASPAN Guidelines 2021-22 Joint Commission Standard/National Patient Safety Goals 2020 Preoperative nursing and anesthesia patient instructions based on the American Society of Anesthesia Care-October 28,2015 (most current version per Chief of Anesthesia) Ongoing education related to technology changes and LIP preferences Nurse Staffing Law, Senate Bill 469 Oregon Administrative Rule (OAR)333-510-0130(2) Annual staff evaluations **Charge Nurse:** ACLS, BLS, PALS, ASPAN -competent **RN:** ACLS, BLS, PALS, ASPAN- competent **CNA2:** BLS

	Float/Travel Staff: ACLS, BLS, PALS, ASPAN- competent **Annual Competencies:** Blood administration Glucometer POC Restraints
Skill Mix and level of competency required to meet the healthcare needs of patients	All RNs – BLS, ACLS, PALS CNA IIs – BLS required All RN staff members are encouraged to achieve the Certified Ambulatory Peri Anesthesia Nurse or Medical/Surgical ANCC certification ASPAN Guidelines 2021-2022 Joint Commission Standards/National Patient Safety Goals 2021 Preoperative nursing and anesthesia patient instructions based on the American Society of Anesthesiologists Basic Standards for Peri Anesthesia Care – October 28, 2015 (most current version per Chief of Anesthesia) Ongoing education related to technology changes and LIP preferences Annual staff evaluations Nurse Staffing Law, Senate Bill 469, 2016 An orientation packet is completed by all employees in PACU with their preceptor. This is submitted to, and housed by, the HR department. The current list of skills per Nurse Staff Member (NSM) will be maintained by respective UPCs.
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	The average amount of time for nurses to complete tasks is 38 minutes per patient. Because we are a recovery unit only, we are always in the process of transfer (to the inpatient floor, SSU, or ED). We do not discharge from PACU. Physicians dictate admission status based on patient status. Average holding time when waiting for rooms is 40 minutes per patient after patients are ready for transfer.
Nationally Recognized Standards or Guidelines	ASPAN Guidelines 2021-2022 Joint Commission Standards/National Patient Safety Goals 2021 Preoperative nursing and anesthesia patient instructions based on the American Society of Anesthesiologists Basic Standards for Peri Anesthesia Care – October 28, 2015 (most current version per Chief of Anesthesia)

How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	**1:2 ONE NURSE TO TWO PATIENTS** Examples may include, but not limited to the following: 1. Two conscious patients, stable and free of complications but not yet meeting discharge criteria 2. Two conscious patients, stable, 12 years of age and over, with family or competent support staff present but not yet meeting discharge criteria 3. One unconscious patient, hemodynamically stable, with a stable airway, over the age of 12 years and one Conscious patient, stable and free of complications **1:1 ONE NURSE TO ONE PATIENT** Example may include, but not limited to the following: 1. At the time of admission, until the critical elements are met 2. Airway and/or hemodynamic instability 3. Pediatric patients-12 years and under 4. Patients with contact precautions until there is sufficient time for donning and removing PPE and washing hands between patients. **Examples of an unstable airway include, but are not limited to, the following**: 1.Requiring active interventions to maintain patency such as manual jaw lift or chin lift or an oral airway 2. Evidence of obstruction, active or probable, such as gasping, choking, crowing, wheezing. 3. Symptoms of respiratory distress including dyspnea, Tachypnea, panic, agitation, cyanosis, etc. Any unconscious patient 12 years of age and under 4. A second nurse must be available to assist as necessary **CLASS 2:1 TWO NURSES TO ONE PATIENT** **Example may include, but not limited to the following:** a. one critically ill, unstable patient b. Patients on Bi-PAP Respiratory Therapy Department provides support to PACU for patients requiring CPAP, Bi-PAP, breathing treatments and ventilator support Copies of the anesthesia sheet are in the PACU prior to the patient's arrival to review needs in the immediate post-operative period. A copy of the RN Admission Worklist is also available to staff prior to patient arrival. Both documents are used for patient acuity and intensity purposes to provide safe, effective care.

	Patient acuity and nursing intensity will be reviewed at the beginning of each shift by Charge RN and as each new patient or staff member enters or leaves the PACU. Charge RN will provide fluid, continuous monitoring of overall acuity and intensity of the unit by monitoring patient condition, staff management of patients, number of staff members and patients on the unit at all times, make changes as necessary and communicate needs of the unit to House Coordinator, other unit Charge nurses, unit Manager, unit Director, Administrator on Call as necessary.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	PACU does not currently staff with LPNs. Core staffing is comprised of 10 RNs and 1 CNA2. The day before, the charge nurse will receive a copy of the next day's surgery schedule with patient numbers. Using the following equation, they will determine how many RNs are needed for the entire day to staff for breaks, lunches, and peak patient hours: (# patients scheduled X 2.2 then divided by 8) + (1.5 Charge RN) = Total RNs required for day. RNs are scheduled with staggered start/end times to offer proper coverage. **Weekday minimum staffing breakdown (this is based on patients all being on the unit at the same time):** 1 patient = 2 RN's 2 patients = 2 RN's 3 patients = 3 RN's 4 patients = 3 RN's and 1 NSM 5 patients = 4 RN's and 1 NSM 6 patients = 4 RN's and 1 NSM 7 patients = 5 RN's and 1 NSM 8 patients = 5 RN's and 1 NSM 9 patients = 6 RN's and 1 NSM 10 patients = 6 RN's and 1 NSM 11 patients = 7 RN's and 1 NSM 12 patients = 7 RN's and 1 NSM SSU and Endo can be contacted for additional nursing or aid support on a PRN basis **On Call Minimum staffing breakdown** 1-4 patients = 2 RN's Transport and meal breaks will be provided/coordinated by the house coordinators when needed *See attached 'Daily Nurse Staffing' form for staffing/start time format

Describe process for limiting admissions/diversions to another hospital etc.	Communicate needs of PACU up the chain of command, i.e., House Coordinator, unit Manager, unit Director, Administrator on Call.
Describe non-direct care tasks including meals and breaks	<u>Meals and rest breaks:</u> Rest/meal breaks will follow the Professional Agreement between MWMC and the ONA/SEIU. Charge nurse will utilize the chain of command for rest/meal break support as needed. The daily staffing sheet shall reflect who has received their rest/meal breaks; to be completed by the Nurse Staff Member Charge Nurse and document actual times in the break/meal column respectively. Meals/rest breaks are completed by charge nurse with regards to patient continuity with minimal hand off. Meals/breaks are completed between patient assignments to avoid hand-offs whenever possible. On-call staff will notify the house coordinator if rest/meal breaks are needed. Involuntary missed/late meals will be communicated to the charge nurse and management as soon as possible. <u>Non-Direct Care in PACU:</u> Preparing unit for the day including- Stocking blankets and IV fluids in warmer Emptying trash Emptying linen carts Cleaning bays between patients Ped and adult crash cart checkoffs Restocking supply carts in each bay CBG QC Creating patient magnets Communication/coordination with other departments Pyxis inventory
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	The day before, the charge nurse will make appropriate staffing based on the surgery schedule (see section “What is the MINIMUM number of RNs, LPN and CNAs on specified shifts” for specifics). When PACU has sick calls or is short of nurses, Charge RN will text/call staff who are not present that day to see if anyone is available to come to work. If the unit CNA is out, PACU will work with Endo and SSU to use an available CNA II. Flexing off guidelines: #1 Staff on Premium pay, Scheduled above their master schedules, by seniority

