PUBLIC HEALTH DIVISION, Center for Health Protection
Health Care Regulation and Quality Improvement Section
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Nurse Staffing Plan

Facility: Providence Portland Medical Center
Received Date: May 30, 2024
Posting Date: May 31, 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

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	2G
Date submitted to Nurse Staffing Committee:	May 2, 2024
Unit-nurse manager signature:	Emily Gray
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	May 30, 2024
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)
CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit
☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.
YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☒ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.

☐ Emergency department patients who are in critical condition, until they are stable.

- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	2R Respiratory Cardiology
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Megan Champagne
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☒ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	5K Cards
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Elnora Grant DNP Elnora Grant
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☒ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	3K Labor and Delivery	Critical
Date submitted to Nurse Staffing Committee:	4/22/24	5/30/24
Unit-nurse manager signature:		
Unit-based counsel, direct nurse co-chair signature:		
Date reviewed by Nurse Staffing Committee:	May 30, 2024	
Date approved by Nurse Staffing Committee:		
Effective date of Nurse Staffing Plan:	5/31/24	5/31/20

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

☐ Emergency Department*:
- Trauma (until stabilized) 1:1
- The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.

☒ Labor and Delivery:
- Active labor or complications 1:1
- No active labor or complications 1:2

☐ Postpartum, antepartum, and well-baby nursery 1:6

☐ Mother-baby unit 1:8

☐ Intensive Care Unit* 1:2

☐ Oncology unit 1:4

☐ Operating room 1:1

☐ Post-anesthesia care unit 1:2

☐ Medical-surgical unit 1:5

☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.

☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.

☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
- If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	3R Perinatal Special Care Unit
Date submitted to Nurse Staffing Committee:	4/22/24
Unit-nurse manager signature:	
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☒ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	4G Surgical
Date submitted to Nurse Staffing Committee:	5/9/2024.
Unit-nurse manager signature:	Nicki Bailey (Nicki Bailey)
Unit-based counsel, direct nurse co-chair signature:	(Amanda Mack)
Date reviewed by Nurse Staffing Committee:	
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☒ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids:

N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids:

N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

N/A

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

American Nurses Association Nursing: Scope and Standards of Practice 2021
Nursing : Scope and Standards of Practice, 4th Edition: Discovery Service for Providence Library Services (ebscohost.com)

Academy of Medical-Surgical Nurses. (2016). Staffing standards for patient care. Academy of Medical-Surgical Nurses. Available from https://www.amsn.org/about-amsn/amsn-positions-issues-nursing/staffing-standards-patient-care

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	4L
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Ralph Pasana
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.* Unit plan will require NSC approval.**

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Intermediate Care Unit 1:3
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☒ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids:

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids:

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ **Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.**
- ☐ **Emergency department patients who are in critical condition, until they are stable.**
- ☐ **Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services**
- ☐ **Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.**
- ☐ **Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.**
- ☐ **Patients in outpatient units that operate under the hospital's license.**
- ☐ **Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)**

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks:

- American Nurses Association. Nursing: Scope and Standards of Practice, 4th Edition. Vol 4th edition. American Nurses Association; 2021. Accessed March 13, 2023. https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=nlebk&AN=2935865&authtype=sso&custid=ns247570&site=eds-live&scope=site

- Academy of Medical-Surgical Nurses. Staffing standards for patient care; 2020. Academy of Medical-Surgical Nurses. Accessed March 13, 2023. https://www.amsn.org/sites/default/files/documents/amsn-statement-staffing-standards-for-patient-care.pdf

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	4R Clinical Decision Unit
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Emily Meschke Emily Meschke 4R Nurse Manager
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, r egardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☒ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	5K Cards
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Elnora Grant DNP Elnora Grant
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☒ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	5G Diabetes Renal Unit
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	[signature]
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	April 23, 2024
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan*. Unit plan will require NSC approval.**

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Intermediate Care Unit 1:3
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☒ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C). Requires NSC approval.**

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)
Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio. **Describe unit's innovative care model here, including relevant staffing grids:**

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)
Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio. **Describe unit's units Type A/B hospital variation here, including relevant staffing grids:**

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ **Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.**
- ☐ **Emergency department patients who are in critical condition, until they are stable.**
- ☐ **Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services**
- ☐ **Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.**
- ☐ **Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.**
- ☐ **Patients in outpatient units that operate under the hospital's license.**
- ☐ **Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)**

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks:

American Nurses Association Nursing: Scope and Standards of Practice 2021

Nursing : Scope and Standards of Practice, 4th Edition: Discovery Service for Providence Library Services (ebscohost.com)

Academy of Medical-Surgical Nurses. (2016). Staffing standards for patient care. Academy of Medical-Surgical Nurses. Available from https://www.amsn.org/about-amsn/amsn-positions-issues-nursing/staffing-standards-patient-care

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	5R
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Stephanie Snyder, BSN, RN
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☒ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids:

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids:

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

American Nurses Association. (2015) Nursing: Scope and standards of practice: Vol. 3rd edition. American Nurses Association. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&db=nlebk&AN=1077002&site=eds-live&scope=site&authtype=shib&custid=ns247570

Academy of Medical-Surgical Nurses. (2016). Staffing standards for patient care.

Academy of Medical-Surgical Nurses. Available from https://www.amsn.org/about-amsn/amsn-positions-issues-nursing/staffing-standards-patient-care

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	Medical Oncology (7 North)
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	[signature]
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☒ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)
Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio. Describe unit's innovative care model here, including relevant staffing grids:

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)
Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio. Describe unit's units Type A/B hospital variation here, including relevant staffing grids:

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.
This section of the NSP template requires Nurse Staffing Committee approval.
☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
☐ Emergency department patients who are in critical condition, until they are stable.
☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
☐ Patients in outpatient units that operate under the hospital's license.
☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)
Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:
Nationally recognized standards or benchmarks
Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	7S Surgical Oncology
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☒ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (If this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (If this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	8N Orthopedics
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Megan Fard
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

☐ Emergency Department*:
- Trauma (until stabilized) 1:1
- The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.

☐ Labor and Delivery:
- Active labor or complications 1:1
- No active labor or complications 1:2

☐ Postpartum, antepartum, and well-baby nursery 1:6

☐ Mother-baby unit 1:8

☐ Intensive Care Unit* 1:2

☐ Oncology unit 1:4

☐ Operating room 1:1

☐ Post-anesthesia care unit 1:2

☒ Medical-surgical unit 1:5

☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.

☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.

☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
- If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	8S Neuro
Date submitted to Nurse Staffing Committee:	4/22/24
Unit-nurse manager signature:	
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	May 30, 2024
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☒ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	Critical Care Services
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	Marie Pronovost CCS Manager
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, r egardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☒ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☒ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	Emergency
Date submitted to Nurse Staffing Committee:	
Unit-nurse manager signature:	Danielle Mendez
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section B)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan*. Unit plan will require NSC approval.**

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

☒ Emergency Department*:
- Trauma (until stabilized) 1:1
- The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.

☐ Labor and Delivery:
- Active labor or complications 1:1
- No active labor or complications 1:2

☐ Postpartum, antepartum, and well-baby nursery 1:6

☐ Mother-baby unit 1:8

☐ Intensive Care Unit* 1:2

☐ Oncology unit 1:4

☐ Operating room 1:1

☐ Post-anesthesia care unit 1:2

☐ Medical-surgical unit 1:5

☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.

☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.

☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
- If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C). Requires NSC approval.**

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids:

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids:

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☒ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

- The Emergency Nurses Association: Recommends ED Nurses become specialized as Certified Emergency Nurses (CEN Certificate)
- The Emergency Nurses Association: Recommends that although fluctuations occur in the ED census, the minimum RN staff in any ED should never be less than two RNs and one ED Provider.
- The Emergency Nurses Association: Triage RN staffing must be considered separately from RN staffing for patient care within the emergency department because comprehensive triage is performed by a dedicated triage nurse or nurses, prior to and separate from the patient assessment and treatment in the emergency department.

Emergency Nurses Association | Home (ena.org)

The ED currently utilizes a five-tiered triage system, Emergency Severity Index (ESi) originally developed in 1998 (see link to training handbook.) This is standard practice as part of the Emergency Nurses Association recommendations.

The Emergency Severity Index (ESI) - Emergency Nurses Association (ena.org)

- This sorts the initial acuity of patients by potential risk and also helps to predict the number of resources that will most likely be needed per patient If, in the charge nurse or staff nurse's judgment, at any time during the patient's visit, the acuity, intensity, specific competencies, or other conditions warrant, a change in nurse-to-patient ratio and/or ancillary support may be provided.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	Main OR Surgery
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (See Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☒ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	Mother Baby Unit (MBU)
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☒ Mother-baby unit 1:8
- ☐ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)
Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio. Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)
Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio. Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.
This section of the NSP template requires Nurse Staffing Committee approval. ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee. ☐ Emergency department patients who are in critical condition, until they are stable. ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record. ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record. ☐ Patients in outpatient units that operate under the hospital's license. ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)
Nurse staffing grid or multidisciplinary staffing grid for psychiatric units
Describe unit staffing guidelines here:
Nationally recognized standards or benchmarks
Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	PACU
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	E. Patterson
Unit-based counsel, direct nurse co-chair signature:	
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/2024

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

☐ Emergency Department*:
- Trauma (until stabilized) 1:1
- The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.

☐ Labor and Delivery:
- Active labor or complications 1:1
- No active labor or complications 1:2

☐ Postpartum, antepartum, and well-baby nursery 1:6

☐ Mother-baby unit 1:8

☐ Intensive Care Unit* 1:2

☐ Oncology unit 1:4

☐ Operating room 1:1

☒ Post-anesthesia care unit 1:2

☐ Medical-surgical unit 1:5

☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.

☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.

☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
- If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids: N/A

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids: N/A

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.
- ☐ Emergency department patients who are in critical condition, until they are stable.
- ☐ Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- ☐ Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- ☐ Patients in outpatient units that operate under the hospital's license.
- ☐ Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks.

Nurse Staffing Plan Template – Portland Providence Medical Center

NOTE: All section references in this template refer to Oregon Hospital Staffing Law HB 2697 (2023).

Unit name:	Neonatal Intensive Care Unit
Date submitted to Nurse Staffing Committee:	5/30/24
Unit-nurse manager signature:	[signature]
Unit-based counsel, direct nurse co-chair signature:	[signature] / RNC - designated charge RN
Date reviewed by Nurse Staffing Committee:	5/30/24
Date approved by Nurse Staffing Committee:	
Effective date of Nurse Staffing Plan:	5/31/24

Each unit nurse staffing plan must be reviewed by the Nurse Staffing Committee (NSC) at least once every year, and at any other date and time specified by either co-chair of the committee. The direct care registered nurse-to patient ratios listed below shall be based on a licensed independent practitioner's classification of the patient, as indicated in the patient's medical record, regardless of the unit where the patient is being cared for.

SECTION A. Certified nursing assistant (CNA) assignment

NOTE: This section applies to all staffing plans, no action required. (*See* Section 8)

CNA staffing may be based on functional 1:1 duties or a patient assignment. If a CNA is assigned patients, the cap is 7 patients on days/evening shifts or 11 patients on night shift.

SECTION B. Does your unit have legally required nurse-to-patient ratios?

NO, nurse-to-patient ratios do NOT apply to my unit

☐ **If this box is selected, must complete section E of this template titled, *No ratio required by Oregon law - staffing plan.*** Unit plan will require NSC approval.

YES, nurse-to-patient ratios apply to my unit

If the "Yes" box is selected, select your unit(s) from the list below and define the role of charge nurses. If your unit will pursue a variation from the ratio for innovative care models or Type A/B hospitals, please follow instructions for completing those sections of the staffing plan template as well.

- ☐ Emergency Department*:
  - Trauma (until stabilized) 1:1
  - The ratio of direct care registered nurses to patients averages no more than one to four over a 12-hour shift and a single direct care registered nurse may not be assigned more than five patients at one time.
- ☐ Labor and Delivery:
  - Active labor or complications 1:1
  - No active labor or complications 1:2
- ☐ Postpartum, antepartum, and well-baby nursery 1:6
- ☐ Mother-baby unit 1:8
- ☒ Intensive Care Unit* 1:2
- ☐ Oncology unit 1:4
- ☒ Intermediate Care Unit 1:3
- ☐ Operating room 1:1
- ☐ Post-anesthesia care unit 1:2
- ☐ Medical-surgical unit 1:5
- ☐ Cardiac telemetry unit 1:4

**The ED and ICU may need to complete section E of this staffing plan template.*

Define charge nurse role if applicable (units with nurse-to-patient ratio must select one)

- ☐ Unit has 10 or fewer beds - charge nurse will take patient assignments, including assignment for purpose of covering staff on meal or rest breaks.
- ☒ Unit has 11 or more beds - charge nurse will not take patient assignments and will not provide coverage for meal and rest breaks.
- ☐ Requires NSC approval: Unit has 11 or more beds - charge nurse will take patient assignments and/or take an assignment for purposes of covering staff on meal or rest breaks.
  - If charge nurse will take a patient assignment, but only under specific circumstances, describe here:

- ☐ **OPTIONAL: Innovative care model (if this box is selected, unit must complete section C).** Requires NSC approval.

N/A OPTIONAL: Type A and B hospital variance (if this box is selected, unit must complete section D). Requires NSC approval.

SECTION C. OPTIONAL: Innovative care model

Innovative care model (only complete this section if unit will utilize an innovative care model)

Requires NSC approval: Unit will utilize an innovative care model in conjunction with, or in replacement of, the legally required nurse-to-patient ratio. Law requires other clinical staff to constitute up to 50 percent of the nurses needed to comply with the applicable unit nurse-to-patient ratio.

Describe unit's innovative care model here, including relevant staffing grids:

SECTION D. OPTIONAL: Type A and B hospital variance

Type A and B hospital (only complete this section if unit will utilize the Type A and B hospital variance)

Requires NSC approval: Unit is in a Type A or B hospital and chosen to vary from the nurse-to-patient ratio.

Describe unit's units Type A/B hospital variation here, including relevant staffing grids:

SECTION E. No ratio required in unit by Oregon law

Select one of the following boxes that applies to your unit.

This section of the NSP template requires Nurse Staffing Committee approval.

- ☐ Patients in intensive care or critical units in circumstances prescribed by the hospital nurse staffing committee.

- [ ] Emergency department patients who are in critical condition, until they are stable.
- [ ] Patients in swing beds, as defined by the Centers for Medicare and Medicaid Services
- [ ] Patients, in inpatient units, who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- [ ] Patients, including patients in an emergency department, who are located in adjacent rooms or the same room in the hospital and who are ready for discharge but are facing a barrier to discharge, as indicated by a licensed independent practitioner in each patient's medical record.
- [ ] Patients in outpatient units that operate under the hospital's license.
- [ ] Patients in psychiatric units (For purposes of psychiatric unit staffing plans, the Multidisciplinary Psychiatric Unit Subcommittee acts as the Nurse Staffing Committee.)

Nurse staffing grid or multidisciplinary staffing grid for psychiatric units

Describe unit staffing guidelines here:

Nationally recognized standards or benchmarks

Describe or reference the nationally recognized nurse staffing standards or benchmarks:

This staffing plan is consistent with the evidence-based standards and guidelines established by the Guidelines for Perinatal Care, 8th edition, American Academy of Pediatrics (AAP), American College of Obstetrics and Gynecology (ACOG). 2017. https://publications.aap.org/aapbooks/book/522/Guidelines-for-Perinatal-Care

Nursing Unit Staffing Plan & Scope of Service
Unit Name: 4K Inpatient Rehab
Date of HNSC Review:
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

PROVIDENCE Portland Medical Center

(4K) Staffing Plan	
Scope of Service	4K Inpatient Rehab is an 18-bed, 24-hour/7-day Inpatient Rehabilitation Facility (IRF) providing a comprehensive, integrated, inpatient rehabilitation program. Admissions and most discharges are planned, and most occur Monday through Saturday, decreasing on the weekends. Under the direction of a Physiatrist, the unit provides physical and physiological care through intensive Physical, Occupational and Speech therapy, Rehabilitation Nursing, a Care Management Coordinator, psychological care, enabling patients to regain maximum self-sufficiency and reintegration into the community. The Inpatient Rehab unit works in collaboration with the PH&S Brain & Spine Institute, PPMC Administration, the Medical Director, PPMC Nursing, Rehabilitation Services, and care managers and social workers for internal and external referrals.
Specialized Qualifications, Competencies, and Skill Mix	• All registered nurses on 4K Inpatient rehab complete "Oregon Region Onboarding Portfolio Med Surg RN" packet prior to delivering direct patient care. All CNA1 and CNA2s on 4K complete "Oregon Region Onboarding Portfolio General Med Surg Orientation" packet prior to delivering direct patient care. Any additional competencies will be completed when applicable clinical scenarios present. Registered Charge Nurses will not assign registered nurses independent patient assignment until mandatory competencies are met. • RN: See Registered Nurse job description • CNA: see CNA1 and CNA2 job description ***Law**: Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure health and safety of patients are met.*

Acuity & Admission, Discharge, Transfers	• The average length of time to admit a patient is 60 minutes, discharge a patient is 60 minutes. 4K Inpatient Rehab does not complete transfers to or from the unit. • Average LOS for patients in this unit is 13.9 days • Average patients admitted for 4K is 1.76 patients/day • Average patients discharged for 4K is 1.83 patients/day • Average Daily Census at Midnight is 15.1 ***Law:*** *Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges* ***Process:*** *With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a brief description of how data was collected and taken into consideration when assignments are made.*

