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How to Build a Better Staffing Plan

Jordan Ferris BSN, RN, CMSRN

Tonya Tittle MSN, RN

Nursing Practice Consultants

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Objectives

- Identify and verbalize what a staffing plan is.
- Identify measures from SB 469 to include in staffing plans.
- Verbalize resources available to create a robust staffing plan.

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The Staffing Law

- Passed in July 2015
- Put additional limits on work hour limits and overtime
- Beefed up staffing committees
- Made certain new elements mandatory in staffing plans

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The Elements

Based on specialized qualifications and competencies of nursing staff:

- **new grads**
- **new hires without certain certs**
  - ACLS
  - NLRP
  - TNCC
  - PALS

All those “within 6 months of hire” certifications”

The ratio of all these should change your staffing plans

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The Elements, cont.

Must take admissions, discharges, transfers and how long it takes to complete them into account:

- How long does it take you to do an admit?
- How long does a DC take?
- How long does it take for a simple v. complex A/D/T?

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The Elements, cont.

Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses

- Morbidly obese patients
- Vented patients
- Isolation patients
- Withdrawal/addiction patients
- What is your patient population?

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The Elements, cont.

Consistent with nationally recognized evidence based standards and guidelines established by professional nursing specialty organizations

- Look at your organization for a position statement or white paper
- ANA is developing guidelines

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Additional Resources

Professional Nursing Associations	*Abbreviation*	*Website*
Academy of Medical-Surgical Nurses	AMSN	www.medsurgnurse.org
American Association of Critical Care nurses	AACN	www.aacn.org
American Association of Neuroscience Nurses	AANN	www.aann.org
American Association of Spinal Cord Injury Nurses	AASCIN	www.aascin.org
American Nephrology Nurses; Association	ANNA	www.annanurse.org
American Nurses Association	ANA	www.nursingworld.org
American Organization of Nurse Executive	AONE	www.aone.org/aone/about/home.html
American Psychiatric Nurses Association	APNA	www.apna.org
American Society of PeriAnesthesia Nurses	ASPAN	www.aspan.org
American Society of Plastic Surgical nurses	ASPSN	www.aspsn.org
Association of Child Neurology Nurses	ACNN	www.acnn.org
Association of Pediatric Gastroenterology and Nutrition Nurses	APGNN	www.apgnn.org
Association of Pediatric Hematology/Oncology Nurses	APHON	www.apon.org
Association of periOperative Registered Nurses	AORN	www.aorn.org
Association of Rehabilitation Nurses	ARN	www.rehabnurse.org
Association of Women's Health, Obstetric and Neonatal Nurses	AWHONN	www.awhonn.org
Emergency Nurses Association	ENA	www.ena.org

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The Elements

Must include a formal process for evaluating and initiating limitations on admissions or diversion of patients when in the judgment of a direct care nurse or manager there is an inability to meet patient care needs or a risk of harm to patients

- Could be a statement
- Could be a flowsheet or algorithm

Good phrase to use “the safety threshold has been met…”

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The Elements

Must consider tasks not related to providing direct care including:

- Meals
- Rest breaks
- Charting
- What do you think are additional things we could add?

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Staffing Plan Example
Medical Surgical Unit

PATIENT POPULATION & NURSING CARE PROVISION	ESSENTIAL STAFFING & EVALUATION PROCESS	STAFFING FOR ACUITY	STANDARDS AND QUALITY

Nursing care is provided for general medical and surgical patients, and stable pediatric patients (>50kg, 14yo and older). The age groups served are pediatric, adult, and geriatric. There are 42 beds on the unit with approximately 8 overflow beds.
 	
General medical and surgical patients include general surgery, gastroenterology, gynecology, urology, neurology, spinal surgery care, pulmonology, orthopedic, vascular, cardiac, cardiac telemetry, endocrinology, oncology, stroke care, hospice, and other Med/Surg entities.
 	