	#2- Nurses who sign up for OIP/OSIP #3- Volunteers according to start time and staffing needs. #4- Resource nurses by seniority #5- the RN with the highest percentage. Routine low census and standby will follow professional agreement between ONA/SEIU and McKenzie-Willamette Medical Center and staffing percentages.
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	UPC meeting will be held at the end of December or early January to gather the date that was obtained during the year. A template will be completed which includes: Patient outcomes that were less than satisfying SRDFs Missed meals and breaks HCAHP results Employee Survey results Overtime hours: Mandatory/voluntary/end of shift overtime Handwashing audits Event reporting in Riskonnect Staff injuries related to post-op bed utilization Annual QI projects SDRF's/Staffing situation when ratios aren't within ASPAN guidelines Annual skills assessment and monthly education series Staff turnover Completion of call to patient's family member when patient transfers to inpatient unit
ATTACH UNIT STAFFING GUIDES	

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Progressive Care Unit (PCU)	
Effective Date: August 5th, 2023	
Staffing Committee Representatives: Lisa Benninger, RN (Primary) and Kendra Ward, RN (Secondary), Kristine Zebede (Nurse Manager)	
Criteria-Description of Patient Population	PCU is an Adult Medical-Surgical Intermediate Care Unit specializing in the care of step-down ICU Patients. The PCU specializes in interventions needed to care for the patient populations as listed: Non-invasive hemodynamic monitoring and support, fixed-rate vasoactive and antiarrhythmic drip interventions, stable BIPAP support, rescue BIPAP support when BIPAP application is expected to stabilize patient, conscious sedation and stabilizing interventions for patients awaiting transfer to the Critical Care Unit such as RRT initiation, Code Blue initiation, defibrillation and intubation. PCU also provides remote telemetry monitoring for MCU patients. **Bedside procedures that take place on the PCU include:** Intubation, central line placement, thoracentesis, paracentesis, hemodialysis catheter placement, bronchoscopy, endoscopy, cardioversions and chest tube insertion. The Charge Nurse or Bedside RN assists as needed with these procedures or with additional house resources, (i.e., House Coordinator, Nurse Manager, Critical Care RN, etc.,) as needed. BIPAP support is considered stable if BIPAP is applied, repeat ABG or VBG has improved and patient's clinical picture is improving. **Patient population includes but is not limited to:** Patients experiencing neurological, cardiac, pulmonary, renal, metabolic and infectious conditions with hemodynamic instability, and those who are in their post-operative period. Population also includes, acute medical, surgical, or telemetry level patients awaiting transfer to an appropriate acute care unit, and/or difficult social and psychiatric patients who are stable but require a higher level of observation. PCU Care is provided 24 hours per day, 7 days a week

	Specialized care in the PCU includes the following: • Telemetry Monitoring and Management • Hemodynamic Monitoring and Management • Vasoactive Drip Management at a fixed rate or minimal titration with improvement • Antiarrhythmic Drip Management at a fixed rate/protocol • Anticoagulation Drip Management • Sedation Drip Management • Pacemaker monitoring of already implanted devices • Chest Tube Management • Thoracentesis • Cheetah Fluid Management System and Assessment • TEE's and Cardioversions • Admission of pre-procedural and pre-operative patients • Moderate Sedation Performance and Management • Recovery from post-op patients from PACU • Recovery of post Cath Lab patients without sheath pulls • Patient education related to all listed disease conditions, pre and post procedural education and discharge teaching **Other Services PCU Provides:** PCU provides remote telemetry monitoring and interpretation for MCU telemetry patients and staff, and assists MCU Staff by notifying of changes in patient telemetry status.

	PCU includes 14 private inpatient rooms numbered 351-364. Rooms are designed to care for most Adult Patient Populations and include a toilet, sink station and patient wardrobe in every room. Two shower rooms are present; one in room 351, and the other across from room 364 in the hallway. All rooms are equipped with advanced cardiac monitoring capability, oxygen monitoring/treatment capability and telemetry capability. Rooms 351 and 364 have cameras for closer monitoring of patients away from the nurse's station/requiring specific monitoring needs. The CVOR, Hybrid, Cath Lab and Critical Care Unit are located past the Med/Surg Units on the 2nd floor with elevator and stair access to the departments. The conference room, clean supply room, equipment room, dirty utility, staff break room, staff locker room and 2 office spaces are located within the PCU. The unit has 2 locked entrances. Our family waiting room is located outside of the PCU on the 2nd floor or within the Conference Room on PCU when unoccupied. Our patients are admitted to PCU via MWMC ED, direct transfer from surrounding area hospitals and directly from local physician offices or urgent care clinics. PCU takes downgraded patients from MWMC's CCU, and transfers requiring higher level of care from the other surrounding units at MWMC. **Patient Population in 2022 Included the Following Primary Diagnoses:** • Acute Coronary Syndrome, Chest Pain • Cardiac Arrhythmias, Conduction Disorders • Pre and Post Cardiac Angiography diagnostic and intervention • Hypertensive Crisis • Pulmonary Edema • Pulmonary Embolus • COPD Exacerbation • Pneumonia/Pneumonia Sepsis • SOB • Failure to Thrive • Atrial fibrillation with RVR • Bowel Obstruction • Wound Infections

	2022 Primary Diagnoses Continued: • Hyperkalemia • Generalized Weakness • COVID • Respiratory Failure • Failure to Thrive • Endocarditis • Heart Failure • CVA • AKI • Respiratory failure • Drug/ETOH withdrawal • Sepsis • Septic Shock • Acute Renal Failure without CRRT intervention • Poisoning & toxic effects of drugs • DKA • Attempted Suicide/Suicidal Ideation monitoring • Gastrointestinal Bleeding • Altered Mental Status • Cellulitis • Aspiration Pneumonia • Syncopal Episodes • Substance Abuse Disorders • NSTEMI • Fall/Injury • Infectious Diseases • Seizures • Post-Surgical patients • Fluid, electrolyte and metabolic disorders • Postpartum patients • Abdominal Surgery • Delirium

	2022 Primary Diagnoses Continued: • Flank Pain • Hypotension • Paroxysmal Atrial Fibrillation • Cardiac Arrest • UTI • SBO • Liver Failure • Acute Pancreatitis • Hypokalemia • Compromised Airway • Encephalopathy • Hyponatremia **Other Surgical Patient Populations on PCU Include:** • **Open Heart Surgeries (OHS):** Pre-Op and Post–Op Day 3-4 Open Heart Surgical patients up to discharge from hospital • **Vascular Surgeries:** Angiograms and peripheral vascular disease without arterial lines or sheath pulls • **Thoracic Surgeries:** Pre-Op and Post-Op care of Video Assisted Thoracotomy (VAT), lobectomy patients Limited outpatient procedures are provided, if any.

Average Daily Census (ADC) annual average	Average Monthly Census from January-to-June, 2022: 360 Average Daily Census from January-to-June, 2022: 12
Average Length of Stay (LOS) annual average	The Average Length of Stay (LOS) on PCU in 2022 was: 4.99
Specialized qualifications and competencies (include requirements for travel nurses)	Required competencies for PCU RNs will be completed and documented in HealthStream, maintained by the Critical Care Educator and Nurse Manager, and the hospital education department. Plan attached to this staffing plan.