Total Diagnosis and Nursing Staffing Requirement (complete list)	• Patients are admitted to 4K Inpatient rehab with a variety of diagnoses, including: 057 - DEGENERATIVE NERVOUS SYSTEM DISORDERS WITHOUT MCC 945 - REHABILITATION WITH CC/MCC 052 - SPINAL DISORDERS AND INJURIES WITH CC/MCC 056 - DEGENERATIVE NERVOUS SYSTEM DISORDERS WITH MCC 949 - AFTERCARE WITH CC/MCC 559 - AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH MCC 560 - AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITH CC 091 - OTHER DISORDERS OF NERVOUS SYSTEM WITH MCC 552 - MEDICAL BACK PROBLEMS WITHOUT MCC 055 - NERVOUS SYSTEM NEOPLASMS WITHOUT MCC 948 - SIGNS AND SYMPTOMS WITHOUT MCC 054 - NERVOUS SYSTEM NEOPLASMS WITH MCC 071 - NONSPECIFIC CEREBROVASCULAR DISORDERS WITH CC 196 - INTERSTITIAL LUNG DISEASE WITH MCC 092 - OTHER DISORDERS OF NERVOUS SYSTEM WITH CC 561 - AFTERCARE, MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT CC/MCC 096 - BACTERIAL AND TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM WITHOUT CC/MCC 099 - NON-BACTERIAL INFECTION OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS WITHOUT CC/MCC STROKE 951 - OTHER FACTORS INFLUENCING HEALTH STATUS • 4K admissions are not limited to these disease entities; however, they are the most common. ***Law:*** *Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.*

National Standards	• This staffing plan is consistent with the evidence-based standards and guidelines established by the Association of Rehabilitation Nurses: Factors to Consider in Decisions About Staffing in Rehabilitation Nursing Settings: An ARN Position Statement. Revised 2017. (Insert QR Code) Staffing in Rehab Settings | ARN (rehabnurse.org) ***Reference:*** *Look for Nationally Recognized Standards that pertain to your area. Think about what certifications are applicable in your department and use that as the national standard. Make sure to sight your source properly.*
Acuity & Nursing Care Intensity	• Patient conditions that may contribute to a higher level of acuity and/or intensity on 4K Inpatient rehab include but are not limited to: See attached acuity tool ***Law:*** *Must recognize differences in acuity and nursing care intensity* *Process: Work with unit UBC validate and update acuity and intensity tool for your unit population.*
Minimum Staffing Guidelines	• When one patient is present on 4K Inpatient rehab there is 1 RN and 1 other nurse staff member. ***Law (Part 1)****: Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. See Appendix A* ***Law (Part 2)****: Minimum number of nursing staff required on specified shifts* *(Place Guideline (Grid) in Appendix B*

Process for Evaluating & Initiating Limitations on Admissions	Nurse Initiated Divert Request Policy:
	POLICY STATEMENT
	• A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment:
	  ☐ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources.
	  ☐ Situations where the skill mix, or the competency of the staff do not meet the nursing care needs of the patient.
	• The RN is to contact the unit Registered Charge Nurse, RN Manager, and/or House Supervisor to escalate their concerns for patient safety.
	• The registered charge nurse, RN manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to make a decision about:
	• Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility
	• Placing the hospital on EMS diversion status
	• If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission.
	• If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (i.e. cancelling elective surgeries
	
	https://phs-orppmc.policystat.com/policy/3171383/latest/
	
	Law: *Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital*

Considers non-direct care tasks including Meal and Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for 4K inpatient rehab • Registered Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks. •

Nursing Unit Staffing Plan & Scope of Service
Unit Name: 4K Inpatient Rehab
Date of HNSC Review:
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

Patient Outcomes	• CAUTI-1 • CLABSI-0 • HAPI- 0 • Patient experience 85% top box score • ***Key Point:*** *Data should be for 12-month span. Make sure to include comparative data with like areas (national goals).*
Unit of service	• HPPD = 8.63 **Law:** This may be HPPD, midnight census, number of cases, etc. **Key Point:** make sure to include comparative data with like areas

Attachments	• Appendix A: Staffing Guidelines • Appendix B: Minimum Staffing Guidelines for Lunches/Breaks • Appendix C: Acuity and Intensity Tool
Unit Staff Input & HNSC Approval Vetting Process Checklist	☐ Unit staffing committee (if unit has one): (date) NA ☐ Unit staff meeting: (date) no meetings ☐ Unit based council: (date) 3/21/23 ☐ Available on unit and huddle topic for 30 days, and sent electronically to staff: 3/29/23 • Names of staff who presented to HNSC: • Date recommended by unit/division to HNSC: • Signature of Manager: Jessica Knister • Signature of Unit Staffing Committee Representative:

Appendix A:

Nursing Unit Staffing Plan & Scope of Service
Unit Name: 4K Inpatient Rehab
Date of HNSC Review:
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

2023 Staffing Guidelines:
Unit: Inpatient Rehab

	DAY SHIFT				EVENING SHIFT				NOC SHIFT			
Census	Charge RN	RN	CNA2	Total # Staff	Charge RN	RN	CNA2	Total # Staff	Charge RN	RN	CNA2	Total # Staff
1	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
2	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
3	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
4	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
5	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
6	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
7	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
8	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
9	1.0	2.0	1.0	4.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
10	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	1.0	0.0	2.0
11	1.0	3.0	1.0	5.0	1.0	2.0	0.5	3.5	1.0	1.0	1.0	3.0
12	1.0	3.0	1.0	5.0	1.0	3.0	0.5	4.5	1.0	2.0	0.0	3.0
13	1.0	3.0	2.0	6.0	1.0	3.0	1.0	5.0	1.0	2.0	0.0	3.0
14	1.0	3.0	2.0	6.0	1.0	3.0	1.0	5.0	1.0	2.0	0.0	3.0
15	1.0	4.0	2.0	7.0	1.0	3.0	1.0	5.0	1.0	2.0	1.0	4.0
16	1.0	4.0	2.0	7.0	1.0	4.0	1.0	6.0	1.0	2.0	1.0	4.0
17	1.0	4.0	2.0	7.0	1.0	4.0	1.5	6.5	1.0	3.0	1.0	5.0
18	1.0	4.0	2.0	7.0	1.0	4.0	1.5	6.5	1.0	3.0	1.0	5.0

Appendix B

Nursing Unit Staffing Plan & Scope of Service
Unit Name: 4K Inpatient Rehab
Date of HNSC Review:
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

Minimum Staffing Guidelines:
Unit: Inpatient Rehab

	DAY SHIFT				EVENING SHIFT				NOC SHIFT			
Census	Charge RN	RN	CNA2	Total # Staff	Charge RN	RN	CNA2	Total # Staff	Charge RN	RN	CNA2	Total # Staff
1	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
2	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
3	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
4	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
5	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
6	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
7	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
8	1.0	1.0	1.0	3.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
9	1.0	2.0	0.0	3.0	1.0	1.0	1.0	3.0	1.0	1.0	0.0	2.0
10	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
11	1.0	2.0	1.0	4.0	1.0	2.0	0.0	3.0	1.0	1.0	1.0	3.0
12	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	1.0	1.0	3.0
13	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	2.0	0.0	3.0
14	1.0	3.0	1.0	5.0	1.0	3.0	0.0	4.0	1.0	2.0	0.0	3.0
15	1.0	3.0	1.0	5.0	1.0	3.0	0.0	4.0	1.0	2.0	0.0	3.0
16	1.0	3.0	1.0	5.0	1.0	3.0	1.0	5.0	1.0	2.0	0.0	4.0
17	1.0	3.0	1.0	5.0	1.0	3.0	1.0	5.0	1.0	2.0	1.0	4.0
18	1.0	4.0	1.0	6.0	1.0	4.0	0.0	5.0	1.0	2.0	1.0	4.0

Appendix C

PROVIDENCE Portland Medical Center

PPMC Inpatient Rehab Acuity Tool

Range: 1 (Min) 7-11 / 2 (Mod) 12-16 / 3 (Max) 17-22 / 4 (Max+) 23+	

Focus	1	2	3	4	Total
Medications	PO Meds 1-2 med passes in 12hr shift	3 Med passes in 12hr shift, One IVPB in 12hr shift	4+ med passes in 12hr shift, Blood products, IVPB (2+) in 12hrs, insulin, crushed meds in puree, mod swallowing and/or cognitive deficits. PRNs every 4+ hrs	5+ Med passes in 12hr shift, Meds via NG, severe swallowing and/or cognitive deficits, PRNS every 2-3hrs	
Skin Care	No wounds	Simple Daily wound care	BID wound care, Q2hr turn (without wounds)	2+ BID wound care, Q2hr turn (with wounds)	
Family/Education	Orientation/expectation for rehab stay. Pain management instruction	Education review: ie long-term diabetic or TF. Foley care, swallowing instruction, safety/fall instruction	Family instruction regarding DC education, goals added/changed, social needs/emotional support	In-depth education: ie new diabetic, TF, PO/IV medication administration, ostomy, wound, foley care, suctioning, O2	
Bowel/Bladder/ Toileting	Continent & independent w/ devices, adjusts own pants up/down, ind w/ hygiene	Continent, Min assist with hygiene/pants management, positions urinal, foley	Mostly continent, Max assist with hygiene, needs help positioning bedpan, ostomy	Incontinent, multiple accidents, straight caths, bowel program, timed toileting or frequent 1-2hr toileting	
Mobility/safety	Up ad lib, no assistance needed	Min assist, 1 person transfer	Mod assist low pivot, 2 person stedy, mildly impulsive	Hower/ceiling lift, max assist, very impulsive	
Eating/Nutrition	Feeds self, uses adpative equipment by self	Calorie count, strict I&Os, cutting food/tray set up, assistance with adapted utensils, oral exercises	High risk for aspiration, frequent checks, continuous TF	1:1 feed, bolus TF.	
Communication/ Social Cognition	No deficits, understands direction/conversation /commands	Requires prompting or longer cueing to express needs some of the time	Requires prompting or longer cueing to express needs most of the time, impulsive behavior, needs use of interpreter	Very impaired communication/highly aphasic, frequent calls (2+ per hr) aggressive behavior	

Acuity tool can be found and updated on "4K Sharepoint", "Documents", "Charge Nurse Information", "Huddle Updates & Cheatsheets"
If you make an updated draft please keep old one in this sleeve for our records

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Adult Behavioral Health 5L/6E Staffing Plan

Scope of Service	**Define the clinical setting:** Scope of Care- • The Adult Inpatient Psychiatric Behavioral Health Unit provides acute inpatient psychiatric care for adults 18 years of age and older. Psychiatric services include ongoing crisis intervention, psychosocial assessment, medication management, alcohol and opiate withdrawal protocols, management of chronic medical problems, mood stabilization, individualized treatment planning, coping skill development, and therapeutic groups and activities. • The department works collaboratively with community partners and families to engage the patient's outpatient circles of support and facilitate patient access to outpatient/community care services. Key partnership with the local Emergency Rooms, community providers, other hospital disciplines, and outpatient services support continuity of care best practice. A multi-disciplinary treatment team structure on the unit develops, monitors progress, and supports attainment of individualized patient treatment goals. The therapeutic environment models of care used are: • Trauma-Informed Care Model • Recovery Model Core Staffing Plan- • Staffing is based on our expected patient volume which comes from historical data looked at on a trend basis, by year, month, week, and day of week to include arrival time of day, expected length of stay, and acuity of patients. Staffing is also based on milieu intensity, which is specific to Behavioral Health. • The Adult Inpatient Psychiatric Behavioral Health Unit is in operation 24 hours a day 7 days a week. • Evaluation of the needs of the unit is ongoing to ensure the department staffing levels are met. • Discharges are determined by the Physician in collaboration with the multidisciplinary team members and are carried out by the assigned SW and direct care nurse. • All RNs must complete a department orientation based on their previous experience level in behavioral health nursing. All RNs are required to have BLS, CSSRS and PMAB, a grace period of 6 months is given for all except BLS. All RNs must be able to function

	in roles assigned. Specific roles in the department require additional training and competency prior to being assigned (Charge Nurse). • All CNA/MHA's are required to have a CNA 2 within 12 months of hire. All must be able to function in the roles assigned described in Scope of Care by scope of practice. • Discharges are determined by the Physician in collaboration with the treatment team and are carried out by the direct care nurse and CNA/MHA's. • The unit has 33 licensed beds divided into two floors (5L/6E). Staff are assigned to a specific patient assignment each shift. There are 5 licensed seclusion rooms. Milieu environment encourages patients to mobilize and participate in treatment program and interact with peers as able.
Specialized Qualifications, Competencies, and Skill Mix	• All registered nurses on Behavioral Health complete "Oregon Region Onboarding Portfolio Behavioral Health RN" packet prior to delivering direct patient care. All CNA1 and CNA2s on 5L/6E complete "Oregon Region Onboarding Portfolio General Certified Nursing Assistant 2 Orientation" packet prior to delivering direct patient care. Any additional competencies will be completed when applicable clinical scenarios present. Registered Charge Nurses will not assign registered nurses independent patient assignment until mandatory competencies are met. • RN: See Registered Nurse job description • CNA: see CNA1 and CNA2 job description ***Law**: Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure health and safety of patients are met.*

Acuity & Admission, Discharge, Transfers	• The average length of time to admit a patient is 180 minutes, discharge a patient is 90 minutes and transfer a patient N/A minute (BH patients discharge and admit only). • Average LOS for patients in this unit is 12.28 • Average patients admitted for 5L/6E is 2.24 patients/day • Average patients discharged for 5L/6E is 2.23 patients/day • Average Daily Census at Midnight: 28.1 The time required for the DCN RN to complete an admission and a discharge was determined through feedback from the staff nurses and reviewed at UBC. ***Law:*** *Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges* ***Process:*** *With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a brief description of how data was collected and taken into consideration when assignments are made.*
Total Diagnosis and Nursing Staffing Requirement (complete list)	• Patients are admitted to Behavioral Health with a variety of diagnoses, including: • Behavioral Health admissions are not limited to these disease entities; however, they are the most common. ***Law:*** *Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.*

National Standards	• This staffing plan is consistent with the evidence-based standards and guidelines established by the American Psychiatric Nurses Association including date of the standard. ***Reference:*** *American Psychiatric Nurses Association (2023). Retrieved from www.apna.org* *Psychiatric Mental Health Nursing: Scope and Standards of Practice*. 3rd ed. Silver Spring, MD: Nursesbooks.org; 2022.
Acuity & Nursing Care Intensity	Acuity refers to the level of nursing skill required.(Ex. medications, drains, tubes, IVs, wound care) Intensity refers to the level of patient need which makes giving nursing care more complicated.(Ex. Language barriers, cognitive barriers, change in condition) • Patient conditions that may contribute to a higher level of acuity and/or intensity on Behavioral Health include but are not limited to: See attached acuity tool • Acuity, including comorbidities with medical and psychiatric conditions- Uncontrolled diabetes, withdrawal, wound care, temporary IV fluids, high fall risks, ADL needs, nursing need for behavioral management, risk for violence, sexual risk, etc. • Intensity- milieu management: Psychosis with violent behaviors, sexually inappropriate behaviors, confusion, intrusiveness, high risk for violence, etc. • Milieu environment- patients encouraged to mobilize and participate in treatment program and interact with peers as able. An individual nurse's assignment that includes any of these higher acuity/intensity patients may be smaller in order to accommodate the increased work and monitoring required to provide safe and comprehensive care during the high acuity phases of the patient's care continuum. The nurse caring for these higher acuity/intensity patients is expected to coordinate with the Charge nurse in order to ensure communication of acuity changes (both when the patient improves or deteriorates in condition), complicated cares, and needs of the other patients in the nurse's group. BH uses the PPMC 5L Acuity Tool. See Appendix A. ***Law:*** *Must recognize differences in acuity and nursing care intensity* *Process: Work with unit UBC validate and update acuity and intensity tool for your unit population.*

Minimum Staffing Guidelines	• When one patient is present on Behavioral Health there is one RN and one other nurse staff member. (RN or CNA/MHA) ***Law (Part 1)**: Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. See Appendix A* ***Law (Part 2)**: Minimum number of nursing staff required on specified shifts (Place Guideline (Grid) in Appendix B*

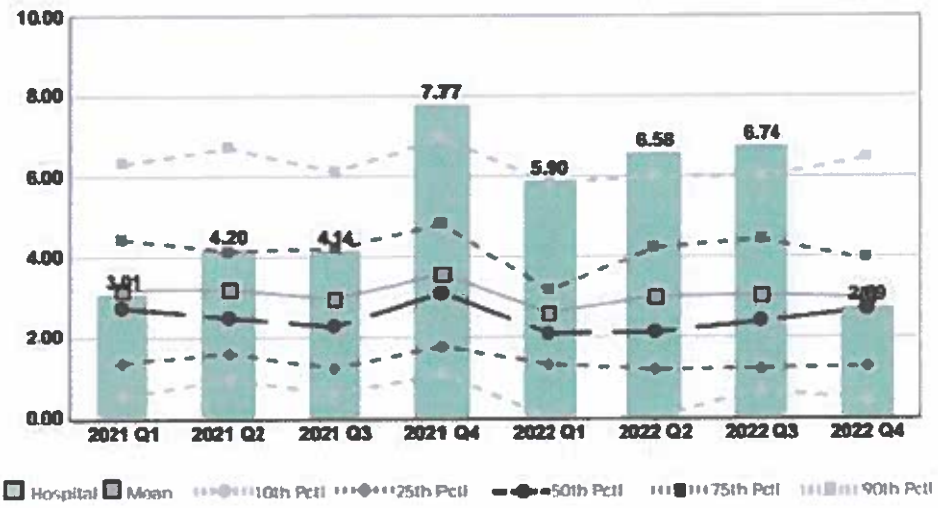
Process for Evaluating & Initiating Limitations on Admissions	Nurse Initiated Divert Request Policy:
	POLICY STATEMENT
	• A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment:
	  ☐ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources.
	  ☐ Situations where the skill mix, or the competency of the staff do not meet the nursing care needs of the patient.
	• The RN is to contact the unit Registered Charge Nurse, RN Manager, and/or House Supervisor to escalate their concerns for patient safety.
	• The registered charge nurse, RN manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to make a decision about:
	• Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility
	• Placing the hospital on EMS diversion status
	• If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission.
	• If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (i.e. cancelling elective surgeries
	
	https://phs-orppmc.policystat.com/policy/3171383/latest/
	
	***Law:** Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital*

Considers non-direct care tasks including Meal and Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for" • Registered Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks.