Primary Nursing Services Provided:
▪ Acute illness care
▪ Telemetry monitoring
▪ Pre and postoperative care
▪ Wound care, including wound vacs
▪ IV infusion therapy
▪ Parenteral nutrition
▪ Palliative/End of Life care
▪ Medication administration
▪ Patient /family education
▪ Psychosocial care and support
▪ Coordination of patient care and collaboration with support services
▪ Assistance with activities of daily living (ADLs)—this includes bathing and hygiene, dressing, linen changes, ambulation, toileting, and HS care.
▪ Close observation for patients who require constant monitoring
▪ Care for the bariatric patient
▪ Medical care for antepartum and postpartum patients
 	
Services Not Provided:
▪ Ventilator support
▪ Titration vasoactive IV drugs
▪ Continuous antiarrhythmic IV drips (exception for Amiodarone)
▪ Management of Temporary Pacemaker
▪ Invasive hemodynamic monitoring
▪ Acute psychiatric therapy/seclusion
▪ Elective cardioversion
	The MedSurg unit provides registered nurses and CNAs, as well as a Health Unit Coordinator (nursing staff), to deliver patient care and carry out unit operations.
	
	All nurses on MedSurg are oriented and trained upon hire to the unit to demonstrate competency in the direct care of the aggregate patient population served. This is documented in the individual nursing staff member's orientation packet and kept on file. Each nursing staff member also receives annual skills training and review via education provided through HealthStream and skills fairs. This ensures the skill mix of the nursing staff on MedSurg is consistent among the individual nursing staff members.
	
	Minimum staffing will include one RN and one other nursing personnel when one patient is present.
	
	A staffing target of 9.66 HPPD is used to construct a staffing grid (see attached) for MedSurg this grid is used as a guideline for staffing the unit with a safe number of nursing staff at varying census levels.
	
	Charge nurses determine the number of staff for the oncoming shift and throughout the shift to ensure the amount of staff and appropriate skill mix are available to ensure safe patient care. Charge nurses track ADT data in four-hour segments throughout the shift, and this data is used to plan for adequate staff to care for expected admissions, transfers, and discharges. The use of "helping hands" nursing staff on MedSurg (including MHAs) can be used to facilitate safe patient care. Nurse staffing is also provided throughout the shift to accommodate meal and rest breaks for all staff on the unit; the goal each shift is to have staff on call in order to meet increases in patient volumes, patient acuity, and/or cover staff illness that occurs during the shift.
	
	The formal process for determining the ability for MedSurg to take admissions is initiated with a consideration for the acuity of the unit—this is determined based on the overall workload of the floor with respect to patient turnover (ADT), and from the direct care nurses' judgment on whether they are able to deliver safe patient care (defined by OAR 333-510-0002-9-a to j). If the acuity of the unit is determined to be high, MedSurg can bring in extra staff or limit the amount of patients to be admitted until the acuity decreases. MedSurg will use nursing staff from other departments who are cross-trained and/or otherwise qualified when a nurse is needed in the department and no other MedSurg nurses are available. Diversion of patients is to be avoided when possible.
	
	Diversion Process:
	▪ Plan ahead for placement of next admission; keep RN and CNA on call each shift; contact Staffing for additional staff as needed
	▪ Contact physicians for possible discharges
	▪ Call huddle with nursing departments to see if patients can be transferred or admitted to other units (temporarily or for duration of admission)
	▪ Collaborate with other nursing departments, managers and/or supervisors on divert options and decision-making
	▪ Initiate divert communication tree when placing MedSurg on divert (includes ED and ICU Charge RNs, Med/Surg managers, ED manager, Nurse Supervisor, Social Work Supervisor, and CNE).
		Staffing for acuity on MedSurg considers the following criteria (as listed in PH&S Oregon Region Nursing Staffing Plan Policy):
		▪ Complexity of patient's condition, assessment and required nursing care
		▪ Knowledge and skills required of nursing staff to provide care
		▪ Type of technology involved in patient care
		▪ Degree of supervision required of nursing staffing members
		▪ Infection control and safety issues
		▪ Continuity of patient care
		
		Patient conditions that contribute to a higher level of acuity on MedSurg include but are not limited to:
		▪ Frequent VS or CBG monitoring
		▪ Multiple IV medications
		▪ CIWA patient with high score
		▪ Dementia/delirium
		▪ Complicated wound care
		▪ Complicated family situation
		▪ Unstable patient
		▪ Bariatric patient
		▪ High fall risk
		▪ Pediatric patient
		▪ Suicide risk
		▪ Requiring dialysis
		▪ Insulin drip
		▪ Amiodarone drip
		▪ CBI
			Qualifications and Competencies:
			
			Charge Nurse: BLS, ACLS, PMAB, Medical/Surgical certification
			
			RN: BLS, EKG competency
			
			Nurse Practice Organization: Academy of Medical Surgical Nurses (AMSN). MedSurg Certification available through AMSN and ANCC.
			