	Specialized Competency Levels for PCU RNs include: ● I-1 RNs are able to competently care for our most critical PCU level patients. I-1 RNs have completed all necessary education requirements and have passed a BKAT Exam through our Critical Care Educator. ● I-2 RNs are actively working towards obtaining their I-1 status, which should be completed within one year of hire or transfer into the unit. I-2 RNs may care for stable PCU level patients independently, and with back-up support from a I-1 RN of unstable PCU level patients. ● These I-1 and I-2 Statuses are tracked/updated upon completion by the Critical Care Educator, Nurse Manager and Staffing Office in Shift Select **Nurses floating to PCU from another unit:** ● Intermediate RNs may care for intermediate level patients per the Intermediate Patient Placement Guidelines. Medical or Surgical RNs may care for the med/surg patients in the PCU per the Patient Placement Guidelines. ● RNs floated to PCU from another unit will be assigned as able a patient care team that has the lowest acuity on the floor and/or a lesser number of patients per the 2021 ONA contract. **Travel RNs working in the PCU will have and maintain competency in the following for the duration of their contract:** ● Basic and Advanced Life Support (BLS and ACLS) ● General Nursing Orientation New Hire Skills Completion checklist for PCU RNs (competency attached)

Skill Mix and level of competency required to meet the healthcare needs of patients	Each shift PCU will be staffed with RNs with the following skill mix in order to adequately meet the needs of the patients. Any one RN may have more than one skill code assigned to them. Overall number of staff is based on minimum and goal staffing guides: ● At least one I-1 RN in addition to the Charge RN who is also an I-1 RN, if able. ● An RN who is certified in Moderate Sedation if planned procedures for the shift
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	Annual 2022 Data January-to-June, 2022 (PCU Closed from June-to-November, 2022) Average Daily Admits: 1 Average Time to Complete an Admission: 60 minutes Average Daily Discharges: 1 Average Time to Complete a Discharge: 60 minutes Average Daily Transfers: 2 Average Time to Complete a Transfer: 30 minutes ADT %: 100%
Nationally Recognized Standards or Guidelines	PCU follows guidelines set forth by American Association of Critical Care Nursing (AACN), American Heart Association (AHA), all McKenzie-Willamette policies and procedures, and per the nursing guidelines listed on facility intranet.
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.)	**Staffing for Acuity and Nurse Intensity:** Patient care is provided following the American Association of Critical Care Nurses (AACN) Scope & Standards for Acute and Critical Care Nursing Practice and AACN's Synergy Model 2015 2nd edition. Daily shift assignments are based on patient acuity, patient intensity and skill level of nurses in order to provide safe patient care while accommodating needs of patients and families.

What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	Charge nurses use their expert judgment, in addition to considering acuity and intensity of the patient in order to make appropriate patient assignments throughout the shift, and at beginning/end of each shift daily. This is reported and discussed between the Primary RN and Charge RN during shift, documented per shift utilizing MWMC Acuity Tool, and ultimately decided by the Charge RN. **Advanced Acuity Levels:** **Recovery from Bedside Procedure –** Patients experience an immediate recovery period following moderate sedation. These patients will be 1:1 nurse to patient ratio until recovery requirements are met for bedside procedures. **Advanced Critical Acuity 1:1:** Hemodynamically unstable patients requiring continuous nursing interventions. In these cases, RRT or Code Blues initiated, patient stabilized and transferred to CCU for continued higher level of care. **Intermediate Acuity 1:3:** See Patient Guidelines under Intermediate Care category. **Medical/Surgical Acuity 1:4:** PCU at times provides care for M/S tele or non-tele patients. These patients are 1:4 nurse/patient ratio depending upon intensity of the nursing care provided. See Patient Placement Guidelines under Med/Surg. **Acuity/Intensity Tool** PCU determines acuity and intensity based on the McKenzie Willamette Medical Center Acuity/Intensity Tool. 3:1 patient team should not have an acuity >12. 1:4 patient team should not have an acuity >12. **Patient Placement on PCU:** Appropriateness of admissions to the PCU is guided by the Hospital Policy CC01-004, Admission and Discharge Criteria for PCU, and the MWMC Patient Placement Guidelines.

	Conditions that can contribute to higher intensity include: • Aggressiveness and/or dementia • Delirium • Incontinence • Frequent wound care • Hourly blood sugars • High fall risk with risk of injury • Total feeder or total care • Frequent toileting assistance • 2-person assist to transfer

What is the MINIMUM number of RNS, LPN and CNAs on specified shifts	Each shift shall be staffed with a 12-hour PCU RN Charge Nurse (CN) who does not take a patient team except transitionally, and other clinical staff members can be requested as a sitter instead of an RN. Core staffing is a mix of I-1 and I-2 trained RNs. High nursing care intensity patients are determined by Primary RN and verified by Charge Nurse. Charge Nurse will determine if high intensity of unit warrants an additional NSM to be added.

PCU Minimum Staffing Grid

Number of Patients	Intermediate with 1:3 Ratio	Med/Surg Overflow with 1:4 Ratio
0	Charge + RN on Call	Charge + RN on Call
1	2	2
2	2	2
3	2	2
4	2	2
5	2	2
6	2	2
7	3	2
8	3	2
9	3	3
10	4	3
11	4	3
12	4	3
13	5	4
14	5 *Charge Nurse included in numbers for all grids*	4

PCU Goal Staffing Grid

Number of Patients	Intermediate with 1:3 Ratio	Med/Surg Overflow with 1:4 Ratio
0	Charge + 2 RNs on Call	Charge + 2 RNs on Call
1	3	3
2	3	3
3	3	3
4	3	3
5	3	3
6	3	3
7	4	3
8	4	3
9	4	4
10	5	4
11	5	4
12	5	4
13	6	5
14	6 *Charge Nurse included in numbers for all grids*	5

	PCU direct care nursing staff is supported by the PCU Nurse Manager, Staffing Office, House Coordinator, the Inpatient Director, colleagues, Hospitalists, Intensivists, Respiratory Care, Physical Therapy, Occupational Therapy, PICC Team, Pharmacists, Dieticians, Care Managers, Cardiac Rehab, Environmental Services, Cath Lab and CVOR staff as needed. Census and acuity fluctuations due to admissions, discharges, transfers in and/or out of the unit, and procedures are managed by utilizing any other qualified Nurses as available. Low census and standby will follow Professional Agreement between Oregon Nurses Association and McKenzie Willamette Medical Center. The Charge Nurse is responsible for evaluating current census, patient acuity levels, staff available, skill code, and anticipated activity in the PCU for the present shift and the next shift. Anticipated activities include admissions, discharges, transfers in or out of the unit, procedures and surgeries. The Charge Nurse will make appropriate assignments based on this information. Throughout the shift the Charge Nurse will delegate additional responsibilities as patient needs warrant. The Charge Nurse will assure that the appropriate Nurse skill level matches the patient's acuity needs in order to maintain unit flow/throughput. Regularly scheduled PCU nurses may be floated to other departments per ONA contract if staffing guides are met PCU will remain open for admissions as long as there is capacity and capability. Per OAR 333-510-0045(3)(g) a direct care Registered Nurse may initiate the process for limiting admissions to PCU when, in their judgment, there is an inability to meet patient care needs or a risk of harm to patients exists. The direct care nurse will notify the PCU charge nurse who will then notify the House Coordinator, PCU Nurse Manager, or the Administrator On-Call. These individuals will collaborate with other departments to accommodate safe patient throughput and to prevent inability to place intermediate level patients on PCU whenever possible utilizing PC01-021: Managing Patient Flow and Inpatient Capacity. SRDF’s are a tool used by nursing staff and the hospital to document incidences of problematic staffing which allows for timely follow up and review of each occurrence. Staff is encouraged to report staffing concerns using the SRDF process. SRDFS are reviewed by the unit’s UPC and discussed at Staffing Committee.