Patient Outcomes	Example: CAUTI, CLABSI, HAPI rates Behavioral Health Quality Outcomes for 2021 include: • Falls rate with and without injury • Restraint events • Seclusion events

Providence Portland Medical Center

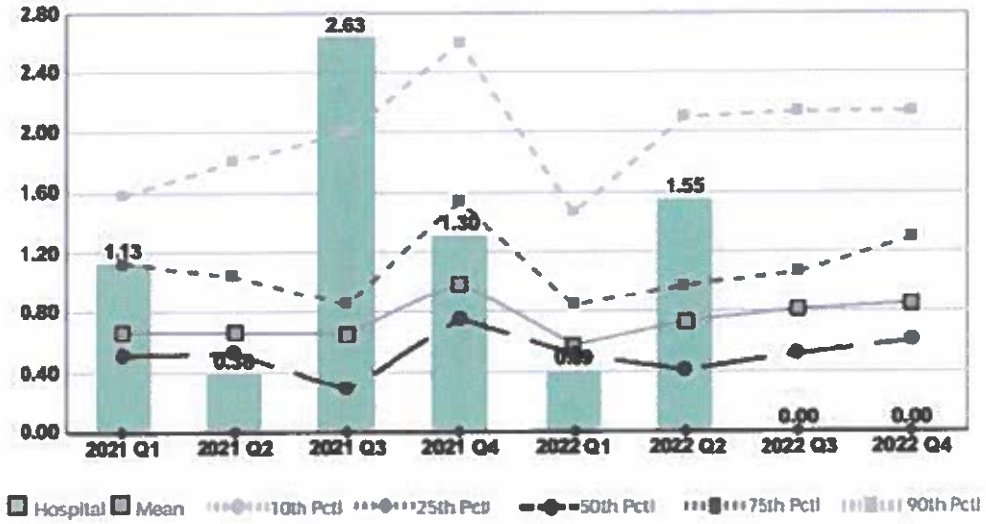
Compared by: Bed Size
Peer Group: Bed Size 300 - 399
Unit Type: Adult Psychiatric
Unit: Behavioral Health RN - 5L
Measure: Total Patient Falls Per 1,000 Patient Days



Quarter	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Average
Unit	3.01	4.20	4.14	7.77	5.90	6.58	6.74	2.69	**5.13**
Mean	3.16	3.18	2.94	3.53	2.60	2.98	3.02	2.97	**3.05**
Standard Deviation	2.54	2.53	2.35	2.41	2.27	3.36	2.66	2.21	**2.54**
10th Percentile	0.52	0.95	0.59	1.07	0.00	0.00	0.67	0.42	**0.53**
25th Percentile	1.36	1.58	1.21	1.73	1.31	1.17	1.19	1.24	**1.35**
50th Percentile (Median)	2.72	2.49	2.27	3.07	2.09	2.12	2.38	2.68	**2.48**
75th Percentile	4.43	4.15	4.21	4.78	3.12	4.21	4.42	3.92	**4.15**
90th Percentile	6.31	6.70	6.11	6.92	5.83	6.00	5.98	6.45	**6.29**
# Units	69	57	56	58	66	67	65	66	**63**

Providence Portland Medical Center

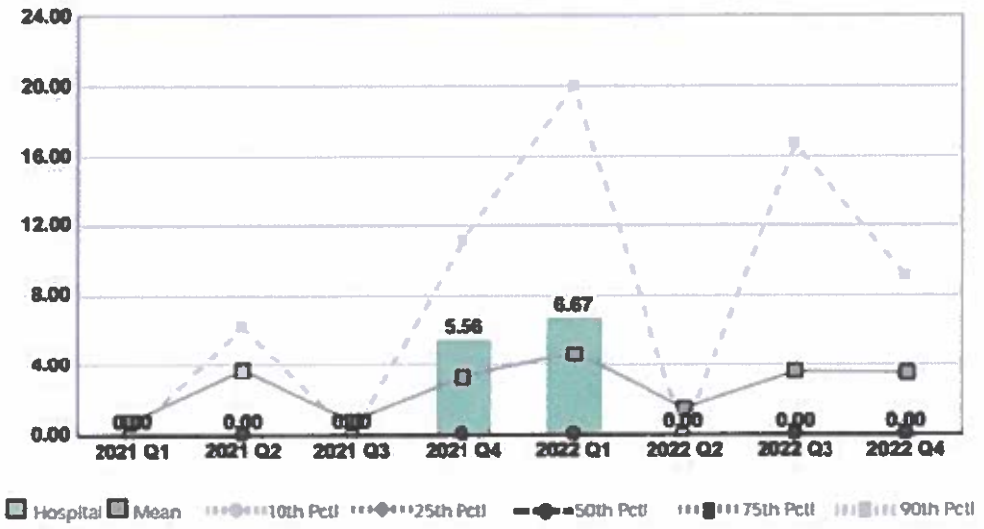
Compared by: Bed Size
Peer Group: Bed Size 300 - 399
Unit Type: Adult Psychiatric
Unit: Behavioral Health RN - 5L
Measure: Injury Falls Per 1,000 Patient Days



Quarter	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Average
Unit	1.13	0.38	2.63	1.30	0.39	1.55	0.00	0.00	**0.92**
Mean	0.66	0.66	0.66	1.00	0.57	0.73	0.81	0.85	**0.74**
Standard Deviation	0.79	0.72	0.97	1.00	0.65	1.11	1.04	1.24	**0.94**
10th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
25th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
50th Percentile (Median)	0.51	0.53	0.28	0.75	0.51	0.41	0.52	0.61	**0.52**
75th Percentile	1.13	1.04	0.85	1.54	0.84	0.98	1.07	1.29	**1.09**
90th Percentile	1.58	1.80	1.99	2.59	1.46	2.11	2.14	2.14	**1.98**
# Units	69	57	56	58	66	67	65	66	**63**

Providence Portland Medical Center

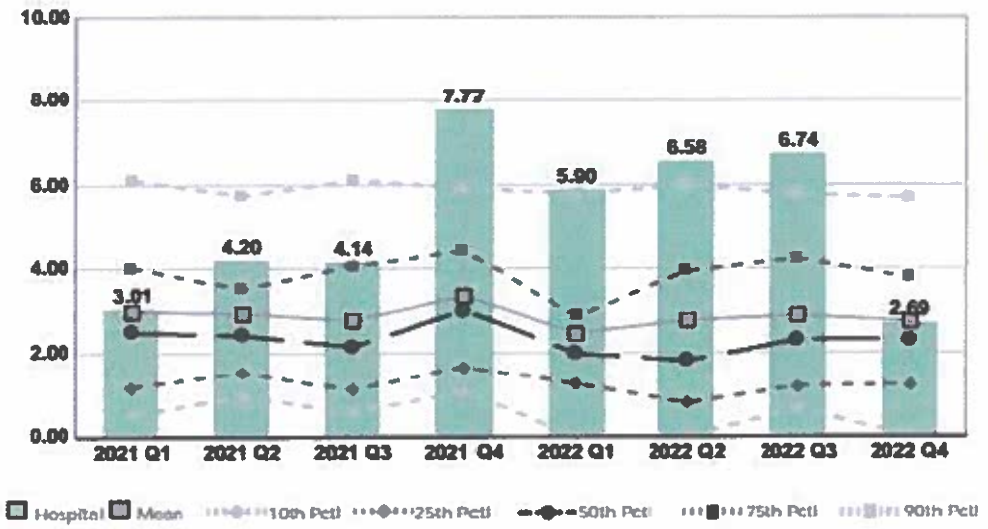
Compared by: Bed Size
Peer Group: Bed Size 300 - 399
Unit Type: Adult Psychiatric
Unit: Behavioral Health RN - 5L
Measure: Percent of Patient Falls that were of Moderate or Greater Injury Severity



Quarter	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Average
Unit	0.00	0.00	0.00	5.56	6.67	0.00	0.00	0.00	**1.53**
Mean	0.79	3.68	0.81	3.31	4.68	1.49	3.54	3.50	**2.73**
Standard Deviation	3.46	15.23	3.80	9.67	13.31	7.31	9.86	13.97	**9.58**
10th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
25th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
50th Percentile (Median)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
75th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
90th Percentile	0.00	6.25	0.00	11.11	20.00	0.00	16.67	9.09	**7.89**
# Units	64	56	56	58	59	58	62	60	**59**

Providence Portland Medical Center

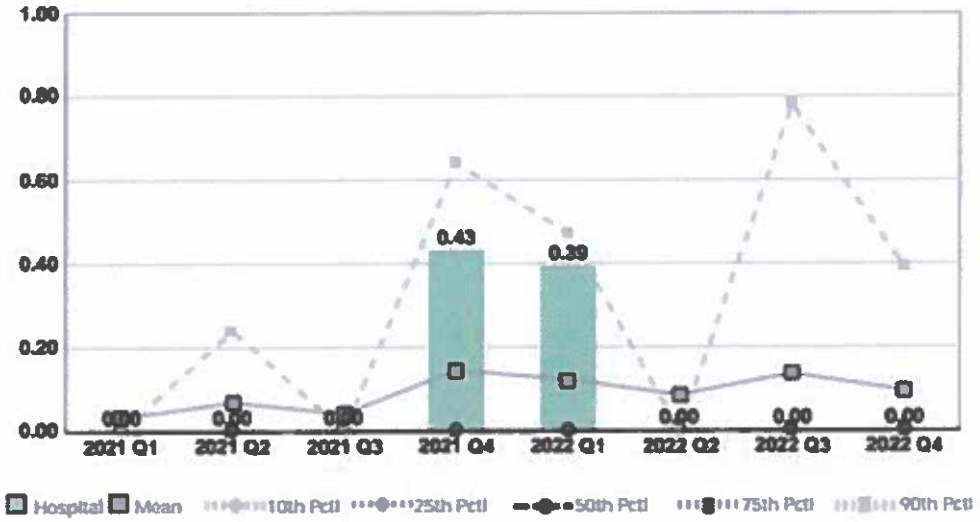
Compared by: Bed Size
Peer Group: Bed Size 300 - 399
Unit Type: Adult Psychiatric
Unit: Behavioral Health RN - 5L
Measure: Unassisted Patient Falls Per 1,000 Patient Days



Quarter	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Average
Unit	3.01	4.20	4.14	7.77	5.90	6.58	6.74	2.69	**5.13**
Mean	3.00	2.94	2.77	3.35	2.47	2.77	2.89	2.75	**2.87**
Standard Deviation	2.34	2.39	2.20	2.26	2.27	3.04	2.38	2.10	**2.37**
10th Percentile	0.52	0.95	0.59	1.07	0.00	0.00	0.67	0.00	**0.47**
25th Percentile	1.18	1.53	1.12	1.68	1.25	0.80	1.19	1.23	**1.25**
50th Percentile (Median)	2.50	2.42	2.16	3.01	1.99	1.81	2.31	2.32	**2.32**
75th Percentile	4.02	3.52	4.06	4.41	2.88	3.94	4.22	3.77	**3.85**
90th Percentile	6.11	5.75	6.11	5.93	5.78	6.00	5.77	5.71	**5.90**
# Units	69	57	56	58	66	67	65	66	**63**

Providence Portland Medical Center

Compared by: Bed Size
Peer Group: Bed Size 300 - 399
Unit Type: Adult Psychiatric
Unit: Behavioral Health RN - 5L
Measure: Injury Falls of Moderate or Greater Severity Per 1,000 Patient Days



Quarter	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	Average
Unit	0.00	0.00	0.00	0.43	0.39	0.00	0.00	0.00	**0.10**
Mean	0.03	0.07	0.04	0.14	0.12	0.09	0.14	0.10	**0.09**
Standard Deviation	0.13	0.23	0.18	0.37	0.36	0.56	0.36	0.36	**0.32**
10th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
25th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
50th Percentile (Median)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
75th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
90th Percentile	0.00	0.24	0.00	0.64	0.47	0.00	0.78	0.39	**0.32**
# Units	69	57	56	58	66	67	65	66	**63**

- ***Key Point:*** *Data should be for 12-month span. Make sure to include comparative data with like areas (national goals).*

Unit of service	• Units of service are hours per patient day = • HPPD = 10.42 (previous 9.87) • This includes fixed hours to staff the telemetry monitoring suite. **Law:** This may be HPPD, midnight census, number of cases, etc. **Key Point:** make sure to include comparative data with like areas

PROVIDENCE Portland Medical Center

Attachments

- Appendix A: Staffing Guidelines

	DAY SHIFT (0700)					NOC SHIFT (1900)					NOC SHIFT (2300)						
Census	Charge RN	RN	CNA/MHA	MHP	Total # Staff	Charge RN	RN	CNA/MHA	MHP	Total # Staff	Charge RN	RN	CNA/MHA	MHP	Total # Staff	Ratio Pt:RN (Day)	Ratio Pt:RN (NOC)
1	1.0	1.0	0.0	0.7	2.7	1.0	1.0	0.0	0.0	2.0	1.0	2.0	0.0	0.0	3.0	1.00	0.50
2	1.0	1.0	0.0	0.7	2.7	1.0	1.0	0.0	0.0	2.0	1.0	2.0	0.0	0.0	3.0	2.00	1.00
3	1.0	1.0	0.0	0.7	2.7	1.0	1.0	0.0	0.0	2.0	1.0	2.0	0.0	0.0	3.0	3.00	1.50
4	1.0	1.0	0.0	0.7	2.7	1.0	1.0	0.0	0.0	2.0	1.0	2.0	0.0	0.0	3.0	4.00	2.00
5	1.0	1.0	0.0	0.7	2.7	1.0	1.0	0.0	0.0	2.0	1.0	2.0	0.0	0.0	3.0	5.00	2.50
6	1.0	2.0	0.0	0.7	3.7	1.0	2.0	0.0	0.0	3.0	1.0	2.0	0.0	0.0	3.0	3.00	3.00
7	1.0	2.0	0.0	0.7	3.7	1.0	2.0	0.0	0.0	3.0	1.0	2.0	0.0	0.0	3.0	3.50	3.50
8	1.0	2.0	0.0	0.7	3.7	1.0	2.0	0.0	0.0	3.0	1.0	2.0	0.0	0.0	3.0	4.00	4.00
9	1.0	2.0	0.0	0.7	3.7	1.0	2.0	0.0	0.0	3.0	1.0	2.0	0.0	0.0	3.0	4.50	4.50
10	1.0	3.0	0.0	0.7	4.7	1.0	3.0	0.0	0.0	4.0	1.0	2.0	0.0	0.0	3.0	3.33	5.00
11	1.0	3.0	0.0	1.4	5.4	1.0	3.0	0.0	0.7	4.7	1.0	3.0	0.0	0.7	4.7	3.67	3.67
12	1.0	3.0	0.0	1.4	5.4	1.0	3.0	0.0	0.7	4.7	1.0	3.0	0.0	0.7	4.7	4.00	4.00
13	1.0	3.0	1.0	1.4	6.4	1.0	3.0	1.0	0.7	5.7	1.0	3.0	1.0	0.7	5.7	4.33	4.33
14	1.0	3.0	1.0	1.4	6.4	1.0	3.0	1.0	0.7	5.7	1.0	3.0	1.0	0.7	5.7	4.67	4.67
15	1.0	4.0	1.0	1.4	7.4	1.0	4.0	1.0	0.7	6.7	1.0	3.0	1.0	0.7	5.7	3.75	5.00
16	1.0	4.0	1.0	1.4	7.4	1.0	4.0	1.0	0.7	6.7	1.0	3.0	1.0	0.7	5.7	4.00	5.33
17	1.0	4.0	1.0	1.4	7.4	1.0	4.0	1.0	0.7	6.7	1.0	4.0	1.0	0.7	6.7	4.25	4.25
18	1.0	4.0	1.0	1.4	7.4	1.0	4.0	1.0	0.7	6.7	1.0	4.0	1.0	0.7	6.7	4.50	4.50
19	1.0	4.0	1.0	1.4	7.4	1.0	4.0	1.0	0.7	6.7	1.0	4.0	2.0	0.7	7.7	4.75	4.75
20	1.0	4.0	2.0	1.4	8.4	1.0	4.0	2.0	0.7	7.7	1.0	4.0	2.0	0.7	7.7	5.00	5.00
21	1.0	5.0	2.0	1.4	9.4	1.0	5.0	2.0	0.7	8.7	1.0	4.0	2.0	0.7	7.7	4.20	5.25
22	1.0	5.0	2.0	1.4	9.4	1.0	5.0	2.0	0.7	8.7	1.0	4.0	2.0	0.7	7.7	4.40	5.50
23	1.0	5.0	2.0	1.4	9.4	1.0	5.0	2.0	0.7	8.7	1.0	4.0	2.0	0.7	7.7	4.60	5.75
24	1.0	6.0	2.0	1.4	10.4	1.0	6.0	2.0	0.7	9.7	1.0	4.0	2.0	0.7	7.7	4.00	6.00
25	1.0	6.0	2.0	1.4	10.4	1.0	6.0	2.0	0.7	9.7	1.0	5.0	2.0	0.7	8.7	4.17	5.00
26	1.0	6.0	2.0	1.4	10.4	1.0	6.0	2.0	0.7	9.7	1.0	5.0	2.0	0.7	8.7	4.33	5.20
27	1.0	6.0	2.0	1.4	10.4	1.0	6.0	2.0	0.7	9.7	1.0	5.0	2.0	0.7	8.7	4.50	5.40
28	1.0	6.0	3.0	1.4	11.4	1.0	6.0	3.0	0.7	10.7	1.0	5.0	3.0	0.7	9.7	4.67	5.60
29	1.0	7.0	3.0	1.4	12.4	1.0	7.0	3.0	0.7	11.7	1.0	5.0	3.0	0.7	9.7	4.14	5.80
30	1.0	7.0	3.0	1.4	12.4	1.0	7.0	3.0	0.7	11.7	1.0	5.0	3.0	0.7	9.7	4.29	6.00
31	1.0	7.0	3.0	1.4	12.4	1.0	7.0	3.0	0.7	11.7	1.0	5.0	3.0	0.7	9.7	4.43	6.20
32	1.0	7.0	3.0	1.4	12.4	1.0	7.0	3.0	0.7	11.7	1.0	5.0	3.0	0.7	9.7	4.57	6.40
33	1.0	7.0	3.0	1.4	12.4	1.0	7.0	3.0	0.7	11.7	1.0	5.0	3.0	0.7	9.7	4.71	6.60