			The annual quality evaluation process for this staffing plan is stipulated in the PH&S Oregon Region Nursing Staffing Plan Policy (PO-002-05-V4) in accordance SB 469 and accompanying Nurse Services Staffing OARs 333-510-0045.
			
			Quality Measures:
			▪ Patient falls
			▪ Missed nursing care
			▪ Medication errors
			▪ Pressure ulcers
			▪ Pain assessment & reassessment
			▪ CAUTI
			▪ Restraint use
			▪ CMS Core Measures:
			  ▪ Stroke
			  ▪ Heart failure
			  ▪ SCIP
			  ▪ Pneumonia
			  ▪ Acute MI
			▪ Staff injuries
			▪ HCAHPS
			▪ Hand washing
			▪ Press Ganey survey scores
			▪ Employee Engagement Survey
			▪ UOR data
			▪ SRDF data

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Staffing Plan Example
Intermediate Care Unit

Patient Population	Acuity Levels	Intensity of Unit and Care	Environmental Factors	Essential Staffing	Measurement Methods
Progressive Care /Intermediate Care/Direct Telemetry Unit for Cardiology, Cardiac surgery, Thoracic surgery, and Vascular surgery. Our patient population, on average, consists of approximately 45% Cardiology, 25% Cardiac surgery, 5 % Thoracic surgery, 13% Vascular surgery, and 7% Direct Telemetry for other services, as well as EMU/Epilepsy Monitoring Unit for 10K (4 beds). Remote telemetry monitoring for adult and pediatric acute care units at KPV, South Hospital and Doernbecher Hospitals 1. **Cardiology** a. ACS patients, pre- and post-catheterization care; Arterial line setup and monitoring; and sheath removal (requiring intensive nurse monitoring – see "Intensity of Unit and Care" for further explanation). b. ST- and Non ST- elevation myocardial infarction patients originally admitted to the CCU who demonstrate 12-24 hours of clinical stability (absence of recurrent ischemia, heart failure, or	Acuity varies widely by service and diagnosis, making 11K a dynamic and diverse population. Acuity tools have been trialed but currently the charge RN and manager manage the acuity level daily to ensure safe RN to patient ratios are maintained.	Out of a total of 30 beds on our unit, our average daily census is 28.5 patients. Our ADT rate is 30%. We have a mix of post-surgical patients, cardiac and post-catheterization patients. Our patients spend several days to weeks. Being an Intermediate Care Unit, patient acuity exceeds that of an acute care floor. All 11K RNs must have ACLS certification. I. **Cardiology** **a. General** Vital signs Q4 hours, but may be more frequent than is specified in Acute Care SOC. Interpretation of EKG rhythms Q4 hours, and management of cardiac versus non-cardiac chest pain, utilizing ACLS guidelines and	30 private patient rooms. 1 positive-pressure isolation room. All rooms accommodate 1 overnight guest. One RN station with decentralized work stations (pods) throughout unit. Family lounge available at end of the unit. Charting in or out of patient rooms. 2 Medication and supply rooms. 1 centralized clean equipment room, dirty utility room, and patient nourishment room. Each pt. Room equipped w/bar code scanning and vital signs integration devices. Most documentation	**Considerations:** 11K has a high ADT rate. There are many discharges (and admissions) during both shifts. High acuities and close working relationships with busy cardiac ICUs dictate frequent transfers. Being an Intermediate Care Unit for adults in the hospital, 11K is almost always full, caring for patients too ill for acute care, but stable enough to transfer out of the ICU. **Plan for Staffing:** The foundation of 11K's staffing plan is The Grid (see attached). On 11K direct patient HPPD is 9.65. The details of the grid are decided upon the following criteria: acuity, complexity, and patient safety by11K's UBNPC with Nurse Manager input. Important factors that affect our staffing needs	**Non-Clinical:** Incremental overtime Staff turnover Staff injury/sick time use **Clinical:** Hematoma monitoring in arterial line sheath removal (research project) CHF education monitoring (research project) Fall rate Pressure ulcer occurrence PSN reports Pain assessment and reassessment Chart audits