Describe process for limiting admissions/diversions to another hospital etc.	PCU will remain open for admissions as long as there is capacity and capability. Per OAR 333-510-0045(3)(g) a direct care Registered Nurse may initiate the process for limiting admissions to PCU when, in their judgment, there is an inability to meet patient care needs or a risk of harm to patients exists. The direct care nurse will notify the PCU charge nurse who will then notify the House Coordinator, PCU Nurse Manager, or the Administrator On-Call. These individuals will collaborate with other departments to accommodate safe patient throughput and to prevent inability to place intermediate level patients on PCU whenever possible utilizing PC01-021: Managing Patient Flow and Inpatient Capacity.
Describe non-direct care tasks including meals and breaks	**Meal and Rest Breaks** Meal and rest breaks will follow Professional agreement between MWMC and ONA. The provision of meal and rest breaks is done on a rotation basis among nurses using the charge nurse or a nurse with a partial patient team that would not be covering teams outside the staffing plan guides. In an event that meal and rest breaks are unable to be provided by the Charge Nurse or another Nurse on the floor with a partial patient team within staffing guides, the Charge Nurse will notify the House Coordinator and Nurse Manager at earliest convenience to establish a plan for break coverage. The House Coordinator can provide meal and rest breaks to the Charge Nurse as needed, and the Nurse Manager will assist with breaks if other options are unattainable.

	Non-Direct Care Nurse Tasks on PCU Include: • Answering phones & Monitor Tech/Unit Secretary Tasks when the MT is absent • Filling blanket & wipes warmer • Stocking gloves throughout unit • Preparing rooms for admits/transfers & Stripping rooms post-discharge for EVS **Non-Direct Care Charge Nurse Tasks on PCU Include:** • Charge Report beginning/end of shift • Percentage points • Staffing & Assignment Sheets • Environment check • Bed Huddle at 1100/1645 and 2300/0445 • Required Shift Audits & NPSG Monthly Audits • Patient report from Staff/Review of Acuity Scores for Assignments • Paperwork to assist with ADT efficiency • Answering phones • Monitor Tech/Unit Secretary Tasks when the MT is absent • Filling blanket & wipes warmer • Stocking gloves throughout unit • Preparing rooms for admits/transfers & Stripping rooms post-discharge for EVS
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	**PCU will utilize its Minimum Staffing Guide when all efforts have been exhausted to support the Goal Staffing Guide, such as:** • House-wide assessments have been completed regarding elective surgical procedures when beds are unavailable, ED and community volumes are high, staffing is poor house-wide or throughput is un-manageable • Staffing Office, House Coordinator, Nurse Manager have attempted all recruitment efforts to obtain adequate staff and have been unsuccessful In the event that PCU has no patients on the unit, PCU will maintain monitoring of telemetry patients on MCU. A Charge RN and one direct care RN will remain on call should patients need to be admitted or transferred into the unit. At least one on call RN needs to hold I-1 status. Scheduled PCU RNS may be floated to other departments per ONA contract.

	Additional/Replacement staff may be obtained from the following options: • Regular PCU RN's who have pre-arranged extra work or standby status. • Med/Surg Nurses who have pre-arranged extra work or standby status. • Resource CCU and PCU Nurses • Float CCU, Float Pool or Med/Surg Tele RNs • Nurse Managers • Per diem Nurse Staffing Agencies and Travel Nurses • Off Duty regularly scheduled PCU staff
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? ● Patient Outcome Data ● Complaints regarding staffing (SRDF) ● Hours per patient day (HPPD) ● Number of mandatory overtime hours worked by nursing staff ● Number of voluntary hours worked by nursing staff ● Percentage of shifts for which staffing differed from the nurse staffing plan ● Did the nurse staffing committee ask for additional information	**PCU 2022 Harm Events:** • CAUTI: 5 • CLABSI: 0 • CDIFF: 2 • FALLS: 8 • HAPI: 5 **SRDFs Filed & Reviewed:** • 28 • Percentage of shifts outside of staffing plan based on SRDFs: 100% **Hours per Patient Day:** • Total Patient Days: 2,094 • Productive Hours: 60,729 hours • Non-Productive Hours: 6,796 hours **Mandatory OT Hours:** • 0 hours **Voluntary OT Hours:** • Total Average of 2022: 1,483 hours • Average of hours per month: 123.58 hours • Average of hours per week: 28.51 hours
Attached: Progressive Care Unit 2023 Professional Development Plan and Calendar, General Nursing Orientation New Hire Skills Completion Checklist for PCU Nurses and Travel Nurses	

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Women's Health, Birth, and Children's Center	
Effective Date: October 2023	
Staffing Committee Representatives: Ruth "Candy" Bigbee and Tiffany Clemo	
Criteria-Description of Patient Population	**Women's Health, Birth, and Children's Center (WHBCC) Nursing Services include but are not limited to the following:** • **Obstetrical triage/out-patient care of women at greater than 20 weeks with obstetrical complaints. Less than 20 weeks, to be seen in Emergency Department.** • **Provide NST'S (Non-Stress Test)/FHT'S (Fetal Heart Tones) in other hospital departments as needed.** • **Antenatal care and observation for obstetric complications or medical conditions associated with pregnancy but likely to deliver after 34 weeks gestation.** • **Intrapartum care of women in labor.** • **Perioperative care for women with Cesarean Section (C/S), and other obstetric care.** • **Recovery care of women who have delivered by vaginal birth or cesarean sections** • **Postpartum care of the newly delivered mother.** • **Postoperative care of stable GYN surgeries, , readmitted stable GYN surgical patients, other postoperative patients which include but are not limited to: hysterectomy, urinary surgeries, exploratory laparoscopy, laparotomy, cholecystectomy, and appendectomy. Admissions including D&C, ectopic pregnancy, ovarian cyst, PID (Pelvic Inflammatory Disease), unexplained abdominal pain, menorrhagia, miscarriage requiring observation, kidney infection or kidney stones; accepted upon the charge nurse's discretion after they have had a chance to thoroughly review patient's chart to ensure they are acceptable for admission to WHBCC.** • **Well-baby care of the stable newborn infant including transitional care and ongoing care.** • **Level II Nursery includes diagnoses of Sepsis, Neonatal Abstinence Syndrome, Hypoglycemia, Hyperbilirubinemia, Respiratory Distress Syndrome (stabilized/not requiring surfactant), Meconium Aspiration, Prematurity, Transient Tachypnea, Stable Pneumothorax, Weight Loss.** • **Level II Nursery Readmissions: Newborns < 28 days of life with dx such as Failure to Thrive, Weight Loss, RSV, Hyperbilirubinemia, pneumonia, dehydration, and sepsis. Newborns in the transitional period. Stable but ill newborn infants at 34 weeks gestation or greater, requiring increased respiratory needs, intravenous fluids, medications, cardio-respiratory monitoring, phototherapy and/or specialized feedings, including infants readmitted for such treatments after discharge.** • **Unstable or ill infant less than 34 weeks gestation with conditions requiring services not offered at MWMC, such as Congenital Diaphragmatic Hernia, Subgaleal Hemorrhage, Pulmonary Hypoplasia, Congenital Cardiac Defects, Congenital defect/anomalies, Pulmonary HTN, and Respiratory Distress Syndrome requiring surfactant. These newborns are stabilized and transferred to a tertiary center according to infant's presentation.** • **Lactation services: breastfeeding support.** • **Stable newborn outpatient checks such as weight checks and bilirubin checks.** • **Stable pediatric patients over 29 days requiring medical attention such as RSV, bronchiolitis, appendectomies, r/o sepsis, gastroenteritis, pyelonephritis, pneumonia, and asthmatics.**