- Appendix B: Minimum Staffing Guidelines with Lunches/Break Relief

	DAY SHIFT				EVENING SHIFT				NOC SHIFT			
Census	Charge RN	RN	CNA/MHA	Total # Staff	Charge RN	RN	CNA/MHA	Total # Staff	Charge RN	RN	CNA/MHA	Total # Staff
1	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
2	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
3	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
4	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
5	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
6	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
7	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0	1.0	1.0	0.0	2.0
8	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
9	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
10	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
11	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
12	1.0	2.0	0.0	3.0	1.0	2.0	0.0	3.0	1.0	1.0	0.0	2.0
13	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	1.0	1.0	3.0
14	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	1.0	1.0	3.0
15	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0
16	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0
17	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0
18	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0
19	1.0	2.0	1.0	4.0	1.0	2.0	1.0	4.0	1.0	2.0	2.0	5.0
20	1.0	2.0	2.0	5.0	1.0	2.0	2.0	5.0	1.0	2.0	2.0	5.0
21	1.0	2.0	2.0	5.0	1.0	2.0	2.0	5.0	1.0	2.0	2.0	5.0
22	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
23	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
24	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
25	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
26	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
27	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
28	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0	1.0	3.0	2.0	6.0
29	1.0	4.0	2.0	7.0	1.0	4.0	2.0	7.0	1.0	3.0	2.0	6.0
30	1.0	4.0	2.0	7.0	1.0	4.0	2.0	7.0	1.0	3.0	2.0	6.0
31	1.0	4.0	2.0	7.0	1.0	4.0	2.0	7.0	1.0	3.0	2.0	6.0
32	1.0	4.0	2.0	7.0	1.0	4.0	2.0	7.0	1.0	3.0	2.0	6.0
33	1.0	4.0	2.0	7.0	1.0	4.0	2.0	7.0	1.0	3.0	2.0	6.0

- Appendix C: Acuity and Intensity Tool

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PPMC 5L Acuity Tool

Nursing	Psychiatric
LEVEL 1 ☐Routine V.S. ☐Independent and/or age appropriate with ADLs ☐Independent ambulation ☐No/low fall risk ☐Routine nursing care ☐No scheduled POC testing (CBGs) ☐Takes scheduled meds with 1-2 prompts and /or <2 prns/shift	**LEVEL 1** ☐Hourly safety checks ☐Follows unit guidelines ☐ Safe behavioral control ☐A & O x 3 ☐Low/mod suicide/violence risk ☐Participates in treatment and/or group activity ☐No D/C within 24 hrs ☐No disruption to milieu
LEVEL 2 ☐V.S. > BID ☐Requires more than age appropriate prompts for ADLs ☐ Managed fall risk (Independent ambulation or independent with assistive device with minimal cueing) ☐ Medically stable but needing greater than routine nursing care (e.g. CBGs, simple wound care) ☐Off unit procedures ≤ 30" (within the next 8 hrs) ☐Mild CIWA/COWS ☐Scheduled meds with 1-2 prompts and/or 2-3 prns/shift	**LEVEL 2** ☐Hourly safety checks ☐Follows unit guidelines with minimal redirection ☐Participates in treatment with minimal assistance or cueing ☐Mod suicide/violence risk (no safety/behavioral issues on the unit) ☐Uncomplicated D/C within 8 hrs ☐Psychiatric impairment requiring minimal intervention ☐Pt and family/visitors minimally disruptive to milieu
LEVEL 3 ☐ V.S. ≥ TID and/or ortho V.S. ☐ADLs requiring regular staff assistance ☐ Unmanaged Fall risk/ mobility impairment requiring staff intervention ☐Off unit procedures > 30" (within the next 8 hrs) ☐Non-emergent but complex medical condition (e.g. moderate wound care, eating disorder management) ☐Mod-High CIWA or sliding scale insulin or staff monitored I & O ☐Moderately increased nursing care and charting ☐Pending routine admission (anticipated to take 2-2.5 hrs) ☐Scheduled meds > 4x's/day and > 3 prns/shift ☐Non-compliant with meds resulting in potential for increased intervention	**LEVEL 3** ☐Hourly safety checks/ Q 15" safety checks ☐Unable/unwilling to engage in treatment plan and /or unit activity ☐Interferes in the treatment of others ☐Mod-high suicide/violence risk (with safety/behavioral issues on the unit) ☐Psych impairment requiring frequent redirection, pt minimally cooperative ☐Potential for self-harm and/or suicidal and/or violent behaviors ☐Complicated or AMA D/C within 24 hrs ☐Pt and/or family visitors disruptive to milieu ☐Requires decreased stimulation with frequent interaction ☐ Pre-code/code grey >1 a shift
LEVEL 4 ☐V.S.≥ q 4 hrs and/or V.S. unstable requiring intervention ☐ADLs requiring total care: feeding, toileting ect ☐Bed-bound ☐ Unmanaged falls risk/ mobility impairment requires staff intervention/assistance ☐Unexpected off unit procedures > 30" ☐Complex nursing care > 1 hr/shift (for complex medical needs) ☐ Brittle diabetic managed by sliding scale and scheduled insulin ☐Complex admission (anticipated to take ≥ 3 hrs) ☐Scheduled meds > 4 x's/day and > 3 prns/shift. ☐Daily IMs	**LEVEL 4** ☐ Hourly safety checks/ Q 15" safety checks with redirection required ☐Actively resisting treatment (no attendance in unit activity) ☐High suicide/violence risk (with active safety/behavioral issues on the unit) ☐Psych impairment requiring frequent redirection with intervention of > 1 staff person ☐Active Suicidal or violent behaviors ☐Disruptive to milieu requiring separation from milieu > 1 x /shift ☐Pre-code/code grey >3 day ☐Family/visitors requiring frequent or time-intensive staff support or intervention

INSTRUCTIONS FOR UTILIZING THE ACUITY TOOL

R.N.s will complete a rating for each pt under her/his care by 4 hrs from the commencement of the shift (1100, 1900, 0300). Obtaining input from your interdisciplinary colleagues is an expectation.

Pending admissions will receive a Level 3 or Level 4 (see descriptors) at the time report is taken by that R.N. This is a matter of nursing judgment and is meant to help us account for the amount of nursing time an admission requires—not the level the patient may transition to once admitted. Communicate the anticipated level to your charge nurse.
Ratings will be written on the nursing board and assignment sheet. The charge nurse will collect these values and utilize them to balance assignments for the following shift. We will not be utilizing the acuity tool to increase unit staffing at this time. However, it may be used for that purpose in the future. Additionally, we hope to be able to track long-term changes in the overall unit acuity.

Descriptions of levels are not exhaustive. They are meant to be viewed as a generalization or composite of the pt's presentation. We want this to be an easy-to-use tool.
In looking at "nursing" and "psychiatric"—if a pt is a lower level on one aspect but higher on another, round up to the higher level. The pt receives one value: 1, 2, 3, or 4.
If a pt is a Level 1, for instance, in all descriptors but one, please be reasonable and make the pt a Level 1. There is no advantage to skewing everyone's scores higher.
If a pt appears to be squarely in the middle of two levels, round up.
Noc shift—at 0300, pts admitted after 1900 on the Eve shift will need a fresh evaluation of their ratings. Their previous ratings were reflective of the admission process. For the most part, other pts may maintain levels from Eve shift unless there is an acute change on your shift such as a pt that is awake all noc and is now exhibiting behavior management issues or is developing a medical problem. A pt not sleeping does not require nursing time. Interventions require nursing time.

1:1s—there is not a specific level for pts on 1:1 staffing. This is because we sometimes put a pt on Constant Obs for our institutional convenience or for liability protection/safety (e.g. A pt might be a Level 2 but, due to a hx of sexual predation, we place her/him on a 1:1). In another example, a pt may be on a 1:1 but still requiring a great deal of nursing care time or a pt may require many staff to intervene for behavioral outbursts nearly every shift. This type of pt could be on a 1:1 and be a level 4. Our hope is that this more flexible system will help us track improvements in our 1:1 pts as they move down in acuity.

Unit Staff Input & HNSC Approval Vetting Process Checklist	☐ Unit staffing committee (if unit has one): (date) ☒ Unit staff meeting: April 11th, 2023 ☒ Unit based council: April 27th, 2023 ☒ Available on unit and huddle topic for 30 days, and sent electronically to staff: • Names of staff who presented to HNSC: Nadan Filipovic (ANM) and Brenda Friend (RN) • Date recommended by unit/division to HNSC: 8/28/23 • Signature of Manager: Sarah Tarter (NM) • Signature of Unit Staffing Committee Representative: Brenda Friend (RN)

Nursing Unit Staffing Plan & Scope of Service
Unit Name: CVL
Date of HNSC Review: 5/10/23
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

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SCOPE OF SERVICE

Define the clinical setting:

- Type of patients: patient, ages, hours of operation/days of week
- Describe complexity, unit orientation and skills/competencies
- Describe services provided or common patient conditions served (i.e., ventilators)
- Describe any services not provided
- Speak to unit admission and discharge criteria
- Number of beds and physical geography
- Define special rooms: shared/flex/overflow, negative pressure rooms, reverse pressure rooms, bariatric rooms with and without lifts, special equipment, procedural rooms and what's performed, special security needs etc.

PROVIDENCE Portland Medical Center

SCOPE OF SERVICE

Providence Portland Medical Center CVL Nursing Staffing Plan		
Date of Review: 5/10/23		Legal Requirement
Scope of service	The CVL provides diagnostic and Interventional Cardiovascular, Radiology, and Vascular Services. We also provide device (pacer, ICD) implantation and removal. We are a procedural area that supports procedures on inpatients and outpatients Our hours of operation are from 730am till 6pm, M-F, with off hours covered by on-call staff	
Specialized qualifications and competencies	All nurses in the Cardiovascular Lab (CVL) complete "Oregon Region Onboarding Portfolio CVL RN" packet prior to delivering direct patient care. Any additional competencies are completed when applicable clinical scenarios present. Charge Nurses will not assign nurses independent patient assignment until mandatory competencies are met. **RN:** See Registered Nurse job description	
Hospital unit activity	CVL Outpatients are admitted and discharged in the Interventional recovery Unit (IRU). Inpatients are discharged post procedure from the inpatient units. Patients are not admitted or discharged from the CVL.	
Total diagnoses and nursing	Patients are admitted to the CVL with a variety of diagnoses, including: Circulatory system disorders, Coronary artery disease, ischemic heart	

staffing requirement	disease, acute myocardial infarction, congenital cardiac disorders, hepato-biliary-pancreatic malignancy, neurologic disorders, acute ischemic stroke, acute respiratory failure, peripheral vascular disease and acute limb ischemia. CVL admissions are not limited to these disease entities; however, they are the most common. Updated with DRG	
National Standards	This staffing plan is consistent with the evidence-based standards and guidelines established by the American Nurses Association Nursing: Scope and Standards of Practice 2022. Unit staffing planning and assignments are consistent with Heart and Vascular Institute services, HR Job descriptions and labor agreements.	
Acuity and Nursing Care Intensity	Each CVL RN has only 1 patient assignment at a given time. If critical care patient and high complex acuity, the CC RN stays with the patient in addition to the CVL RN. If needed, the rapid response team also assists with care of unstable patient during the procedure. The CVL Charge RN is also available to assist with care during the procedure.	

	Ventilated patients have RT &/or Anesthesia in attendance during the procedure.	
Minimum Staffing Guidelines	• A maximum of 4 procedure rooms are scheduled each day. • Room availability is based on the staffing resources available and the necessity of having a minimum of 1 RN and 1 RT per procedure room. Cases are delayed or rescheduled if insufficient/appropriate staff available to safely care for the patient. • Each Procedure is assigned a team made up of 1 RN, 1RT, and 2 other technologists. • Based on patient acuity, the Charge RN or the Rapid response team can also assist with patient care during the procedure. • Based on patient acuity/complexity, anesthesia is consulted for MAC anesthesia or sedation. • The 2 RN minimum staffing is not applicable to this department during call hours due to a wavier from the Oregon Health Authority. Update with waiver info • The CVL also has required call and this is assigned on a rotational basis based on modality. Caregivers on call must arrive within 30 minutes of activation. Weekend and weekday call is rotated on a rotational basis and balanced out among all staff. Draft or emergency call is only mandated when caregivers who are on call- call in sick. The draft or emergency list is then utilized- the top person on the list works the call shift if they are	

	working that day. This person then drops to the bottom of the draft list and this is rotated evenly among the RN's.	
Process for evaluating and initiating limitations on admissions	**Nurse Initiated Divert Request Policy:** POLICY STATEMENT • A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment: ▪ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources; ▪ Situations where the skill mix or the competency of the staff do not meet the nursing care needs of the patient. • The RN is to contact the unit Charge Nurse, Nurse Manager, and/or House Supervisor to escalate their concerns for patient safety. • The charge nurse, nurse manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to make a decision about: ○ Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility ○ Placing the hospital on EMS diversion status ○ If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission.	

	• If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (ie cancelling elective surgeries) https://phs-orppmc.policystat.com/policy/3171383/latest/	
Work Environment	• Percentage of BSN RNs: 75% • Percentage of certified RNs: 75% • Level of shared governance: Team of 2RNs, 2 CVTs, 2 ARRT • Staff engagement: 55% Highly sustainable Engagement	
Meals and Rest Breaks	• Meal and rest breaks are assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements. Each team goes on break after procedure is completed. Average length of procedure is 120 min. • Procedures are delayed if necessary to allow for staff to take their designated break. • Charge Nurses and Nurse Manager assist to facilitate and support meal and rest breaks.	
Nurse Sensitive Outcomes and Quality Metrics	• STEMI door to balloon <90 min- current metric met 87% of time • STROKE door to device< 90 min- current met 35% of time • SSI- no known SSIs YTD	
SRDF's and reporting trends	**Per the ONA contract:** Nurses are encouraged to raise any staffing concerns, without fear of retaliation. For specific staffing concerns the Medical Center will make	

	available a form that is mutually agreeable to the Medical Center and Association. Nurses will leave completed forms (SRDF) in a designated place and the Medical Center will not discourage the reporting, documentation and submission of such forms. A copy of such reports received by the Medical Center will be provided to the Association, a member of the PNCC designated by the Association and the appropriate unit manager. • Number of SRDF's: 0 • Trends in SRDF's: None	
Unit of Service	The CVL uses procedure count as productivity measure.	
Resource Use	The CVL doesn't use the resource pool for staffing. IF unable to have the necessary and appropriate number of staff to run a procedure room, cases are delayed or rescheduled.	
Average and mode census	• Average census: 12cases • Mode census: 10	

Number of Procedure Rooms with cases in progress	Number of staff
1	4
2	8
3	11-12
4	15-16

Nursing Unit Staffing Plan & Scope of Service
Unit Name: CVL
Date of HNSC Review: 5/10/23
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

*Based on type of procedure, the majority of procedures are performed with 4 staff made up of 1 RN, 1 ARRT and 2 Technologists (ARRT or CVT). * Less complex cases can be done with minimal 3 staff made up of 1 RN, 1 ARRT and 1 Technologist (ARRT or CV). * * CVL Staffing guidelines are based on regional and national standards *** Note OHA Waiver for minimum number of RNs in the department

Unit Staff Input and HWSC Approval:

Vetting Process Checklist:

☐ Unit staffing committee (if unit has one)
☐ Unit staff meeting: 5/10/23

Nursing Unit Staffing Plan & Scope of Service
Unit Name: CVL
Date of HNSC Review: 5/10/23
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

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☐ Unit based council: All staff who are on the UBC were at the staff meeting
☐ Available on unit and huddle topic for 30 days, and sent electronically to staff: All RNs in the department

Names of staff who presented to HWSC: _Megan Faris Nikki Fritts_____

Date recommended by unit/division to HWSC: ___5/10/23_____

Signature of Manager __Megan Faris _____

Signature of Unit Staffing Committee Representative- Nikki Fritts/Shavon Albee

This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024

SCOPE OF SERVICE

The Kidney Dialysis Unit provides hemodialysis treatments to inpatients at Providence Portland Medical Center, 4K rehabilitation unit, and emergent ESRD and acute patients from the community. Apheresis and cell collection services are performed on an as needed basis for outpatients and inpatients. The KDU serves the age specific population of early-middle aged adults 18-60 years, late adults 61-79, and late-late adults 80 years and up. The team provides coverage 7 days a week, 24 hours a day.

The Kidney Dialysis staff are trained to care for all acuities of patients throughout the hospital with primary focus on managing electrolytes and hemodynamic status throughout the hemodialysis procedure, with a complimentary focus on maintaining and improving physical, mental, and spiritual comfort. Members of the interdisciplinary team provide education to both patients and families, taking into consideration individual needs, language, and culture.

Unit Staff includes a Nurse Manager, Registered Nurses, and Hemodialysis Technicians. All staff have met initial and ongoing competencies as defined by national benchmarks/evidence-based practice, internal quality improvement data and the introduction of new technology or monitoring. National certification from the American Nurses Credentialing Center or the American Association of Critical Care Nurses is highly encouraged for all qualified RNs.

Technology in the KDU includes but is not limited to bedside documentation systems, 3-lead cardiac telemetry, oximetry, infusion pumps, Fresenius 2008K dialysis machines, Spectra Optia apheresis machines, blood glucose testing machines and defibrillator non-invasive pacer.