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ICU Staffing Plan Example

PATIENT POPULATION & CARE ENVIRONMENT	INTENSITY OF UNIT AND CARE	ACUITY LEVELS	ESSENTIAL STAFFING	STANDARDS AND QUALITY
Nursing care is provided for unstable adult medical and post surgical patients. Also limited outpatient procedures are provided. Most of the patient population consists of the following: ▪ Acute respiratory failure ▪ Sepsis syndromes ▪ Acute renal failure ▪ Hypertensive crisis ▪ DKA ▪ Drug overdose/ Suicide Ideation ▪ Severe gastrointestinal bleeding ▪ Acute Coronary Syndromes ▪ CVA,CNS infections, seizures ▪ Unstable post-surgical patients ▪ S/P vascular surgery, Abdominal Aortic Aneurysm ▪ Cardiac Arrest ▪ Serious fluid, electrolyte and metabolic disorders ▪ Multiple system organ failure ▪ Life threatening infections ▪ Complex high risk antepartum and postpartum patients ▪ Major Abdominal Surgery ▪ Severe Delirium Outpatient procedures include: ▪ TEE ▪ Cardioversion **Environment of Care:** One open floor plan with 8 patient rooms that surround the nursing station. The unit has a locked entrance. Two rooms are negative air pressure rooms for isolation as needed. Four of the patient rooms have overhead patient lift systems in place. All rooms are dialysis ready.	The ICU is an eight bed adult and geriatric Medical-Surgical Intensive Care Unit. Care is provided 24 hours per day, 7 days per week. The ICU specializes in: ▪ Cardiac monitoring ▪ Ventilator support ▪ Vasoactive gtts ▪ Temporary Pace Makers ▪ Antiarrythmic gtts ▪ Conscious sedation ▪ Hemodynamic monitoring One ICU nurse must respond to a Rapid Response. The ICU will also staff in order to have a crash bed available for any inpatient adult that deteriorates and needs critical care. Whether a nurse is called in when a crash patient is admitted is dependent on the acuity of the unit at the time and is determined through collaboration between the ICU charge nurse, and the requesting unit charge nurse. The ICU will admit house convenience patients on a case-by-case process. Appropriateness of admission to this unit is guided by the "Admission, Discharge, and Transfer Criteria" PH&S Oregon Region Nursing Policy for Critical Care. Multidisciplinary rounds on ICU patients are done Monday through Friday using a systematic format for review.	**ICU Core Staffing Patterns** Care is provided to patients following the American Association of Critical Care Nurses (AACN) Scope & Standards for Acute and Critical Care Nursing Practice. The AACN Synergy Model is incorporated into the decision of acuity levels and staffing. The condition of the critically ill patient can rapidly fluctuate. Relying on the above staffing ratios alone can ignore variance in patient needs and acuity (see AACN Staffing). Unit ICU | 24/7 RN | Budget hrs 20.91 NHPPD Census | RNs 1 | 2 | 48 2 | 2 | 24 3 | 2-3 | 16 4 | 2-3 | 18 5 | 3-4 | 19.2 6 | 3-4 | 16 7 | 4-5 | 17.1 8 | 4-5 | 15 The Charge RN utilizes the acuity guidelines to make patient assignments. **Acuity tool (nurse to patient ratio)**: **2:1** – Massive Transfusion Protocol, Newly admitted Intensivist patient only if necessary **1:1** – Hypothermia Protocol during cooling and warming period, hemodynamically unstable requiring multiple pressors being titrated up or interventions q 15min, neurologically unstable requiring assessment and intervention q 15 min, high frequency oscillating ventilation, proning, organ donation preparation, persistently agitated patient at risk of self-harm or harm to others, unrecovered patients who are unstable, anticipated trips off unit **1:2** – Typical ICU patient assignment **1:3** – house convenience If the patient census is zero it will be staffed with one RN on the unit and the remaining staff on call.	The ICU core staffing is 3 RNs for each shift. Staff is supported by the Nurse Manager, Hospitalists, Attending Physicians, respiratory therapists, pharmacists, IV therapy, orderly, dietician, Social Services, Spiritual care and rehab therapies. Charge nurse making staffing decisions for the oncoming shift must consider the possible need of specific treatment modalities to ensure that the right skill mix is achieved in the case of staff cancellation or sick calls. Census and acuity fluctuations are managed by bringing in more or less nurses to care for the number of patients present and expected. If there are three nurses in the ICU, the provision of rests and meal breaks is done on a rotation among the nurses with at least two nurses remaining on the unit. If there are two nurses staffed in the unit, the Nurse Supervisor and/or IVT provides breaks to ensure there are still two nurses in the unit. In case of staffing issues that are problematic, the nurse has a chain of command to follow: ▪ Charge Nurse→ Manager /Nursing Supervisor → CNO/Admin On Call Staffing issues are dealt collaboratively between manager, staff, and staffing office. Additional staffing may be obtained from the following: ▪ Regular ICU staff working extra ▪ Per diem ICU RNs ▪ M/S RNs ▪ ICU Cross-trained nurses ▪ Helping Hands staff ▪ RN Supervisors ▪ IVT RNs ▪ Nurse Staffing Agencies and sharecare Diversion of patients is handled on a case by case basis depending on resources available and skill mix of staff. If the unit has no beds available due to maximum capacity of beds or available staffing, the charge nurse contacts the manager during the day, supervisor at night, ED and Med/Surg charge nurses to determine a plan. Collaboration is done with other departments to accommodate safe patient throughput (admits, transfers, discharges), and to prevent critical care diversion when possible.	All RNs are BLS, ACLS and moderate sedation certified. All RNs are PMAB trained. Core Charge nurses are required to be CCRN certified. Clinical measures are collected and reviewed at Quality Committee annually and Critical Care Committee every other month. **Quality Measures:** ▪ Patient falls ▪ Missed nursing care ▪ Medication errors ▪ Pressure ulcers ▪ Pain assessment & reassessment ▪ CAUTI ▪ Restraint use ▪ VAP rates ▪ CLABSI ▪ CMS Core Measures: ▪ Stroke ▪ Heart failure ▪ SCIP ▪ Pneumonia ▪ Acute MI ▪ Staff injuries ▪ HCAHPS ▪ Hand washing ▪ Press Ganey survey scores ▪ Employee Engagement Survey ▪ UOR data ▪ SRDF data The annual quality evaluation process for this staffing plan is stipulated in the PH&S Oregon Region Nursing Staffing Plan Policy (PO-002-05-V4) in accordance SB 469 and accompanying Nurse Services Staffing OARs 333-510-0045.