	• **Unstable or ill pediatric patients requiring services not offered at MWMC, are stabilized and transferred to a tertiary center according to patient's presentation such as mental health illnesses requiring psychiatry (suicide attempt, behavior/combative issues), severe head injuries, bacterial meningitis, spinal cord injuries, pertussis** • **The Birth Center consists of 15 LDRP's (Labor, Delivery, Recovery, Postpartum rooms equipped with central fetal monitoring,14 Jacuzzi tubs, sleep couches for support person, infant warmer and resuscitation supplies), one Operating Suite (equipped with infant warmer and resuscitation supplies), and a three- bed Level II nursery (equipped with three radiant warmers and resuscitation supplies). When nursery is full, a patient room with appropriate equipment will be converted to accommodate already stabilized level II newborns.** **The Birth Center provides care 24 hours a day, 7 days a week for pregnant women generally greater than 20 weeks gestation, newborns, and pediatric patientsEmergency staffing issues are dealt with collaboratively between the Director, Manager, Charge Nurse, House Supervisor, and Staffing Office. If the unit has reached capacity, due to limited bed or staff availability, the Charge Nurse contacts the House Supervisor, and the patient's provider to determine a plan.**
Average Daily Census (ADC) annual average	The ADC is 9.4
Average Length of Stay (LOS) annual average	The average LOS is 1.87 days
Specialized qualifications and competencies (include requirements for travel nurses)	**Qualifications and Competencies:** **RNs:** • **Current Neonatal Resuscitation Program (NRP), Acute Cardiac Life Support (ACLS)- labor nurses only, Basic Life Support (BLS) certifications.** • **Advanced Fetal Monitoring (required within one year of hire) for nurses holding labor skill code (L1 or L2).** • **Remain current in specific unit competencies and protocols as well as required online education which includes adolescent training module** • **STABLE Class** **Pediatric Nurses:** • **Pediatric Advanced Life Support (PALS), Basic Life Support (BLS) certifications** • **Remain current in required online education**
Skill Mix and level of competency required to meet the healthcare needs of patients	**Each shift will be staffed with the following skill mix in order to adequately meet the needs of the patients. Overall number of staff based on minimum and goal staffing guidelines** • **2 nurses required (preferably both with labor skill code) with 1 nurse being charge, but each nurse holding separate OR skill codes, as outlined. 1 nurse to be N1, 1 nurse to be labor/circulator and a scrub tech who could be sleeping in house if no patients (labor nurse should be a L1 with 2 years of experience) to be able to**

	safely care for a woman presenting with an OB emergency • **RNs and OB Techs can sleep in-house when staff agrees and staffing permits.** • **Another labor nurse shall be called in to be available to take another labor if one presents during the OB emergency.** • **Plan may be in place to include a Standby to cover situations when existing staffing is inadequate** • **Charge RN may take a patient team and cover a skill code until another RN is available while all other RNs with needed skill codes are being contacted.**
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	**Admissions, Discharges, and Transfers (ADT)- Average Times:** **Admissions: One hour for stable/non-complicated patients.** **Discharges: 2 hours** **Transfers: 30 minutes**
Nationally Recognized Standards or Guidelines	**AWHONN Staffing Guidelines, 2022** **AAP/ACOG** **Joint Commission Standard/National Patient Safety Goals** **NANN** **AORN**
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	**Recommended Registered Nurse-to-Patient Ratios for perinatal care services:** **-- Ratios are defined as RN(s): Patient(s)** **-- Acuity tool being utilized to ensure staffing assignments are equitable (see tool below). Acuity tool is to be done every shift and when the status of a patient changes. Assignments can be adjusted during shift to ensure equitable distribution of patient assignments amongst staff.** **Obstetric triage and Antepartum Care: (L1, L2 skill codes with at least one year of experience may care for these patients depending on patient type)** • **EMTALA requires a medical screening to determine whether an emergency medical condition exists. In obstetrics the process requires assessment of both the mother and the fetus. Triage refers to the initial interview and assessment as well as care in the triage unit for up to several hours before patient disposition. The initial Triage process, up to 20 minutes, requires 1:1 care until maternal/fetal status is deemed to be stable. This ratio may change to 1:2-3 until patient disposition.** • **During non-stress testing nurse patient ratio is 1:2-3.** • **Hospitalized antepartum patients are assumed to have complications and are staffed 1:3 if in stable condition without continuous fetal monitoring. If the antepartum patient is not in stable condition, they are staffed 1:1.**

	Intrapartum, Birth, and Recovery:
	Intrapartum: (L1 or L2 may care for these patients)
	• **Patients are staffed as 1:2 for women in early labor, without complications**
	• **All patients in active labor, patients with medical conditions, patients with obstetric complications, and patients receiving Pitocin are 1:1 care.**
	• **Patients in 1:1 care with continuous bedside attendance are as follows:**
	  • **Women receiving IV Magnesium Sulfate for the first hour of administration.**
	  • **During placement of regional anesthesia for the first 30 minutes from bolus and until stable.**
	  • **During the active pushing phase of the second stage of labor.**
	Birth: (L1, L2 and/or N1, N2 may care for these patients)
	• **At least two RNs:**
	One nurse is responsible for the mother and one nurse is responsible for each baby (1 for singleton, 2 for twins, etc.) until critical elements are met:
	  • **The placenta is delivered, the perineal repair is complete, and the mother is hemodynamically stable.**
	  • **The newborn's initial assessment (Temperature, Heart Rate, Respiratory rate and color) is stable and documented, and Identification bands have been applied.**
	At that time one nurse may care for both mother and baby/babies.
	Recovery: (L1, L2, may care for these patients)
	• **Vaginal Birth: Recovery begins after the delivery of the placenta and is a minimum of 2 hours of continuous 1:1 maternal care.**
	• **Cesarean Birth (C/S): Recovery begins upon arrival to PACU and is a minimum of 2 hours of continuous bedside 1:1 maternal care.**
	
	Post-partum /Stable Newborn /GYN: (L1, L2, M, M2, N1, N2, or a trained float may care for these patients)
	• **1:3 mom/baby couplets if stable with no BF issues or other complications, may take up to 4 mom/baby couplets if Charge Nurse is available to assist**
	• **If mom is on magnesium sulfate**
	  • **Stable mom not requiring interventions for blood pressure, can take only 1 other mom/baby pair that is stable.**
	  • **Unstable mom requiring repeat doses of IV blood pressure meds, adjusting Magnesium doses, increased Deep Tendon Reflexes (DTR), Central Nervous System (CNS) symptoms, should only care for that mom and baby until mom is stable**
	• **No more than 2 moms that have had a C/S in the last 24 hrs in a team of 1:3 mom/baby ratio**
	• **Charge Nurse is not to take patients so they can assist staff with complications, assist with feeds, and medication administration. If census is low (3-4 mom/baby couplets or less and no labors), the Charge Nurse can take an assignment (see minimum guide).**
	• **No more than two babies in a team of 1:3 mom/baby couplets with breastfeeding complications. Infants requiring full assist with breastfeeding and supplemental nutrition system with feeds, more time intensive lactation support is needed, and assignments may need to be adjusted accordingly.**
	--When deciding patient acuity consider in the mix of mom/baby care complications arising with postpartum moms:
	• **Postpartum hemorrhage- Ongoing observation of mom for continual bleeding, increased bleeding, weighing pads, and/or more frequent vital signs due to blood loss**
	• **Moms (not on magnesium) requiring close monitoring for increased blood pressure, increased CNS symptoms, and/or labs**

	• **Moms that may require need for blood products**
	• **Increased pain with C/S patients, unstable vital signs after C/S (high or low blood pressure)**
	• **Moms with infection requiring antibiotics, either post-op or postpartum**
	