Providence Portland Medical Center KDU Nursing Staffing Plan		
Date of Review:		Legal Requirement
Specialized qualifications and competencies	All nurses and technicians on KDU complete orientation and competency documents specific to their roles before providing direct patient care, independently. Any additional competencies will be completed when applicable clinical scenarios present. Charge Nurses will not assign nurses an independent patient assignment until mandatory competencies are met. Supplemental nursing staff, (Agency and Travelers) are on-boarded, oriented, and their competency verified according to the regional "Orientation/education plan for temporary nursing staff" plan. The nurse manager/charge nurse can verify competencies by calling the Providence Oregon Clinical Resources Department. **RN:** See Registered Nurse job description **Tech:** See Dialysis technician job description	**Law:** Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure health and safety of patients are met. *Update with standard onboarding*
Hospital unit activity	KDU is a procedural unit and treatment duration is based on MD orders. EPIC data show KDU average hemodialysis treatment duration time is 4.5 hours from patient arrival to departure. The KDU averages 10-12 in a 24-hour period. There are situations that can make admits and discharge more complex that will extend the listed time. In these situations, the direct care nurse updates the charge nurse regarding complexities. The staffing assignment is determined by the acuity of the patient. The Nurse Manager or charge nurse will determine the need in collaboration with staff RN's. Usually a 1:1 Nurse to patient ratio, or 1:2 ratio is maintained for the acute renal	**Law:** Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges **Process:** With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a

	failure patient. A 1:2 ratio is maintained for the chronic renal failure patient. A 1:4 ratio is maintained for the chronic renal failure patient with a RN and a dialysis tech. A 1:1 ratio is maintained for apheresis patients, cell collection/research patients, patients requiring treatment in their room, critical care patients, for patients undergoing their first dialysis treatment and for patients who may require extra monitoring during treatment.	brief description of how data was collected and that this information is taken into consideration when assignments are made. 1:1 for Isolation
Total diagnoses and nursing staffing requirement	Patients are admitted to KDU with a variety of diagnoses, including: CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC HEART FAILURE & SHOCK W MCC SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC OTHER VASCULAR PROCEDURES W MCC G.I. HEMORRHAGE W MCC MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC RENAL FAILURE W MCC SYNCOPE & COLLAPSE OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC HYPERTENSION W MCC CONNECTIVE TISSUE DISORDERS W CC CONNECTIVE TISSUE DISORDERS W/O CC/MCC EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MC OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	**Law:** Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.

	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS POISONING & TOXIC EFFECTS OF DRUGS W MCC SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS KDU admissions are not limited to these disease entities; however, they are the most common.	
National Standards	This staffing plan is consistent with the evidence-based standards and guidelines established by the American Nephrology Nurses Association: Nephrology Nursing Scope and Standards of Practice.	
Acuity and Nursing Care Intensity	Acuity refers to the level of nursing skill required. (i.e., medications, drains, tubes, IVs, wound care) Intensity refers to the level of patient need which makes giving nursing care more complicated. (i.e., Language barriers, cognitive barriers, change in condition) Patient conditions that may contribute to a higher level of acuity and/or intensity on KDU include but are not limited to: • New start patients • Problematic access • Behavioral/Cognitive barriers • Language barriers • Pressure injuries • BPAP, CPAP	**Law:** Must recognize differences in acuity and nursing care intensity **Process:** Work with unit UBC to make a list of factors that influence acuity and nursing care intensity based on your patient population.

	• Hypotension and hypertension • Sepsis • Multi-organ disorder An individual nurse's assignment that includes any of these higher acuity/intensity patients may be adjusted to accommodate the increased work and monitoring required to provide safe and comprehensive care. The nurse caring for these higher acuity/intensity patients is expected to coordinate with the Charge nurse to ensure communication of acuity changes (both when the patient improves or deteriorates in condition), complicated CARES, and needs of the other patients in the nurse's group.	
Minimum Staffing Guidelines	See Appendix B for minimum staffing	**Two parts for this section:** **Part 1 The Law States:** Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. **Part Two:** Minimum number of nursing staff required on specified shifts
Benchmarking	• The National Database Action OI is utilized for benchmarking but is not the sole determination for the staffing model. Other considerations for the staffing model include but not limited to, national standards, nurse sensitive indicators, and patient outcomes.	

Process for evaluating and initiating limitations on admissions	**Nurse Initiated Divert Request Policy:** POLICY STATEMENT • A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment: ▪ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources. ▪ Situations where the skill mix or the competency of the staff do not meet the nursing care needs of the patient. • The RN is to contact the unit Charge Nurse, Nurse Manager, and/or House Supervisor to escalate their concerns for patient safety. • The charge nurse, nurse manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to decide about: o Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility o Placing the hospital on EMS diversion status o If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission. • If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider	**Law:** Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital

	transfers to other hospitals or other viable options to address concerns (i.e., cancelling elective surgeries) https://phs-orppmc.policystat.com/policy/3171383/latest/	
Work Environment	• Percentage of BSN RNs: 85% • Percentage of certified RNs: 31% • Level of shared governance: Representative to IPC • Staff engagement: 2022 Employee Engagement Survey Sustainable Engagement-63%	**Key Point:** Data should be for 12-month span.
Meals and Rest Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for KDU. • Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks.	**Law:** Staffing plans have to show break process and how staffing is maintained during breaks.
Nurse Sensitive Outcomes and Quality Metrics	• CAUTI rate: N/A • CLABSI rate: N/A • HAPI rate: N/A • HCAHPS: N/A ***The KDU doesn't have a NSI.*** Because the Dialysis unit is a procedural unit these quality measures are not directly attributed to Dialysis. Assistance is provided to the inpatient unit investigation CLABSI events attributed to hemodialysis patients that have been cared for in the dialysis unit.	**Key Point:** Data should be for 12 month span. Make sure to include comparative data with like areas (national goals).
SRDF's and reporting trends	**Per the ONA contract:** Nurses are encouraged to raise any staffing concerns, without fear of retaliation. For specific staffing concerns the Medical Center will	**Key Point:** Data should be for 12 month span. List noted trends on the unit.

	make available a form that is mutually agreeable to the Medical Center and Association. Nurses will leave completed forms (SRDF) in a designated place and the Medical Center will not discourage the reporting, documentation, and submission of such forms. A copy of such reports received by the Medical Center will be provided to the Association, a member of the PNCC designated by the Association and the appropriate unit manager. • Number of SRDF's: None • Trends in SRDF's: None	
Unit of service	• **As of Fiscal Year Date (Sept. 23, 2023) We serviced 2880 patients**	**Law:** This may be HPPD, midnight census, number of cases, etc. **Key Point:** make sure to include comparative data with like areas
Resource Use	• Resource Pool utilization: Float pool and per diem caregivers • Per Mandatory Overtime for Nursing Staff policy: Overtime is considered voluntary unless the staff member and manager or designee declares the overtime as mandatory and documents such on the Mandatory Overtime Record regarding the need for mandatory overtime • Link to Mandatory Overtime Policy: https://phs-orppmc.policystat.com/policy/3171346/latest/ • Overtime percentage: Voluntary Overtime YTD 2.59 No Mandatory Overtime • Gap to core staffing: Staffed to core • Retention rate: 100%	**Key Point:** Data should be for 12 month span.

Average and mode census	Average census: 10 **Yes! Average daily census is 10 because we no longer have routine dialysis outpatients coming through the admitting office. The last time was on January 15, 2023.**	Not a required section per law. This may be located in a position control document. If so, please include reference here.

Appendix B:

KDU Staffing Guideline

Census	Charge RN	RN*	Total # of Staff
1	1	1	2
2	1	1	2
3	1	1	2

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4	1	1	2
5	1	2	3
6	1	3	4
7	1	4	5
8	1	4	5
9	1	5	6
10	1	5	6

KDU Minimum Staffing Guideline

Census	Charge RN	RN	Total # of Staff	

1	1	1	2	
2	1	1	2	
3	1	1	2	
4	1	1	2	
5	1	2	3	
6	1	2	3	
7	1	3	4	
8	1	3	4	
9	1	4	5	
10	1	4	5	

***Dialysis Technicians**

The Hemodialysis unit utilizes Technicians in their skill mix:

- Technicians are qualified to perform the technical aspects of a dialysis procedure
- Must work under the supervision of a Registered Nurse
- For every nurse/technician paring:
  - The pair is assigned up to 4 patients:
  - The tech is assigned up to 2 patients
  - The Registered Nurse is responsible for all nursing assessments, processing of physician orders, blood administration and medications the patient may require
- The Dialysis unit currently has 2 full time Dialysis Technicians
- There are typically no more than 2 technicians working on a given day

Unit Staff Input and HWSC Approval:

Vetting Process Checklist:

☐ Unit staffing committee (if unit has one)
☒ Unit staff meeting: 8/4/23
☒ Unit based council: In process of forming a council
☒ Available on unit and huddle topic for 30 days, and sent electronically to staff: 9/14/23

Names of staff who presented to HWSC: E_____

Date recommended by unit/division to HWSC: _____

Signature of Manager: _____

Signature of Unit Staffing Committee Representative: __Nikki Fritt_____

Nursing Unit Staffing Plan & Scope of Service
Unit Name: Interventional Recovery Unit
Date of HNSC Review: 5/22/2023
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

PROVIDENCE Portland Medical Center

Interventional Recovery Unit Staffing Plan	
Scope of Service	• The Interventional Recovery Unit (IRU) at Providence Portland Medical Center has 10 bays located in 2L. The IRU provides services to Outpatients who require Cardiovascular Lab (CVL) and/or Interventional Radiology (IR) procedural care. The IRU serves patients ranging in age from 18 to 150 years old. The operation hours of the IRU are from 0600 to 1830, Monday through Friday. • IRU consists of a nurse manager, assistant nurse manager, and registered nurses (RNs). It is a mandatory requirement that all caregivers working in the IRU must have Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) training. The new hire orientation of RN caregivers joining the IRU includes preoperative and postoperative care for CVL and IR procedures. • The IRU offers preoperative and phase 2 postoperative care for patients undergoing CVL and IR procedures. This care is provided only to outpatient. Our comprehensive service is based on a multidisciplinary approach that involves collaboration between the IRU caregivers, patients, their family and significant others, as well as medical staff affiliated with surgical services and other departments that play a critical role in care delivery. • As part of the service, the IRU RNs perform physical, psychological, and educational assessments to evaluate the patient's needs. They also coordinate pre- and post-procedural teaching, communicate results, and develop and coordinate a comprehensive plan of care for preoperative and postoperative periods. The effectiveness and outcome of any interventions are evaluated, and necessary referrals are made.
Specialized Qualifications, Competencies, and Skill Mix	• All registered nurses on IRU complete "Oregon Region Onboarding Portfolio Perioperative Surgical Service RN" packet prior to delivering direct patient care. Any additional competencies will be completed when applicable clinical scenarios present. Registered Charge Nurses will not assign registered nurses independent patient assignment until mandatory competencies are met. • RN: See Registered Nurse job description ***Law**: Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure health and safety of patients are met.*

Acuity & Admission, Discharge, Transfers	• The average length of time to Preop a patient is 55 minutes, postop a patient is 240 minutes. • Average Daily surgical and procedural cases is 8. ***Law:*** *Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges* ***Process:*** *With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a brief description of how data was collected and taken into consideration when assignments are made.*

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Total Diagnosis and Nursing Staffing Requirement (complete list)

- Patients are admitted to IRU with a variety of diagnoses, including:

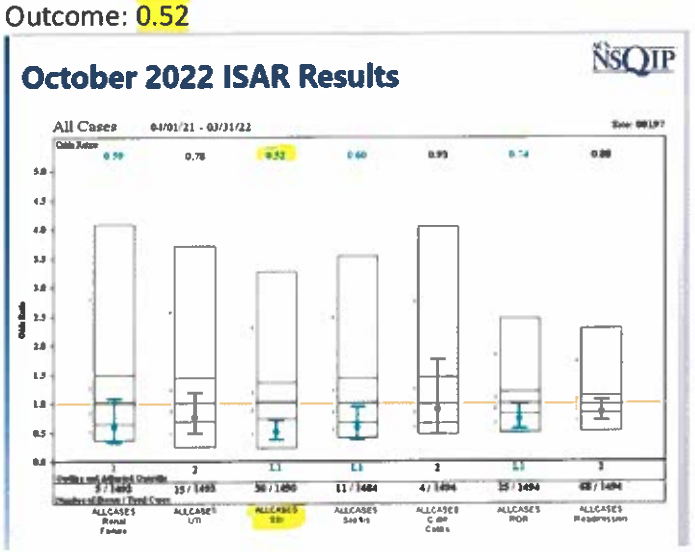
Row Labels	Count of Pt Acct Nbr
307 - CARDIAC CONGENITAL AND VALVULAR DISORDERS WITHOUT MCC	259
303 - ATHEROSCLEROSIS WITHOUT MCC	255
949 - AFTERCARE WITH CC/MCC	138
315 - OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC	90
700 - OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITHOUT CC/MCC	61
699 - OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH CC	59
842 - LYMPHOMA AND NON-ACUTE LEUKEMIA WITHOUT CC/MCC	58
292 - HEART FAILURE AND SHOCK WITH CC	56
093 - OTHER DISORDERS OF NERVOUS SYSTEM WITHOUT CC/MCC	56
950 - AFTERCARE WITHOUT CC/MCC	51
310 - CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITHOUT CC/MCC	51
309 - CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH CC	49
313 - CHEST PAIN	41
182 - RESPIRATORY NEOPLASMS WITHOUT CC/MCC	40
302 - ATHEROSCLEROSIS WITH MCC	37
694 - URINARY STONES WITHOUT MCC	36
300 - PERIPHERAL VASCULAR DISORDERS WITH CC	33
314 - OTHER CIRCULATORY SYSTEM DIAGNOSES WITH MCC	31
688 - KIDNEY AND URINARY TRACT NEOPLASMS WITHOUT CC/MCC	29
437 - MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITHOUT CC/MCC	29
293 - HEART FAILURE AND SHOCK WITHOUT CC/MCC	27
951 - OTHER FACTORS INFLUENCING HEALTH STATUS	26
301 - PERIPHERAL VASCULAR DISORDERS WITHOUT CC/MCC	26
316 - OTHER CIRCULATORY SYSTEM DIAGNOSES WITHOUT CC/MCC	24
376 - DIGESTIVE MALIGNANCY WITHOUT CC/MCC	23
148 - EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITHOUT CC/MCC	22
599 - MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	20
NO DATA - NO DATA	20
375 - DIGESTIVE MALIGNANCY WITH CC	19
204 - RESPIRATORY SIGNS AND SYMPTOMS	18
291 - HEART FAILURE AND SHOCK WITH MCC	18
393 - OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC	18
068 - NONSPECIFIC CVA AND PRECEREBRAL OCCLUSION WITHOUT INFARCTION WITHOUT MCC	17
841 - LYMPHOMA AND NON-ACUTE LEUKEMIA WITH CC	17
687 - KIDNEY AND URINARY TRACT NEOPLASMS WITH CC	16
312 - SYNCOPE AND COLLAPSE	15
394 - OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC	14
598 - MALIGNANT BREAST DISORDERS WITH CC	13
845 - OTHER MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASTIC DIAGNOS	13
724 - MALIGNANCY, MALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	13
436 - MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH CC	12
181 - RESPIRATORY NEOPLASMS WITH CC	12
812 - RED BLOOD CELL DISORDERS WITHOUT MCC	12
544 - PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY	12
445 - DISORDERS OF THE BILIARY TRACT WITH CC	12
698 - OTHER KIDNEY AND URINARY TRACT DIAGNOSES WITH MCC	11
443 - DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITHOUT C(	11
306 - CARDIAC CONGENITAL AND VALVULAR DISORDERS WITH MCC	11
556 - SIGNS AND SYMPTOMS OF MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE WITHOUT M	11
057 - DEGENERATIVE NERVOUS SYSTEM DISORDERS WITHOUT MCC	10

919 - COMPLICATIONS OF TREATMENT WITH MCC	9
920 - COMPLICATIONS OF TREATMENT WITH CC	9
147 - EAR, NOSE, MOUTH AND THROAT MALIGNANCY WITH CC	9
446 - DISORDERS OF THE BILIARY TRACT WITHOUT CC/MCC	9
287 - CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITHOUT MCC	9
813 - COAGULATION DISORDERS	8
435 - MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH MCC	8
690 - KIDNEY AND URINARY TRACT INFECTIONS WITHOUT MCC	7
442 - DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH CC	7
311 - ANGINA PECTORIS	6
441 - DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH MCC	6
603 - CELLULITIS WITHOUT MCC	6
065 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH CC OR TPA IN 24 HOURS	6
373 - MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS WITHOUT CC/MCC	6
066 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITHOUT CC/MCC	5
543 - PATHOLOGICAL FRACTURES AND MUSCULOSKELETAL AND CONNECTIVE TISSUE MALIGNANCY	5
308 - CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH MCC	5
846 - CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITH MCC	4
299 - PERIPHERAL VASCULAR DISORDERS WITH MCC	4
281 - ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH CC	4
607 - MINOR SKIN DISORDERS WITHOUT MCC	4
756 - MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITHOUT CC/MCC	4
835 - ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITH CC	4
848 - CHEMOTHERAPY WITHOUT ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS WITHOUT CC/MCC	4
836 - ACUTE LEUKEMIA WITHOUT MAJOR O.R. PROCEDURES WITHOUT CC/MCC	4
392 - ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MCC	4
444 - DISORDERS OF THE BILIARY TRACT WITH MCC	4
755 - MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM WITH CC	4
440 - DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITHOUT CC/MCC	4
596 - MAJOR SKIN DISORDERS WITHOUT MCC	4
434 - CIRRHOSIS AND ALCOHOLIC HEPATITIS WITHOUT CC/MCC	4
811 - RED BLOOD CELL DISORDERS WITH MCC	3
395 - OTHER DIGESTIVE SYSTEM DIAGNOSES WITHOUT CC/MCC	3
069 - TRANSIENT ISCHEMIA WITHOUT THROMBOLYTIC	3
091 - OTHER DISORDERS OF NERVOUS SYSTEM WITH MCC	3
693 - URINARY STONES WITH MCC	3
948 - SIGNS AND SYMPTOMS WITHOUT MCC	3
641 - MISCELLANEOUS DISORDERS OF NUTRITION, METABOLISM, FLUIDS AND ELECTROLYTES WITHI	2
092 - OTHER DISORDERS OF NERVOUS SYSTEM WITH CC	2
Grand Total	**2150**

- IRU admissions are not limited to these disease entities; however, they are the most common.

Law: *Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.*

National Standards	• This staffing plan is consistent with the evidence-based standards and guidelines established by the by the Society of Perianesthesia Nursing (ASPAN) (2021) including date of the standard. ) . ***Reference:*** *Look for Nationally Recognized Standards that pertain to your area. Think about what certifications are applicable in your department and use that as the national standard. Make sure to sight your source properly.*
Acuity & Nursing Care Intensity	• Patient conditions that may contribute to a higher level of acuity and/or intensity on IRU include but are not limited to: See attached acuity tool. ***Law:*** *Must recognize differences in acuity and nursing care intensity* *Process: Work with unit UBC validate and update acuity and intensity tool for your unit population.*
Minimum Staffing Guidelines	• When one patient is present on IRU, there are one RN and one other nurse staff member. ***Law (Part 1)****: Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. See Appendix A* ***Law (Part 2)****: Minimum number of nursing staff required on specified shifts.* *(Place Guideline (Grid) in Appendix B*
Considers non-direct care tasks including Meal and Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for IRU. • Registered Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks.

Patient Outcomes	SSI Goal: O/E <1.0 Outcome: 0.52  ***Key Point:*** *Data should be for 12-month span. Make sure to include comparative data with like areas (national goals).*
Unit of service	• Target Worked Hours per Unit = 23.82 • Budgeted volume = 14 per day **Law:** This may be HPPD, midnight census, number of cases, etc. **Key Point:** make sure to include comparative data with like areas

Process for Evaluating & Initiating Limitations on Admissions	Nurse Initiated Divert Request Policy: POLICY STATEMENT • A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment: ☐ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources. ☐ Situations where the skill mix, or the competency of the staff do not meet the nursing care needs of the patient. • The RN is to contact the unit Registered Charge Nurse, RN Manager, and/or House Supervisor to escalate their concerns for patient safety. • The registered charge nurse, RN manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to make a decision about: • Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility • Placing the hospital on EMS diversion status • If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission. • If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (i.e. cancelling elective surgeries https://phs-orppmc.policystat.com/policy/3171383/latest/ ***Law:*** *Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital*
References	Donna M. DeFazio Quinn & Lois Schick. (2023). *Practice Recommendation: Patient Classification/Staffing Recommendations*. American Society of Paranesthesia Nurses. Retrieved April 4, 2023, from PR_Patient_Classification_Staffing_Recommendations.pdf (aspan.org)
Attachments	• Appendix A: Staffing Guidelines • Appendix B: Minimum Staffing Guidelines for Lunches/Breaks • Appendix C: Acuity and Intensity Tool

Unit Staff Input & HNSC Approval Vetting Process Checklist	☐ Unit staffing committee (if unit has one): NA ☒ Unit staff meeting: 4/12/2023 ☒ Unit based council: 4/12/2023 ☒ Available on unit and huddle topic for 30 days, and sent electronically to staff: 4/12-5/12/2023 • Names of staff who presented to HNSC: Larissa Ellis • Date recommended by unit/division to HNSC: 5/22/2023 • Signature of Manager: Kelly Kong • Signature of Unit Staffing Committee Representative: Denis Devoe

Appendix A	IRU Staffing Guideline				
Unit: Interventional Recovery Unit		**Target Hours per Unit = 23.8282**			
	DAY SHIFT			Total Worked Hours	
Census	Charge RN	RNs	Total # Staff		Variance
1	1	1	2	20	3.8282
2	1	1	2	20	3.8282
3	1	1	2	20	3.8282
4	1	2	3	31	-7.1718
5	1	2	3	31	-7.1718
6	1	2	3	31	-7.1718
7	1	2	3	31	-7.1718
8	1	3	4	42	-18.1718
9	1	3	4	42	-18.1718
10	1	3	4	42	-18.1718
			Target Hours per unit = Target hours/ 14 calendar days		

Nursing Unit Staffing Plan & Scope of Service
Unit Name: Interventional Recovery Unit
Date of HNSC Review: 5/22/2023
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

Appendix B	IRU Minimum Staffing Guideline				
Unit: Interventional Recovery Unit		**Target Hours per Unit = 23.8282**			
	DAY SHIFT			Total Worked Hours	Variance
Census	Charge RN	RNs	Total # Staff		
1	1	1	2	21	2.8282
2	1	1	2	21	2.8282
3	1	1	2	21	2.8282
4	1	1	2	21	2.8282
5	1	2	3	21	2.8282
6	1	2	3	21	2.8282
7	1	2	3	29	-5.1718
8	1	2	3	29	-5.1718
9	1	2	3	29	-5.1718
10	1	3	4	41	-17.1718
		Target Hours per unit = Target hours/ 14 calendar days			

Appendix C IRU Patient Acuity & Intensity of Nursing Work (Adapted from Mallech, 2000)

Population: IRU Postop patients
Rating Scale 1= Normal Function/Status 5 = Very Abnormal/ Disrupted/Unstable

Focus		1	2	3	4	5	Score
Comfort	Acuity	No expressed or observed discomfort	Episodic mild discomfort	Episodic moderate pain/discomfort	Very frequent serious pain/discomfort	Intense pain on nearly continuous basis with physical response (Nausea)	
	Intensity	None	Oral meds and nursing measures effective	Assistance and/or q2-4 hours plus nursing measures	Assistance and/or oral and IV for pain; Frequent nursing measures	Oral/IV/IM meds: nearly continuous nursing care	
Treatments, Tasks, Interventions	Intensity	Very few	Oral meds; simple dressings	Simple but frequent, or complex infrequent	complex medical nursing interventions; technology required	Multiple, and/or continuous, complex medication and nursing interventions,	
Total Score							

Scale:
3-6 Low
7-9 Medium
10-15 High

* **Acuity** – the complexity of patient care needs requiring the skill and the care of nursing staff.
* **Intensity** – the level of patient need for nursing care as determined by the nursing assessment

Nursing Unit Staffing Plan & Scope of Service
Unit Name: Medical Procedures Unit
Date of HNSC Review:
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

MPU 2023 Staffing Plan	
Scope of Service	The Medical Procedures Unit (MPU) provides services to both adult inpatients and outpatients who need procedures including Endoscopy and Endoscopic Ultrasound (of both the upper and lower GI tract), Bronchoscopy, Endobronchial Ultrasound, Endoscopic Retrograde Cholangiopancreatography (ERCP), Transesophageal Echocardiogram (TEE), Cardioversions, Feeding Tube Placements/ Exchanges, and Tracheostomy tube exchanges. The MPU also provides Pain Management services such as Epidural Steroid Injections and other pain management modalities. The unit is open Monday-Friday from 0600-1830. RN and Endoscopy Technicians provide 24/7 standby coverage after hours and on weekends. There are 6 procedure rooms, four of which are negative pressure rooms. There is also a workroom for reprocessing endoscopes and equipment/scope storage area(s). MPU Registered Nurses (RNs) provide nursing assessments, administer moderate sedation, assist with endoscopy procedures, and perform scope reprocessing. Endoscopy Technicians assist with endoscopy procedures and perform scope reprocessing.
Specialized Qualifications, Competencies, and Skill Mix	• All registered nurses on the MPU complete "Oregon Region Onboarding Portfolio Unit Specific Orientation Addendum: PPMC MPU RN" packet prior to delivering direct patient care. All Endoscopy Technicians on the MPU complete "Oregon Region Onboarding Portfolio Surgical Services Unit Orientation – PHSOR Endoscopy Tech" packet prior to delivering direct patient care. Any additional competencies will be completed when applicable clinical scenarios present. Registered Charge Nurses will not assign registered nurses independent patient assignment until mandatory competencies are met. • **RN**: See Registered Nurse job description. • **Endoscopy Tech**: See Senior Endoscopy Technician job description. ***Law**: Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure health and safety of patients are met.*

Acuity & Admission, Discharge, Transfers	The MPU is a procedural unit that has pre-scheduled and daily add on cases. In 2022 data indicate that: • The average number of procedures per day was 30. • The average number of add on procedures per day was 5. ***Law:*** *Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges This may be HPPD, midnight census, number of cases, etc.* ***Process:*** *With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a brief description of how data was collected and taken into consideration when assignments are made.*

Total Diagnosis and Nursing Staffing Requirement (complete list)	• Patients are admitted to the MPU with a variety of diagnoses, including: SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC GASTROINTESTINAL HEMORRHAGE WITH CC GASTROINTESTINAL HEMORRHAGE WITH MCC HEART FAILURE AND SHOCK WITH MCC INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH MCC ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITHOUT MCC CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH MCC ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH MCC CIRRHOSIS AND ALCOHOLIC HEPATITIS WITH MCC DIGESTIVE MALIGNANCY WITH MCC LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH CC DISORDERS OF THE BILIARY TRACT WITH CC MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH MCC ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS WITH MCC DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITIS WITH MCC OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH MCC MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC DISORDERS OF THE BILIARY TRACT WITH MCC LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH MCC EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC MAJOR ESOPHAGEAL DISORDERS WITH MCC • MPU admissions are not limited to these disease entities; however, they are the most common. ***Law:*** *Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.*

National Standards	This staffing plan is consistent with the evidence-based standards and guidelines established by the Society of Gastroenterology Nurses and Associates (SGNA) Professional Standards and Guidelines for Staffing 2016. https://www.sgna.org/Portals/0/Minimum%20RN%20Staffing_FINAL.pdf ***Reference:*** *Look for Nationally Recognized Standards that pertain to your area. Think about what certifications are applicable in your department and use that as the national standard. Make sure to sight your source properly.*

Acuity & Nursing Care Intensity	• Patient conditions that may contribute to a higher level of acuity and/or intensity on the MPU may include but are not limited to:
	  • Specific needs required by the procedure(s) such as bleeding complication or increased interventions.
	  • Requirement for RN administered sedation.
	An individual registered nurse's assignment that includes any of these higher acuity/intensity patients may be smaller to accommodate the increased work and monitoring required to provide safe and comprehensive care during the high acuity phases of the patient's care continuum. The registered nurse caring for these higher acuity/intensity patients is expected to coordinate with the Registered Charge nurse to ensure communication of acuity changes (both when the patient improves or deteriorates in condition), and the needs of other patients undergoing procedures in the department.
	
	Law: *Must recognize differences in acuity and nursing care intensity*
	Process: Work with unit UBC validate and update acuity and intensity tool for your unit population.

Minimum Staffing Guidelines	• When one patient is present on the MPU there is a minimum of one RN and one other staff member, who can be either another RN or a Tech. See approved waiver by OHA. • This staffing requirement is met both during regular weekday hours and after hours for call back. • Staffing is based on patient volume, maintaining at least one RN and another RN or Tech for each procedure (for cardioversions there is only one RN in addition to the cardiologist and anesthesiologist). • Cases cannot proceed without this level of staffing. • One RN during each procedure will provide on-going nursing assessment, communicate effectively with the patient and healthcare team, and ensure quality and continuity of care. One technician or RN will be assisting the proceduralist during every procedure. • RNs administering procedural sedation must not have other responsibilities that would compromise their ability to monitor the patient during the procedure. Core staffing is based on the number of cases/ procedure rooms with scheduled cases for each day. Unit of service in the MPU is calculated as worked hours per unit (WHpU) = 3.03 ***Law (Part 1)**: Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. See Appendix A* ***Law (Part 2)**: Minimum number of nursing staff required on specified shifts (Place Guideline (Grid) in Appendix B*

Process for Evaluating & Initiating Limitations on Admissions	Nurse Initiated Divert Request Policy:
	POLICY STATEMENT
	• A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment:
	  ☐ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources.
	  ☐ Situations where the skill mix, or the competency of the staff do not meet the nursing care needs of the patient.
	• The RN is to contact the unit Registered Charge Nurse, RN Manager, and/or House Supervisor to escalate their concerns for patient safety.
	• The registered charge nurse, RN manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to make a decision about:
	• Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility.
	• Placing the hospital on EMS diversion status
	• If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission.
	• If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (i.e., cancelling elective surgeries
	
	https://phs-orppmc.policystat.com/policy/3171383/latest/
	
	The MPU routinely assesses the ability to provide services for patients requiring procedures.
	• The charge nurse evaluates the caseload throughout the day and informs the Nurse Manager regarding resources needed if procedure caseload extends beyond the hours of operation.
	• Elective cases may be moved to later procedure start times or to another day to accommodate emergent cases after consultation with the Nurse Manager and proceduralist.
	• The call back team is dedicated to urgent/ emergent cases after hours and on weekends.
	• If multiple emergent cases need triaging, the charge nurse, in consultation with the proceduralist involved, will review the case load and triage cases appropriately.
	The Nurse Manager and Hospital supervisor will be contacted to strategize/ coordinate transfers for cases needing to be triaged to another ministry.

	Law: *Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital*
Considers non-direct care tasks including Meal and Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for the MPU. • Registered Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks. • Staff are scheduled and assigned each day to provide meal and rest breaks for staff. If necessary, procedures may be delayed to allow for scheduled meal and rest breaks.
Patient Outcomes	Nursing outcome metrics for 2022 include: • Scope cultures negative for pathogens. zero – goal was zero • Safe procedure checklist compliance. 98.5% - goal was 98% • Specimen handling errors. zero – goal was one ***Key Point:*** *Data should be for 12-month span. Make sure to include comparative data with like areas (national goals).*
Attachments	• Appendix A: Minimum Staffing Guidelines with Lunches/Break Relief
Unit Staff Input & HNSC Approval Vetting Process Checklist	☐ Unit staffing committee (if unit has one): (date) ☐ Unit staff meeting: 4/27/23 ☐ Unit based council: 4/27/23 ☐ Available on unit and huddle topic for 30 days, and sent electronically to staff: 4/27/23 • Names of staff who presented to HNSC: • Date recommended by unit/division to HNSC: • Signature of Manager: • Signature of Unit Staffing Committee Representative:

Appendix A: Minimum Staffing Guidelines

MPU Minimum Staffing Guidelines	
Number of Procedure Rooms with procedures in progress	**Number of RNs/ staff***
1	2
2	5
3	7
4	9
5	11
6	13

*Cases require two staff, one RN and the other may be an RN or a technician.

Nursing Unit Staffing Plan & Scope of Service
Unit Name: PPMC Outpatient Infusion
Date of HNSC Review:
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

PPMC OP Infusion Staffing Plan	
Scope of Service	OP Infusion at PPMC is a hospital-based outpatient infusion unit with a total of 14 infusion chairs, 4 of which are semi-private rooms and a capability to utilize an additional (15th) chair when needed to accommodate one additional patient. Hours of operation are 0700-1730 Monday – Friday and 0800-1630 Saturday and Sunday. Patients arrive at a scheduled appointment time and remain under OP Infusion care until their treatment is complete. Outpatient Infusion provides care and educational support for patients that require intravenous infusions as well as injections and other therapies. These patients have to meet the ambulatory patient requirements in order to be treated at OP Infusion. OP Infusion provides care for patients needing the following services: ❖ Focused symptom assessment and treatment related management ❖ Medication infusions/injections ❖ Chemotherapy ❖ Biotherapy ❖ Clinical Trial related infusions ❖ Stem cell collection (in coordination with the Red Cross) ❖ Blood products transfusions ❖ Therapeutic phlebotomy ❖ PICC line placement by IV therapy ❖ IV Antimicrobial/antifungal/antiviral therapy ❖ Anticoagulant therapies ❖ Support the Emergency department and Radiation Oncology department when needed with the above therapies.
Specialized Qualifications, Competencies, and Skill Mix	All registered nurses in OP Infusion complete "Oregon Region Onboarding Portfolio Outpatient Infusion RN" packet prior to delivering direct patient care. All CNA2s in OP Infusion complete "Oregon Region Onboarding Portfolio General CNA Orientation" packet prior to delivering direct patient care. Any additional competencies will be completed when applicable clinical scenarios present. Registered Charge Nurses will not assign registered nurses independent patient assignment until mandatory competencies are met. Nurses are required to obtain their Chemo and Bio Certification through the ONS and attend the Providence ASCT class prior to caring for transplant patients. • RN: See Registered Nurse job description • CNA: see CNA2 job description ***Law**: Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure the health and safety of patients are met.*

Acuity & Admission, Discharge, Transfers	• The average length of time to admit a patient is 15-30 minutes, discharge a patient is 5-10 minutes and transfer a patient (N/A) minutes. These times were derived from "Outpatient Minimum Charting Standards" policy and direct observation of the discharge and admission process. • Average LOS for patients in this unit is 3.5 hours. • Average number of patients admitted for the year 2022 was 32 patients/day for a weekday and 17 patients per day on a weekend day. • Average number of patients discharged for the year 2022 was 32 patients/day for a weekday and 17 patients per day on a weekend day. • Average Daily Census at Midnight N/A (unit does not operate 24 hours/day) ***Law:*** *Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges* ***Process:*** *With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a brief description of how data was collected and taken into consideration when assignments are made.*

Total Diagnosis and Nursing Staffing Requirement (complete list)	Patients are admitted to OP Infusion with a variety of diagnoses, including: • ALS (Amyotrophic Lateral Sclerosis) • Multiple Sclerosis • Anemia/ OB iron infusions • Chronic Kidney Disease • Chronic Migraine • Chronic Vomiting • CIDP (Chronic Inflammatory Demyelinating Polyneuropathy) • Crohn's disease • Hemochromatosis • Polycythemia rubra • Iron deficiency anemia • Myasthenia gravis • Osteoporosis • Short gut syndrome • Rheumatoid arthritis • Lymphoma • Leukemia • Multiple Myeloma • Other Cancer Diagnoses • COVID-19 • Infection • Hyperemesis • Chronic pain/CRPS OP Infusion visits are not limited to these disease entities; however, they are the most common. ***Law:*** *Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.*

National Standards	• This staffing plan is consistent with the evidence-based standards and guidelines established by the nationally recognized guidelines, including information from ONS and ACCC. References Guidy, T., and Kloos, E. (2014, May-June). *Productivity Benchmarks for Outpatient Cancer Programs.* Association of Community Cnacer Centers. https://www.accc-cancer.org/docs/Documents/oncology-issues/articles/MJ14/mj14-productivity-benchmarks-for-outpatient-cancer-programs Staffing of Ambulatory Treatment Centers. (October 2022). *Oncology Nursing Society.* https://www.ons.org/make-difference/ons-center-advocacy-and-health-policy/position-statements/nurse-staffing-ambulatory-treatment-centers West, S., and Sherer, M. (2009, November-December). *ISO: The "Right" Nurse Staffing Model.* Oncology Issues. https://www.accc-cancer.org/docs/Documents/oncology-issues/articles/ND09/nd09-iso-the-right-nurse-staffing-model ***Reference:*** *Look for Nationally Recognized Standards that pertain to your area. Think about what certifications are applicable in your department and use that as the national standard. Make sure to sight your source properly.*
Acuity & Nursing Care Intensity	• Patient conditions that may contribute to a higher level of acuity and/or intensity in OP Infusion include but are not limited to: See attached acuity tool (Appendix C).***Law:*** *Must recognize differences in acuity and nursing care intensity* **Process:** *Work with unit UBC validate and update acuity and intensity tool for your unit population.*

Minimum Staffing Guidelines	• When one patient is present in OP Infusion, there has to be one RN and one other nurse staffing member on duty on the unit. • In OP Infusion, weekend days (Saturdays and Sundays) and nationally recognized holidays are staffed differently. See Appendix A-1 for Monday – Friday Staffing Guidelines and Appendix A-2 for Saturday/Sunday/Holiday Staffing Guidelines. • For **minimum** staffing guidelines, see appendix B. ***Law (Part 1)**: Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. See Appendix A* ***Law (Part 2)**: Minimum number of nursing staff required on specified shifts (Place Guideline (Grid) in Appendix B*

Process for Evaluating & Initiating Limitations on Admissions	Nurse Initiated Divert Request Policy:
	POLICY STATEMENT
	• A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment:
	  ☐ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources.
	  ☐ Situations where the skill mix, or the competency of the staff do not meet the nursing care needs of the patient.
	• The RN is to contact the unit Registered Charge Nurse, RN Manager, and/or House Supervisor to escalate their concerns for patient safety.
	• The registered charge nurse, RN manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care needs the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to decide about:
	• Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility
	• Placing the hospital on EMS diversion status
	• If admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission.
	• If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (i.e., cancelling elective surgeries)
	
	https://phs-orppmc.policystat.com/policy/3171383/latest/
	
	Law: *Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital*

Considers non-direct care tasks including Meal and Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for OP Infusion. • Registered Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks.