	<u>GYN/Surgery/Women's Health: (L1, L2, M, M2, N1, N2, or a trained float may care for these patients)</u>
	• **1: 4 for stable GYN or post-op patients to include but not limited to: hysterectomy, urinary surgeries, exploratory laparoscopy, laparotomy, cholecystectomy, appendectomy**
	• **Staffing ratios depend on acuity and are assigned under Charge RN discretion. Patients with increased complications may need a smaller nurse to staff ratio: unstable vital signs, blood transfusions, uncontrolled pain, RRT's, and patients with existing health issues such as HTN, cardiac issues, respiratory issues. May need to evaluate if beneficial to transfer patient to SCU if staffing permits when WHBCC is full.**
	• **Patient population includes readmitted stable GYN patients and admissions including D&C, ectopic pregnancy, ovarian cyst, PID, unexplained abdominal pain, menorrhagia, miscarriage requiring observation, kidney infection or kidney stones.**
	
	<u>Level 2 Nursery: (N1, N2, or M, or M2 depending on diagnosis may care for these patients)</u>
	• **Classification of care for babies is delineated by AAP and ACOG (2007) as follows:**
	  • **Newborn Nursery Care is provided for heathy newborns. Late preterm babies also may be cared for in the newborn nursery if they are physiologically stable. Late preterm babies are not usually ill but may require more frequent feeding and more hours of nursing care than do normal term babies.**
	  • **Intermediate care is provided to sick babies who do not need intensive care but who require 6 to 12 hours of nursing care per day.**
	  • **Intensive care is provided to severely ill babies who require constant nursing care and continuous cardiopulmonary and other support.**
	• **Level 2 Nursery Staffing ratios:**
	  • **1:2-3 newborns requiring intermediate care**
	  • **1:1-2 newborns requiring intensive care**
	  • **1:1 newborn requiring multisystem support**
	  • **When 6 intermediate care newborns or 4 intensive care neonatal care newborns are in the nursery, a minimum of two N1s are required. (*Minimum staffing in NICUs,* National Association of Neonatal Nurses (NANN), 2008).**
	• **Unstable newborns require at least one N1 plus team as necessary (NRP guidelines). Based on gestational age, oxygen requirements, life threatening anomalies, persistent acid/base imbalance, and need of diagnostic evaluation or services not available at MWMC, prior to stabilization and transport.**
	• **The N1 responsible for nursery newborns requiring intensive care will not be assuming level II newborns on the floor, nor be responsible for attending deliveries unless there is another N1 available to replace them.**
	• **The hospital will make every attempt to schedule two N1s at all times (this is not to include the charge RN as an N1 for staffing purposes, unless attempts have been made to staff with an additional N1 without success).**
	• **When the N1 has Level II newborns on the floor and is expected to also attend deliveries, another qualified RN shall assume care of those Level II newborns.**
	--Newborn Outpatients: Stable newborns. One RN designated for weight checks, bilirubin checks, and breastfeeding assistance as necessary for identified follow-up requirements. RN may have an assignment when performing outpatient checks.

	Pediatrics: (RN's with P skill code are the only ones qualified to care for these patients) • **All WHBCC RN's are capable of caring for an adolescent patient who is defined as 10 years and > 40kg to 18 years of age.** • **MWMC will have a minimum of one dedicated pediatric skilled RN scheduled regardless of pediatric census. If there are no pediatric patients in-house, the nurse will have an alternate assignment within their skill set or be placed on standby.** • **Staffing is determined by patient care needs and complexity.** • **According to ANA, staffing ratios shall be adjusted based on workload assessment which includes patient acuity, staff skill level, and patient intensity (including patient and family education, procedures, admission, discharges, and transfers).** • **The pediatric nurse may also hold an additional skill code on the Women's Health, Birth, and Children's Center and have an additional patient assignment.** • **A pediatric nurse may be assigned to care for a pediatric patient in isolation and a patient in the mother/baby population when necessary. However, priority should always be to cohort the pediatric nurse with pediatric patients only, especially when those patients are in isolation. Strict standard and transmission-based isolation precautions must be adhered to at all times when caring for these patients to reduce the risk of transmission of infection.** • **The RN is responsible for communicating to the Charge RN for the need of additional staff on an ongoing basis. The Charge RN will attempt to staff according to staff RN recommendations.** **Recommended Pediatric Staffing:** • **1:3 pediatric patients (no additional mom/baby couplet)** • **1:2 pediatric patients and one mom/baby couplet (stable and low intensity)** **Floating as a Sitter:** • **Nurses working extra shifts beyond their master schedule cannot be floated unless agreed upon.** • **Regularly scheduled nurses may be floated and will be immediately relieved from floating duties to return to WHBCC within 15 minutes. These nurses can be relieved by the Director, Manager, Supervisor, or Charge RN, the House Supervisor, etc. of the unit that the WHBCC staff member floated to. If unable to have a plan to be relieved, floating may not occur.** • **Any nurses working in excess of their master schedule will not be available for floating to other units. Extra nurses working over their master schedule may not work to allow for nurses working their master schedule to be floated.**
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	**Minimum Staffing:** • **2 nurses required (preferably with each holding a labor skill code) with 1 nurse being charge, but each nurse holding separate OR skill codes, as outlined. 1 nurse to be N1, 1 nurse to be labor/circulator and a scrub tech who could be sleeping in house if no patients (labor nurse should be a L1 with 2 years of experience) to be able to safely care for a woman presenting with an OB emergency** • **RNs and OB Techs can sleep in-house when staff agrees and staffing permits.** • **Another labor nurse shall be called in to be available to take another labor if one presents during the OB**

	emergency. • **Plan may be in place to include a Standby to cover situations when existing staffing is inadequate**
Describe process for limiting admissions/diversions to another hospital etc.	**Diversion of patients is handled on a case-by-case basis and is avoided when possible (includes rescheduling elective social inductions). Any employee may ask his/her supervisor, charge nurse, manager/director or House Supervisor to evaluate the need to limit admissions or go on diversion if he/she believes there is an inability to meet patient care need or risk of harm to patients. If the unit has no beds available due to maximum capacity of beds or available staffing, the Charge RN contacts the manager during the day, supervisor at night to determine a plan. Collaboration with other departments occurs as well to accommodate safe RN to patient ratios.**
Describe non-direct care tasks including meals and breaks	**<u>Meals and Breaks:</u>** • **A Dedicated RN, assigned as "Break Nurse", the Charge RN, and direct care nurses with a partial team that would remain within proper staffing ratios during breaks shall be available to provide breaks to each scheduled RN on the unit, including the charge RN, while utilizing appropriate skill code coverage. The staffing of a "Break Nurse" will be determined by the previous Charge RN when staffing prior to the shift based on census and patient acuity.** • **Charge RN may take an assignment for the purpose of covering meals and breaks.** • **The primary RN will report off to the dedicated RN for breaks.** • **In the event of interruptions, the break period(s) is/are eliminated and accounting for the missing break must be reflected/documented in Kronos and reported to the charge RN. Overtime pay will then be granted following ONA contract until a full break can be accommodated** • **RN's are responsible for documenting breaks in the Kronos system. If a nurse is not able to take a break, they will document that on their Kronos sheet as well as the Kronos system. It is the Nurse's responsibility to ensure this is filled out.** **Breaks are defined as the following:** **--One unpaid meal period consisting of one-half hour by 7 hours of work and one paid fifteen-minute rest period during each 4 hours of work. (One 12-hour shift will consist of three fifteen-minute breaks and one 30 minute break.) If possible, the Charge RN may allow an RN to combine breaks dependent upon unit needs.** **--A "Break" is defined as "time away from patient care, with no interruptions that are related to nursing or the nurses' assignment." The RN shall be able to physically step away from the unit/floor if desired.**
Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	**Predicted staffing needs are sent out on each Monday forecasting staffing needs based off current staffing and known patient admits for the coming week. Able and willing staff fill these staffing needs. When additional staff are needed due to call outs or an increase in patient census, the charge RN notifies the House Coordinator and/or staffing office. Group texts are sent to all staff able to work on WHBCC. If unable to fill staffing needs, Manager of unit is notified, and every effort made to find additional staff are completed. Low census and standby will follow professional agreement between ONA/SEIU and McKenzie-Willamette Medical Center, staffing percentages, and skill codes. Utilization of the Memorandum of Understanding,ONA & MWMC – WHBCC Essential On-Call (EOC) will also be used as written while active in the collective bargaining agreement.**