Patient Outcomes	Example: CAUTI, CLABSI, HAPI rates **CAUTI rate – N/A** **CLABSI rate – N/A** **HAPI rate – N/A** **Falls for 2022: 3 (three) events.** **Key Point:** Data should be for a 12-month span. Make sure to include comparative data with like areas (national goals).
Unit of service	• **Total number of procedures for year 2022: 46,851.** This number includes all procedures performed in OP Infusion between 1/1/2022 and 12/31/2022. • **Law:** This may be HPPD, midnight census, number of cases, etc. **Key Point:** make sure to include comparative data with like areas
Attachments	• Appendix A: Staffing Guidelines • Appendix B: Minimum Staffing Guidelines for Lunches/Breaks • Appendix C: Acuity and Intensity Tool
Unit Staff Input & HNSC Approval Vetting Process Checklist	☐ Unit staffing committee (if unit has one): (N/A) ☐ Unit staff meeting: 5/3/2023 ☐ Unit based council: 5/3/2023, updated version on 7/26/2023. ☐ Available on unit and huddle topic for 30 days, and sent electronically to staff: 5/3/2023-6/5/2023 • Names of staff who presented to HNSC: Angela Chausov • Date recommended by unit/division to HNSC: 8/28/23 • Signature of Manager: Angela Chausov, ANM • Signature of Unit Staffing Committee Representative: N/A

Appendix A-1

Staffing Guidelines for *Monday, Tuesday, Wednesday, Thursday, and Friday.*

Census	Charge RN	RN	CNA	HUC	Total Staff
1	1	1.5	0	0	2.5
2	1	1.5	0	0	2.5
3	1	1.5	0	0	2.5
4	1	1.5	0	0	2.5
5	1	1.5	0	0	2.5
6	1	1.5	0	0	2.5
7	1	1.5	0	0	2.5
8	1	1.5	0	0	2.5
9	1	1.5	0	0	2.5
10	1	1.5	0	0	2.5
11	1	2	0	0	3
12	1	2	0	0	3
13	1	2	0	0	3
14	1	2	0	0	3
15	1	2	0	0	3
16	1	2	1	0	4
17	1	2.5	1	1	5.5
18	1	2.5	1	1	5.5
19	1	2.5	1	1	5.5
20	1	3	1	1	6
21	1	3	1	1	6
22	1	3	1	1	6
23	1	3.5	1	1	6.5
24	1	3.5	1	1	6.5
25	1	3.5	1	1	6.5
26	1	4	1	1	7
27	1	4	1	1	7
28	1	4	1	1	7
29	1	4.5	1	1	7.5

30	1	4.5	1	1	7.5
31	1	4.5	1	1	7.5
32	1	5	1	1	8
33	1	5	1	1	8
34	1	5	1	1	8
35	1	5.5	1	1	8.5
36	1	5.5	1	1	8.5
37	1	5.5	1	1	8.5
38	1	5.5	1	1	8.5
39	1	6	1	1	9
40	1	6	1	1	9

Appendix A-2

Staffing Guidelines for *Saturday, Sunday, and nationally recognized holidays*

Census	Charge RN	RN	Total Staff
1	1	1.5	2.5
2	1	1.5	2.5
3	1	1.5	2.5
4	1	1.5	2.5
5	1	1.5	2.5
6	1	1.5	2.5
7	1	1.5	2.5
8	1	1.5	2.5
9	1	1.5	2.5
10	1	1.5	2.5
11	1	2	3
12	1	2	3
13	1	2	3
14	1	2	3
15	1	2	3
16	1	3	4
17	1	4	5
18	1	4	5
19	1	4	6

20	1	4	5
21	1	4	5
22	1	4	5
23	1	4	5
24	1	4	5

Appendix B
Minimum Staffing Guidelines for Lunches/Breaks

	Charge RN	RN	CNA	Total Staff
1	1	1.5	0	2.5
2	1	1.5	0	2.5
3	1	1.5	0	2.5
4	1	1.5	0	2.5
5	1	1.5	0	2.5
6	1	1.5	0	2.5
7	1	1.5	0	2.5
8	1	1.5	0	2.5
9	1	1.5	0	2.5
10	1	1.5	0	2.5
11	1	1.5	0	2.5
12	1	1.5	0	2.5
13	1	2	0	3
14	1	2	0	3
15	1	2	0	3
16	1	2	0	3
17	1	2	0	3
18	1	2	0	3
19	1	2	0	3
20	1	2	0	3

21	1	2	0	3
22	1	2	0	3
23	1	2	0	3
24	1	2	0	3
25	1	2	0	3
26	1	3	0	4
27	1	3	0	4
28	1	3	0	4
29	1	3	0	4
30	1	3	0	4
31	1	3	0	4
32	1	3	0	4
33	1	4	0	5
34	1	4	0	5
35	1	4	0	5
36	1	4	0	5
37	1	4	0	5
38	1	4	0	5
39	1	4	0	5
40	1	4	0	5

Appendix C
Acuity and Intensity Tool

Intensity Levels	Average Treatment Time	Direct patient care	Indirect patient care	Total time allocated	Acuity examples
I	<30 min	20	15	35	Injection, dressing change, port access, pump d/c. Such patients can be accounted as 2 for 1 in staffing guidelines.
II	30-60 min	45	20	65	Iron, Zometa, Entyvio, etc.
III	60-120 min	50	30	80	Iron Dextran, Hydration, Vidaza, etc.

IV	>120 min	70	30	100	Electrolyte replacement, blood transfusion 2 units, IVIG.

Nursing Unit Staffing Plan & Scope of Service
Unit Name: Short Stay Unit
Date of HNSC Review: 5/22/2023
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

PROVIDENCE Portland Medical Center

Short Stay Unit Staffing Plan	
Scope of Service	• The Short stay unit (SSU) at Providence Portland Medical Center has 55 beds located in 3F. The SSU provides services to both Inpatients and Outpatients who require surgical and/or procedural care. The SSU serves patients ranging in age from 18 to 150 years old. The operation hours of the SSU are from 0530 on Monday through 1930 on Sunday. However, the department is closed from 1930 on Sunday until 0530 on Monday. • In the SSU, the caregivers consist of a nurse manager, assistant nurse manager, registered nurses (RNs), certified nursing assistants (CNAs), and health unit coordinators (HUCs). It is a mandatory requirement that all caregivers working in the SSU must have Basic Life Support (BLS) training. The new hire orientation of RN caregivers joining the SSU includes preoperative and postoperative care for Operating rooms (OR), Medical Procedure Unit (MPU), Diagnostic Imaging (DI), and Cardiovascular Lab (CVL). • The SSU offers preoperative and phase 2 postoperative care for patients undergoing surgical, MPU, DI, and CVL procedures. This care is provided to both outpatient and inpatient (excluding critical care patients). Our comprehensive service is based on a multidisciplinary approach that involves collaboration between the SSU caregivers, patients, their family and significant others, as well as medical staff affiliated with surgical services and other departments that play a critical role in care delivery. • As part of the service, the SSU RNs perform physical, psychological, and educational assessments to evaluate the patient's needs. They also coordinate pre- and post-procedural teaching, communicate results, and develop and coordinate a comprehensive plan of care for preoperative and postoperative periods. The effectiveness and outcome of any interventions are evaluated, and necessary referrals are made. The SSU RNs also assist anesthesiologists in performing nerve blocks at the bedside during preoperative care. Currently, the SSU provides care exclusively to surgical patients, with the exception of critical care patients.

Specialized Qualifications, Competencies, and Skill Mix	• All registered nurses on Short Stay Unit complete "Oregon Region Onboarding Portfolio Perioperative Surgical Service RN" packet prior to delivering direct patient care. All CNA1 and CNA2s on Short Stay Unit complete "Oregon Region Onboarding Portfolio General Certified Nursing Assistant (CNA1/CNA2) Orientation" packet prior to delivering direct patient care. Any additional competencies will be completed when applicable clinical scenarios present. Registered Charge Nurses will not assign registered nurses independent patient assignment until mandatory competencies are met. • RN: See Registered Nurse job description • CNA: see CNA1 and CNA2 job description ***Law**: Be based on the qualifications and competencies of its nursing staff and provide for the skill and competency necessary to ensure health and safety of patients are met.*
Acuity & Admission, Discharge, Transfers	• The average length of time to Preop a patient is 55 minutes, postop a patient is 322 minutes. • Average Daily surgical and procedural cases is 83. • Data on pre-op and post-op times is collected through Epic and taken into consideration when assignments are made. ***Law:** Be based on a measurement of hospital unit activity (admissions, discharges, transfers) and time required for a direct care RN to complete admissions, transfers, and discharges* ***Process:** With UBC review and verify times for admissions, discharges, and transfers (measure activity relevant to your area). List times for each with a brief description of how data was collected and taken into consideration when assignments are made.*

Total Diagnosis and Nursing Staffing Requirement (complete list)	• Patients are admitted to Short Stay Unit with a variety of diagnoses, including:

DRG Name	Distinct Patient C
INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	221
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	196
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITHOUT CC/MCC	154
O.R. PROCEDURES FOR OBESITY WITHOUT CC/MCC	150
STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITHOUT CC/MCC	109
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	107
MAJOR CHEST PROCEDURES WITH CC	92
MAJOR CHEST PROCEDURES WITHOUT CC/MCC	91
GASTROINTESTINAL HEMORRHAGE WITH CC	90
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	87
STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH CC	87
INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH CC	76
SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC	66
GASTROINTESTINAL HEMORRHAGE WITH MCC	65
STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH MCC	63
AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITHOU	60
HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH CC	60
LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH CC	49
PANCREAS, LIVER AND SHUNT PROCEDURES WITH CC	48
HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITH MCC	43
OTHER VASCULAR PROCEDURES WITH CC	42
AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DIS	40
HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITHOUT MCC	40
REVISION OF HIP OR KNEE REPLACEMENT WITHOUT CC/MCC	40
CAROTID ARTERY STENT PROCEDURES WITHOUT CC/MCC	39
OTHER VASCULAR PROCEDURES WITH MCC	39
CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH MCC	34
KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITHOUT CC/MCC	34
MAJOR CHEST PROCEDURES WITH MCC	33
OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH MCC	32
HEART FAILURE AND SHOCK WITH MCC	32
INFECTIOUS AND PARASITIC DISEASES WITH O.R. PROCEDURES WITH MCC	32
MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREI	31
CERVICAL SPINAL FUSION WITH CC	30
LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH MCC	30
STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH MCC	30
HIP REPLACEMENT WITH PRINCIPAL DIAGNOSIS OF HIP FRACTURE WITH MCC	29
CAROTID ARTERY STENT PROCEDURES WITH CC	28
KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH CC	28
OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH CC	27
UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITHOUT CC/MCC	27
ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS V	26
PANCREAS, LIVER AND SHUNT PROCEDURES WITH MCC	25
COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITH CC	24
KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITHOUT CC/MCC	24
LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITHOUT CC/MCC	24
LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR W	24
MAJOR MALE PELVIC PROCEDURES WITHOUT CC/MCC	24
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	24
KIDNEY AND URETER PROCEDURES FOR NON-NEOPLASM WITH MCC	23
PANCREAS, LIVER AND SHUNT PROCEDURES WITHOUT CC/MCC	23
TRACHEOSTOMY FOR FACE, MOUTH AND NECK DIAGNOSES OR LARYNGECTOMY W	23
CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH MCC	23

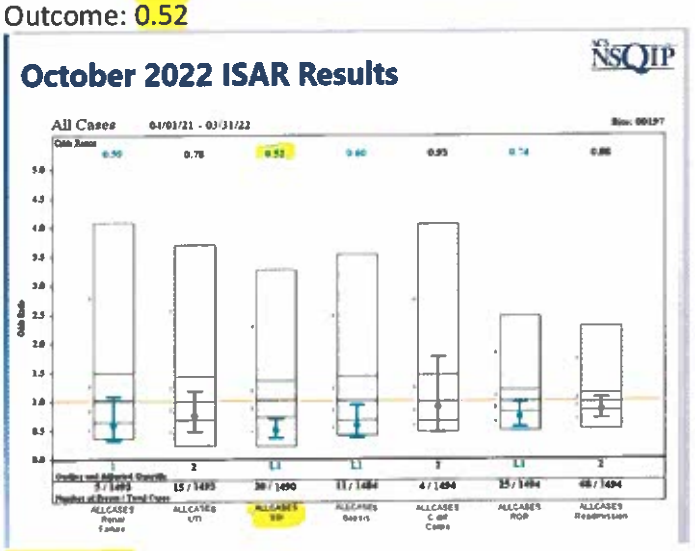
BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH CC	22
POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS WITH O.R. PROCEDURES WITH	22
ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE WITH MCC	22
REVISION OF HIP OR KNEE REPLACEMENT WITH CC	21
CIRRHOSIS AND ALCOHOLIC HEPATITIS WITH MCC	21
DIGESTIVE MALIGNANCY WITH MCC	21
LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH CC	21
KIDNEY AND URETER PROCEDURES FOR NEOPLASM WITH CC	20
OTHER O.R. PROCEDURES FOR INJURIES WITH CC	20
O.R. PROCEDURES FOR OBESITY WITH CC	19
OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES	19
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	19
UTERINE AND ADNEXA PROCEDURES FOR NON-MALIGNANCY WITH CC/MCC	19
UTERINE AND ADNEXA PROCEDURES FOR OVARIAN OR ADNEXAL MALIGNANCY WI	19
CRANIOTOMY WITH MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PRINCIPAL	18
EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	18
MAJOR HEAD AND NECK PROCEDURES WITHOUT CC/MCC	18
DISORDERS OF THE BILIARY TRACT WITH CC	18
OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH CC	17
MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS WITH MCC	17
MAJOR HEAD AND NECK PROCEDURES WITH CC	16
ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DIGESTIVE DISORDERS V	16
HIP AND FEMUR PROCEDURES EXCEPT MAJOR JOINT WITHOUT CC/MCC	15
OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH MCC	15
OTHER O.R. PROCEDURES FOR INJURIES WITH MCC	15
OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	15
DISORDERS OF LIVER EXCEPT MALIGNANCY, CIRRHOSIS OR ALCOHOLIC HEPATITI	15
OTHER DIGESTIVE SYSTEM DIAGNOSES WITH CC	15
OTHER DIGESTIVE SYSTEM DIAGNOSES WITH MCC	15
COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITHOUT CC/MCC	14
EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH CC	14
OTHER VASCULAR PROCEDURES WITHOUT CC/MCC	14
PERITONEAL ADHESIOLYSIS WITH CC	14
DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH MCC	14
MAJOR SMALL AND LARGE BOWEL PROCEDURES WITH MCC	14
AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB AND T	13
AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DIS	13
ECMO OR TRACHEOSTOMY WITH MV >96 HOURS OR PRINCIPAL DIAGNOSIS EXCEPT	13
HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITH MCC	13
LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR W	13
SPINAL PROCEDURES WITH CC OR SPINAL NEUROSTIMULATORS	13
DISORDERS OF THE BILIARY TRACT WITH MCC	13
LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITH MCC	13
AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORI	12
AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITH MC	12
CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT C/	12
EXTRACRANIAL PROCEDURES WITHOUT CC/MCC	12
HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITH CC	12
MAJOR JOINT OR LIMB REATTACHMENT PROCEDURES OF UPPER EXTREMITIES	12
OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH MCC	12
EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH MCC	12
MAJOR ESOPHAGEAL DISORDERS WITH MCC	12
OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH MCC	12
CERVICAL SPINAL FUSION WITHOUT CC/MCC	11

COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION WITH MCC	11
CRANIOTOMY AND ENDOVASCULAR INTRACRANIAL PROCEDURES WITH CC	11
LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITHOUT CC/MCC	11
MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WI1	11
OTHER MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE O.R. PROCEDURES	11
OTHER O.R. PROCEDURES FOR INJURIES WITHOUT CC/MCC	11
SOFT TISSUE PROCEDURES WITH CC	11
UTERINE AND ADNEXA PROCEDURES FOR NON-OVARIAN AND NON-ADNEXAL MALI	11
AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS EXCEPT UPPER LIMB AND T	10
LYMPHOMA AND LEUKEMIA WITH MAJOR O.R. PROCEDURES WITH CC	10
MAJOR MALE PELVIC PROCEDURES WITH CC/MCC	10
MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WI1	10
POSTPARTUM AND POST ABORTION DIAGNOSES WITH O.R. PROCEDURES	10
COMPLICATED PEPTIC ULCER WITH MCC	10
COMPLICATIONS OF TREATMENT WITH MCC	10
INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION WITH MCC	10
LAPAROSCOPIC CHOLECYSTECTOMY WITHOUT C.D.E. WITHOUT CC/MCC	10
AMPUTATION FOR MUSCULOSKELETAL SYSTEM AND CONNECTIVE TISSUE DISORI	9
CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT C	9
CELLULITIS WITHOUT MCC	9
CERVICAL SPINAL FUSION WITH MCC	9
MAJOR BLADDER PROCEDURES WITH CC	9
MAJOR HEAD AND NECK PROCEDURES WITH MCC	9
MINOR SMALL AND LARGE BOWEL PROCEDURES WITH CC	9
MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS WI1	9
OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	9
OTHER DIGESTIVE SYSTEM O.R. PROCEDURES WITH CC	9
OTHER SKIN, SUBCUTANEOUS TISSUE AND BREAST PROCEDURES WITH MCC	9
SPINAL PROCEDURES WITHOUT CC/MCC	9
CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITH M	9
INTERSTITIAL LUNG DISEASE WITH MCC	9
STOMACH, ESOPHAGEAL AND DUODENAL PROCEDURES WITH CC	9
ADRENAL AND PITUITARY PROCEDURES WITHOUT CC/MCC	8
BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITHOUT CC/MCC	8
CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT C	8
HERNIA PROCEDURES EXCEPT INGUINAL AND FEMORAL WITHOUT CC/MCC	8
LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES EXCEPT HIP AND F	8
LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR W	8
NON-EXTENSIVE O.R. PROCEDURES UNRELATED TO PRINCIPAL DIAGNOSIS WITH M	8
OTHER ENDOCRINE, NUTRITIONAL AND METABOLIC O.R. PROCEDURES WITH MCC	8
OTHER KIDNEY AND URINARY TRACT PROCEDURES WITH CC	8
PERITONEAL ADHESIOLYSIS WITH MCC	8
RECTAL RESECTION WITHOUT CC/MCC	8
SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFEC	8
SPINAL PROCEDURES WITH MCC	8
TRANSURETHRAL PROCEDURES WITH CC	8
CARDIAC ARRHYTHMIA AND CONDUCTION DISORDERS WITH CC	8
DIGESTIVE MALIGNANCY WITH CC	8
DISORDERS OF PANCREAS EXCEPT MALIGNANCY WITH CC	8
MAJOR ESOPHAGEAL DISORDERS WITH CC	8
OTHER CIRCULATORY SYSTEM DIAGNOSES WITH MCC	8
SEPTICEMIA OR SEVERE SEPSIS WITH MV >96 HOURS	8
SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	8
ANAL AND STOMAL PROCEDURES WITH CC	7

	• Short Stay Unit admissions are not limited to these disease entities; however, they are the most common. ***Law:*** *Be based on total diagnoses for each hospital unit and nursing staff required to manage these diagnoses.*
National Standards	• This staffing plan is consistent with the evidence-based standards and guidelines established by the by the Society of Perianesthesia Nursing (ASPAN) (2021) including date of the standard. • SCAN ME) ***Reference:*** *Look for Nationally Recognized Standards that pertain to your area. Think about what certifications are applicable in your department and use that as the national standard. Make sure to sight your source properly.*
Acuity & Nursing Care Intensity	• Patient conditions that may contribute to a higher level of acuity and/or intensity on Short Stay Unit include but are not limited to: See attached acuity tool ***Law:*** *Must recognize differences in acuity and nursing care intensity* *Process: Work with unit UBC validate and update acuity and intensity tool for your unit population.*
Minimum Staffing Guidelines	• When one patient is present on Short Stay Unit, there are two RNs and one other nurse staff member. ***Law (Part 1)****: Staffing Plan must provide that no fewer than one registered nurse and one other nurse staffing member is on duty in a unit when a patient is present. If your unit does not meet this minimum requirement the need to have a waiver, reference the waver. See Appendix A* ***Law (Part 2)****: Minimum number of nursing staff required on specified shifts* *(Place Guideline (Grid) in Appendix B*

Process for Evaluating & Initiating Limitations on Admissions	Nurse Initiated Divert Request Policy:
	POLICY STATEMENT
	• A Registered Nurse (RN) may initiate a conversation regarding the hospital diversion of a patient or placing the unit on diversion if in their professional judgment:
	  ☐ Individual and/or aggregate patient needs and requirements for nursing care exceed current resources.
	  ☐ Situations where the skill mix, or the competency of the staff do not meet the nursing care needs of the patient.
	• The RN is to contact the unit Registered Charge Nurse, RN Manager, and/or House Supervisor to escalate their concerns for patient safety.
	• The registered charge nurse, RN manager and the house supervisor will work together to secure resources for the department or patient in need. If this team is unable to meet the patient care need the House Supervisor will escalate the concern to the Chief Nursing Officer or designee to make a decision about:
	• Diverting the patient from the facility by contacting the sending facility to admit the patient to another qualified facility
	• Placing the hospital on EMS diversion status
	• If the admission was requested from an external source, the House Supervisor will document the reason for the diversion and reasons for denial of admission.
	• If the patient is diverted the House Supervisor will document the event and decisions made by the team. In these situations, we would huddle with leaders and consider transfers to other hospitals or other viable options to address concerns (i.e. cancelling elective surgeries
	
	https://phs-orppmc.policystat.com/policy/3171383/latest/
	
	Law: *Include process for evaluating and initiating limitations on admission or diversion of patients to another hospital*

Considers non-direct care tasks including Meal and Breaks	• Meal and rest breaks will be scheduled and assigned each shift. Schedules for meal and rest periods will be compliant with BOLI requirements, the Collective Bargaining agreement, and minimum staffing for Short Stay Unit. • Registered Charge Nurses, Nursing Supervisors, and Nurse Managers assist to facilitate and support meal and rest breaks. • In Short Stay unit, there are many staggered shifts that consist of caregivers specifically assigned to provide meal breaks for other caregivers.

Patient Outcomes	SSI Goal: O/E <1.0 Outcome: 0.52  ***Key Point:*** *Data should be for 12-month span. Make sure to include comparative data with like areas (national goals).*
Unit of service	• Target Worked Hours per Unit = 1.46 • Budget Volume = 304,546.81 per month **Law:** This may be HPPD, midnight census, number of cases, etc. **Key Point:** make sure to include comparative data with like areas
References	Donna M. DeFazio Quinn & Lois Schick. (2023). *Practice Recommendation: Patient Classification/Staffing Recommendations*. American Society of Paranesthesia Nurses. Retrieved April 4, 2023, from PR_Patient_Classification_Staffing_Recommendations.pdf (aspan.org)
Attachments	• Appendix A: Staffing Guidelines • Appendix B: Minimum Staffing Guidelines for Lunches/Breaks • Appendix C: Acuity and Intensity Tool

Unit Staff Input & HNSC Approval Vetting Process Checklist	☐ Unit staffing committee (if unit has one): NA ☒ Unit staff meeting: 4/20/2023 ☒ Unit based council: 4/10/2023 ☒ Available on unit and huddle topic for 30 days, and sent electronically to staff: 4/12-5/12/2023 • Names of staff who presented to HNSC: Emily Barnes • Date recommended by unit/division to HNSC: 5/22/2023 • Signature of Manager: Kelly Kong • Signature of Unit Staffing Committee Representative: Denise Devoe

Nursing Unit Staffing Plan & Scope of Service
Unit Name: Short Stay Unit
Date of HNSC Review: 5/22/2023
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

Appendix A — SSU Staffing Guideline

Unit: Short Stay Unit — **Target Worked Hours per Total Minute 1.46**

	DAY SHIFT				NOC SHIFT							
Census	Charge RN	RNs	CNAs	Total # Staff	Charge RN	RNs	CNAs	Total # Staff	Total Worked Hours	Total Patient Minutes	Worked hr/ total min	Variance
1	1	1	0	2	1	1	0	2	96	1440	6.6666667	5.2066667
2	1	1	0	2	1	1	0	2	96	2880	3.3333333	1.8733333
3	1	1	1	3	1	1	0	2	120	4320	2.7777778	1.3177778
4	1	2	0	3	1	1	1	3	144	5760	2.5	1.04
5	1	2	1	4	1	1	1	3	168	7200	2.3333333	0.8733333
6	1	3	1	5	1	1	1	3	192	8640	2.2222222	0.7622222
7	1	3	1	5	1	1	1	3	192	10080	1.9047619	0.4447619
8	1	4	1	6	1	2	1	4	240	11520	2.0833333	0.6233333
9	1	4	2	7	1	2	1	4	264	12960	2.037037	0.577037
10	1	5	2	8	1	2	1	4	288	14400	2	0.54
11	1	5	2	8	1	3	1	5	312	15840	1.969697	0.509697
12	1	6	2	9	1	3	1	5	336	17280	1.9444444	0.4844444
13	1	6	2	9	1	3	1	5	336	18720	1.7948718	0.3348718
14	1	7	2	10	1	3	1	5	360	20160	1.7857143	0.3257143
15	1	7	2	10	1	4	1	6	384	21600	1.7777778	0.3177778
16	1	8	2	11	1	4	2	7	432	23040	1.875	0.415
17	1	9	2	12	1	5	2	8	480	24480	1.9607843	0.5007843
18	1	10	2	13	1	5	2	8	504	25920	1.9444444	0.4844444
19	1	10	2	13	1	5	2	8	504	27360	1.8421053	0.3821053
20	1	11	2	14	1	5	2	8	528	28800	1.8333333	0.3733333
21	1	11	3	15					360	30240	1.1904762	-0.269524
22	1	12	3	16					384	31680	1.2121212	-0.247879
23	1	12	3	16					384	33120	1.1594203	-0.30058
24	1	13	3	17					408	34560	1.1805556	-0.279444
25	1	13	3	17					408	36000	1.1333333	-0.326667
26	1	14	3	18					432	37440	1.1538462	-0.306154
27	1	14	3	18					432	38880	1.1111111	-0.348889
28	1	15	3	19					456	40320	1.1309524	-0.329048
29	1	15	3	19					456	41760	1.091954	-0.368046
30	1	16	4	21					504	43200	1.1666667	-0.293333
31	1	16	4	21					504	44640	1.1290323	-0.330968
32	1	17	4	22					528	46080	1.1458333	-0.314167
33	1	17	4	22					528	47520	1.1111111	-0.348889
34	1	18	4	23					552	48960	1.127451	-0.332549
35	1	18	4	23					552	50400	1.0952381	-0.364762
36	1	19	4	24					576	51840	1.1111111	-0.348889
37	1	19	4	24					576	53280	1.0810811	-0.378919
38	1	20	4	25					600	54720	1.0964912	-0.363509
39	1	20	4	25					600	56160	1.0683761	-0.391624
40	1	21	5	27					648	57600	1.125	-0.335
41	1	21	5	27					648	59040	1.097561	-0.362439
42	1	22	5	28					672	60480	1.1111111	-0.348889
43	1	23	5	29					696	61920	1.124031	-0.335969
44	1	23	5	29					696	63360	1.0984848	-0.361515
45	1	24	5	30					720	64800	1.1111111	-0.348889
46	1	24	5	30					720	66240	1.0869565	-0.373043
47	1	25	5	31					744	67680	1.0992908	-0.360709
48	1	25	5	31					744	69120	1.0763889	-0.383611
49	1	26	5	32					768	70560	1.0884354	-0.371565
50	1	26	5	32					768	72000	1.0666667	-0.393333
51	1	27	5	33					792	73440	1.0784314	-0.381569
52	1	27	5	33					792	74880	1.0576923	-0.402308
53	1	28	5	34					816	76320	1.0691824	-0.390818
54	1	28	5	34					816	77760	1.0493827	-0.410617
55	1	29	5	35					840	79200	1.0606061	-0.399394

PROVIDENCE Portland Medical Center

Nursing Unit Staffing Plan & Scope of Service
Unit Name: Short Stay Unit
Date of HNSC Review: 5/22/2023
Status: **This Staffing Plan remains in effect through deliberation and arbitration if needed as of 5/30/2024**

Appendix B — SSU Minimum Staffing Guideline

Unit: Short Stay Unit — **Target Worked Hours per Total Minu 1.46**

	DAY SHIFT				NOC SHIFT							
Census	Charge RN	RNs	CNAs	Total # Staff	Charge RN	RNs	CNAs	Total # Staff	Total Worked Hours	Total Patient Minutes	Worked hr/ total min	Variance
1	1	0	1	2	1	0	1	2	96	1440	6.66666667	5.20666667
2	1	0	1	2	1	0	1	2	96	2880	3.33333333	1.87333333
3	1	0	1	2	1	0	1	2	96	4320	2.22222222	0.76222222
4	1	1	0	2	1	1	0	2	96	5760	1.66666667	0.20666667
5	1	1	0	2	1	1	0	2	96	7200	1.33333333	-0.1266667
6	1	2	1	4	1	1	1	3	168	8640	1.94444444	0.48444444
7	1	2	1	4	1	1	1	3	168	10080	1.66666667	0.20666667
8	1	2	1	4	1	1	1	3	168	11520	1.45833333	-0.0016667
9	1	3	1	5	1	2	0	3	192	12960	1.48148148	0.02148148
10	1	3	1	5	1	2	1	4	216	14400	1.5	0.04
11	1	3	1	5	1	2	1	4	216	15840	1.36363636	-0.0963636
12	1	4	1	6	1	2	1	4	240	17280	1.38888889	-0.0711111
13	1	4	1	6	1	3	0	4	240	18720	1.28205128	-0.1779487
14	1	5	1	7	1	3	1	5	288	20160	1.42857143	-0.0314286
15	1	5	1	7	1	3	1	5	288	21600	1.33333333	-0.1266667
16	1	6	1	8	1	3	1	5	312	23040	1.35416667	-0.1058333
17	1	6	1	8	1	4	0	5	312	24480	1.2745098	-0.1854902
18	1	6	2	9	1	4	1	6	360	25920	1.38888889	-0.0711111
19	1	6	2	9	1	4	1	6	360	27360	1.31578947	-0.1442105
20	1	7	2	10	1	4	1	6	384	28800	1.33333333	-0.1266667
21	1	7	2	10					240	30240	0.79365079	-0.6663492
22	1	8	2	11					264	31680	0.83333333	-0.6266667
23	1	8	2	11					264	33120	0.79710145	-0.6628986
24	1	8	3	12					288	34560	0.83333333	-0.6266667
25	1	9	2	12					288	36000	0.8	-0.66
26	1	9	3	13					312	37440	0.83333333	-0.6266667
27	1	9	3	13					312	38880	0.80246914	-0.6575309
28	1	10	3	14					336	40320	0.83333333	-0.6266667
29	1	10	3	14					336	41760	0.8045977	-0.6554023
30	1	10	4	15					360	43200	0.83333333	-0.6266667
31	1	11	3	15					360	44640	0.80645161	-0.6535484
32	1	11	4	16					384	46080	0.83333333	-0.6266667
33	1	11	4	16					384	47520	0.80808081	-0.6519192
34	1	12	4	17					408	48960	0.83333333	-0.6266667
35	1	12	4	17					408	50400	0.80952381	-0.6504762
36	1	12	4	17					408	51840	0.78703704	-0.672963
37	1	13	4	18					432	53280	0.81081081	-0.6491892
38	1	13	4	18					432	54720	0.78947368	-0.6705263
39	1	13	4	18					432	56160	0.76923077	-0.6907692
40	1	14	5	20					480	57600	0.83333333	-0.6266667
41	1	14	5	20					480	59040	0.81300813	-0.6469919
42	1	14	5	20					480	60480	0.79365079	-0.6663492
43	1	15	5	21					504	61920	0.81395349	-0.6460465
44	1	15	5	21					504	63360	0.79545455	-0.6645455
45	1	15	5	21					504	64800	0.77777778	-0.6822222
46	1	16	5	22					528	66240	0.79710145	-0.6628986
47	1	16	5	22					528	67680	0.78014184	-0.6798582
48	1	16	5	22					528	69120	0.76388889	-0.6961111
49	1	17	5	23					552	70560	0.78231293	-0.6776871
50	1	17	6	24					576	72000	0.8	-0.66
51	1	17	6	24					576	73440	0.78431373	-0.6756863
52	1	18	6	25					600	74880	0.80128205	-0.6587179
53	1	18	6	25					600	76320	0.78616352	-0.6738365
54	1	18	6	25					600	77760	0.77160494	-0.6883951
55	1	19	6	26					624	79200	0.78787879	-0.6721212

Appendix C SSU Patient Acuity & Intensity of Nursing Work (Adapted from Malloch, 2000)

Population: SSU Postop patients
Rating Scale 1 = Normal Function/Status 5 = Very Abnormal/ Disrupted/Unstable

Focus		1	2	3	4	5	Score
Comfort	Acuity	No expressed or observed discomfort	Episodic mild discomfort	Episodic moderate pain/discomfort	Very frequent serious pain/discomfort	Intense pain on nearly continuous basis with physical response (Nausea)	
	Intensity	None	Oral meds and nursing measures effective	Assistance and/or q2-4 hours plus nursing measures	Assistance and/or oral and IV for pain; Frequent nursing measures	Oral/IV/IM meds: nearly continuous nursing care	
Treatments, Tasks, Interventions	Intensity	Very few	Oral meds; simple dressings	Simple but frequent, or complex infrequent	complex medical nursing interventions; technology required	Multiple, and/or continuous, complex medication and nursing interventions,	
Total Score							

Scale:
3-6 Low
7-9 Medium
10-15 High

* **Acuity** – the complexity of patient care needs requiring the skill and the care of nursing staff.
* **Intensity** – the level of patient need for nursing care as determined by the nursing assessment