How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan • Did the nurse staffing committee ask for additional information	**UPC Meeting, first of each year, will gather data that was obtained during the previous year. A report will be made including:** • **SRDFs** • **Missed Meals and Breaks** • **Average ADT results** • **Overtime hours** • **Audits** • **Event reporting in Riskonnect** • **Annual QI projects** • **Annual Skill Assessments** • **Staff Turnover** **Quality Measures and Patient Outcomes:** • **Pain Assessment /Reassessment** • **Newborn Screen Sampling** • **Elective Inductions prior to 39 weeks (Press Ganey results)** • **Cesarean Section Rate** • **Inductions delayed due to staffing** • **Exclusive Breastfeeding** • **HCAHPS/SRDF Data** • **Annual Quality Evaluation for this Staffing Plan is done. If necessary, may be review more often.**

WHBCC STAFFING GUIDES

Labor Census 1:1*

RN	Patients
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10
11	11
12	12
13	13
14	14
15	15

*Continuous bedside attendance; active labor, medical conditions, obstetrical complications, and patients receiving Pitocin

Labor Census 1:2**

RN	Patients
1	1
1	2
2	3
2	4
3	5
3	6
4	7
4	8
5	9
5	10
6	11
6	12
7	13
7	14
8	15

**Early labor, without complications or medications, Induction of labor without continuous fetal monitoring

Couplet, Antepartum, Pediatric 1:3

RN	Couplet/Ante/Ped
1	1
1	2
1	3
2	4
2	5
2	6
3	7
3	8
3	9
4	10
4	11
4	12
5	13
5	14
5	15

Nursery 1:2 (1:1 during initial stabilization)

RN	Patients
1	1
1	2
2	3
2	4
3	5
3	6
4	7
4	8
5	9
5	10
6	11
6	12
7	13
7	14
8	15

Nursery Floor Level 2 1:3

RN	Patients	Delivery Attendent
1	1	2
1	2	1
1	3	-
2	4	2
2	5	1
2	6	-
3	7	2
3	8	1
3	9	-
4	10	2
4	11	1
4	12	-
5	13	2
5	14	1
5	15	-

"-" indicates another NRP certified RN to attend delivery

GYN/Medical Overflows 1:4

RN	Patients
1	1
1	2
1	3
1	4
2	5
2	6
2	7
2	8
3	9
3	10
3	11
3	12
4	13
4	14
4	15

Acutiy Tools

****Acuity for GYN and Medical Overflow patients use acutity tool in Medhost each shift and with status change.**

MOTHER		
ADL Activities Daily Living	Bath Independently	1
	Bath Partial Assist	2
	Bath Complete	3
	Up Ad Lib	1
	Ambulates w/Assist	2
	Bedridden	3
	Incontinence / Bedside Commode	3
Nutrition	Self-Feeding	1
	Partial Assist w/Feed	2
Medication	PO Meds / IM Meds / SQ / IV Push	1
	NS Lock	1
	Continuous IV Infusion ≤ 2	2
	Continuous IV Infusion ≥ 3	3
	Supplemental O2	1
Vital Signs	Routine VS 4 – 8 Hours	1
	Frequent VS 1 – 3 Hours	2
	Continuous or ≤ 15 Min	3
	CNS Checks	1
Treatments	Tele	1
	SCD – Sequential Compression Device	1
	NG Tube	1
	Dressing – Simple	1
	Dressing – Complex (PICC & Central Line)	2
	Wound Care - Simple	2
	Wound Care - Complex	3
	Suctioning	2
	Foley Catheter Care	2
	Blood Sugar Testing (Ongoing)	2
	Pre-Op	2
	Post-Op Recovery	2
	Pumping	1
	Fall Risk	2
	Blood Transfusion	2
	Bed Side Procedure(s)	3
	Isolation	3
	Post Mortem Care	3
	Admission / Discharge / Transfer	3
Behavior	Confused / Disoriented / Combative	2
	Psychologically Dependent / Dev. Delayed	2
	Communication Barriers	2
	Active Suicidal	3
Teaching	Simple Education	1
	Moderate Education	2
	Complex Education	3
	Laboring Mother	52
	Induction 1:2	25
	Mother Acuity Score	

Obstetrics – Couplet Patient Classification Acuity Tool
Classifying Patient for the next shift – Tool to Charge Nurse by 0400 & 1600

INFANT		
ADL	Bath	1
Nutrition	Feeding Independently	1
	Feeding with Assist	2
	Feeding Full Assist	3
	Using Supplement	1
	Gavage Feeding	1
Medication	PO Meds / IM Meds / SQ / IV Push	1
	NS Lock	1
	Continuous IV Infusion	2
	Supplemental O2	1
	CPAP	15
Vital Signs	Routine VS 4 – 8 Hours	1
	Frequent VS 1 – 3 Hours	2
	Continuous or ≤ 15 Min	3
Treatments *Only score if treatment to be performed on next shift*	Admission Footprints	1
	Lab Draw	1
	Umbilical Cath	2
	Hearing Screening	1
	Newborn Screen	1
	Phototherapy	1
	DAS Collection	1
	Transcutaneous Bili Reading	1
	CCHD	1
	Chest Tube / Needle Aspiration	3
	NG/ OG Tube	1
	Cardio-Resp Monitor	2
	Suctioning	2
	Urine Catheter	1
	Blood Sugar Testing	2
	Bed Side Procedure(s)	3
	Car Seat Challenge	2
	Isolation	3
	Admission / Discharge / Transfer	3
Teaching	Simple Education	1
	Moderate Education	2
	Complex Education	3
	Boarder Infant w/ family/cuddler/staff	25
	Boarder Infant w/o family/cuddler/staff	52
	Infant Acuity Score	

PEDIATRIC ACUITY TOOL WHBCC Room #:		
ADL Activities Daily Living	Bath Independently	1
	Bath Partial Assist	2
	Bath Complete	3
	Up Ad Lib	1
	Ambulates w/Assist	2
	Bedridden	3
	Bowel Care / Enema	2
	Diaper Weights	1
	Bladder Scan	1
	Straight Cath	2
	Incontinence / Bedside Commode	3
Nutrition	Self-Feeding	1
	Partial Assist w/Feed	2
	Full Assist w/Feed	3
Medication	PO Meds / IM Meds / SQ / IV Push	1
	NS Lock	1
	Continuous IV Infusion ≤ 2	2
	Continuous IV Infusion ≥ 3	3
	Supplemental O2	1
Vital Signs	Routine VS 4 – 8 Hours	1
	Frequent VS 1 – 3 Hours	2
	Continuous or ≤ 15 Min	3
	CNS Checks	1
Treatments	Tele	1
	SCD – Sequential Compression Device	1
	NG/OG Tube	2
	Dressing – Simple	1
	Dressing – Complex (PICC & Central Line)	2
	Wound Care - Simple	2
	Wound Care - Complex	3
	Suctioning	2
	Foley Catheter Care	2
	Blood Sugar Testing (Ongoing)	2
	Pre-Op	1
	Post-Op Recovery	2
	JP Drain	2
	Accompany pt to Radiology for MRI/CT/US	1
	Fall Risk	2
	Blood Transfusion	2
	Bed Side Procedure(s)	3
	Isolation	3
	Lab Draw	1
	Admission / Discharge / Transfer	3
Behavior	Confused / Disoriented / Combative	2
	Psychologically Dependent / Dev. Delayed	2
	Communication Barriers	2
	Active Suicidal	3
Teaching	Simple Education	1
	Moderate Education	2
	Complex Education	3
	Pediatric Acuity Score	

McKenzie Willamette Medical Center Nurse Staffing Plan	
Department: Outpatient Wound Center	
Effective Date: October 2023	
Staffing Committee Representatives: Bonnie Chase, RN / Martin Mitchell, RN	
Criteria-Description of Patient Population	The Wound Care Center (WCC) is a specialty outpatient clinic of the hospital. Patients treated in the wound clinic are treated on an outpatient basis for acute and chronic problem wounds. Treatment in the center is provided under the directions of the Wound Care Center (WCC) Providers. The age group served are primarily the adult and geriatric population but does include pediatric and adolescents. The Wound center has two locations, each clinic has 6 treatment rooms and 2 Hyperbaric Oxygen (HBO) chambers. Hours of operation are 0800-1630 Monday through Friday. Closed on major holidays. **Diagnoses commonly treated to the WCC include, but are not limited to:** • Diabetic foot ulcers, Venous leg ulcers, Arterial ulcers, Pressure ulcers, Neuropathic ulcers, Open surgical/dehisced wounds, Osteomyelitis, Delayed effects of radiation injuries, Burns, Trauma wounds, Lymphedema. **Primary Services Provided:** • Wound consultation/evaluation • Diagnostic and ongoing assessment / treatment of wounds and ulcers • Non-invasive vascular screening • Bio-engineered skin substitutes/grafts • Compression therapy • Wound cultures/biopsies • Wound debridement • Treatment of wound, skin, and bone infections including administration of topical antibiotic therapy • Negative pressure wound therapy (NPWT) • Total contact casting • Pressure off-loading devices • Patient and family education • HBO therapy

Average Daily Census (ADC) annual average	ADC: Hospital clinic OR028 – 18 W11th clinic OR02Y – 16 Annual average: Hospital clinic OR028 – 4,825 W11th clinic OR02Y – 4,123
Average Length of Stay (LOS) annual average	Medial days to heal: Hospital clinic OR028- 21 days W11th clinic OR02Y- 22 days
Specialized qualifications and competencies (include requirements for travel nurses)	**RN/LPN:** BLS **Initial Competencies:** Wound assessment/measurement, wound etiologies, wound cleaning, Lower extremity assessment, arterial/brachial index (ABI), negative pressure wound therapy (NPWT), compression therapy, total contact cast (TCC). **Quarterly Competencies: HBO specific** 3 treatments, open chamber, close chamber, weekly check. **Annual Competencies:** Wound assessment/measurement, wound etiologies, wound cleaning, Lower extremity assessment, arterial/brachial index (ABI), negative pressure wound therapy (NPWT), compression therapy, total contact cast (TCC), HBO therapy (for those staff who have initial competency).

Skill Mix and level of competency required to meet the healthcare needs of patients	All nurses in the WCC are oriented and trained up hire to the unit to demonstrate competency in the direct care of the aggregate patient population served. This is documented in the individual nursing staff members orientation packet and kept on file.
Activity Measure including rate of admissions, discharges, transfers, and time required for nurse to complete tasks:	Patients are scheduled in time blocks based upon the average time for each type of visit (new patient, follow up, nurse visit, HBO therapy): New patient – 60 min Follow up – 45 min Nurse visit – 30 min HBO therapy – 2 hrs Assessment of patient needs not only takes into consideration the above types of visits, but also any extra level of care required. The schedule can be adjusted accordingly to allow sufficient time for those patients. Patient conditions that contribute to a higher level of acuity in the WCC include, but are not limited to: Transfer assistance Comorbidities Isolation precautions Dementia Complexity of wound care Number of wounds
Nationally Recognized Standards or Guidelines	Joint Commission Standards and National Patient Safety Goals
How will patient acuity and nursing intensity be accounted for in assignments? Include how often the acuity and intensity will be reviewed (hourly, beginning of shift etc.) What is the process of changing the overall acuity and intensity of the unit and who is allowed to make that change?	A scheduling matrix will determine the total number of patients to be seen for the day related to staff scheduled: 2 Nurses = 15 patients/day 3 Nurses = 22 patients/day 4 Nurses = 26 patients/day 5 Nurses = 29 patients/day

	Acuity is built into the scheduling matrix: 2 Nurses - 0 complex/new patients 3 Nurses - 5 complex/new patients 4 Nurses - 6 complex/new patients 5 Nurses - 6 complex/new patients UPC has ability to increase/approve higher matrix as needed due to cancellation rate. As diagnosis does not determine patient acuity in this setting, the Clinical Nurse Manager (CNM), Program Director (PD), and charge nurse will collaborate to determine the appropriate number of staff for oncoming shift and throughout the shift to ensure the amount of staff and appropriate skill mix are available to ensure safe patient care.
What is the MINIMUM number of RNs, LPN and CNAs on specified shifts	Minimum staffing in the wound center at any time a patient is in treatment is at least one RN and one other nursing staff member.
Describe process for limiting admissions/diversions to another hospital etc.	Staff have the ability to request patient diversion/rescheduling at the start of each shift based on call ins and appropriate staff. If appropriate, patients will be rescheduled.
Describe non-direct care tasks including meals and breaks	<u>Rest and Meal Breaks</u> Rest/meal breaks will follow the professional agreement between MWMC and the ONA. Rest/meal break times are posted on the scheduling template. <u>Non-Direct Care</u> Prepare exam rooms for each day and between patients Set up cleaning cart beginning every day Clean exam rooms between patients Communication with home health, care facilities, etc. Order supplies for care at home Restock exam rooms at the end of each day Stock delivered supplies,linen,medication in storage closet (w11th)

Describe how the unit utilizes replacement staff for sick calls, changes in census, etc.?	Staff may be reassigned clinical sites due to specific needs for appropriate staff. The Clinical Nurse Manager (CNM) may fill in at the hospital location. Utilize resource staff if available. If appropriate, patients will be rescheduled. Low census call off guidelines will be followed but may deviate in consideration of the differences in RN and LPN standard/scope of practice qualifications only when necessary to maintain qualified staff for patient care: -Volunteers – if more than one volunteer, the nurse with the highest percentage will be called off first. -Resource nurses by seniority. -Nurses with the highest percentage ratio. Low census/call offs will be determined by scheduled staff vs scheduled patients for the am/pm blocks. Will call off 1 NSM if scheduled patients is at, or below determined ratio for morning and/or afternoon: 3 Nurses – 6 patients 4 Nurses – 9 patients 5 Nurses – 11 patients
How will the unit and the staffing committee representatives present an annual review of the staffing plan and what elements will it address? • Patient Outcome Data • Complaints regarding staffing (SRDF) • Hours per patient day (HPPD) • Number of mandatory overtime hours worked by nursing staff • Number of voluntary hours worked by nursing staff • Percentage of shifts for which staffing differed from the nurse staffing plan	UPC will review the staffing plan annually in September, and Staffing Committee will review annually in October. Elements to address: Missed meals and breaks Employee survey results Overtime hours Productivity Staff turnover QMs: healing rate, median days to heal, outliers, patient satisfaction

• Did the nurse staffing committee ask for additional information	
ATTACH UNIT STAFFING GUIDES	