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Major Elements of a Nurse Staffing Plan A nurse staffing plan aligns human resources (e.g. staff numbers, skills, experience and credentials) with patient needs. The plan should incorporate staff input, with nurses having significant control over their own practice.	***Compliance Y/N***
Plan Fundamentals	
1. Does the staffing plan advance the organizations mission of delivering quality care by - Emphasizing patient safety? - Setting optimum patient-to-nurse ratios? - Accounting for variations among units and services? - Identifying staffing constraints within the hospital's regions, such as the number and qualifications of available nursing candidates? - Supporting the care delivery model utilized in nursing units, such as a primary or team-based care model? - Complying with human resources policies and procedures?	
2. Does the staffing plan focus on improving quality of patient care, clinical outcomes, staff retention and job satisfaction?	
3. Are staffing patterns and support based on patient volume, acuity and needs?	
4. Does the staffing plan accommodate budgetary realities without compromise patient care?	
5. Is the staffing plan in strict compliance with federal, state and local staffing laws and/or regulations?	
Plan components	
1. Does the staffing plan define the following terms? - Nursing staff - Assistive nursing personnel - Direct and indirect patient care activities - Patient acuity - Complexity of care - Quality of care - Retaliatory action - Hospital workweek	
2. Does the staffing plan identify the needs of each unit, ward and service department by analyzing the following criteria? - Patient population and average daily census - Patient acuity - Length of stay - Specialty needs - Physical environment and available technology - Staff competences and skill mix - Specialty certification or training of nursing personnel - Availability of specialized or intensive care equipment - Nursing-sensitive outcomes - Evidence-based staffing standards	
3. Does the staffing plan articulate optimal nurse-to-patient ratios, required skills, staffing models (such as primary care or team approach) and resources for each unit, ward and/or service department?	
4. Does the staffing plan utilize an evidence-based method for calculating work hours, such as the following? surgical procedure or other type of service)	
5. Does the plan prohibit working more than 48 hours in a hospital-defined workweek?	
6. Does the plan prohibit working more than 12 hours in a 24-hour period?	
1. Does the plan prohibit requiring an RN, licensed practical nurse or certified nursing assistant from working beyond an agreed shift in non-emergency situations?	
2. Are exceptions to overtime prohibitions – including natural disasters, facility emergencies and situations where a patient could be harmed due to the lack of a replacement nurse at the end of the shift- clearly defined in written policy?	
3. Is time spent on orientation, training sessions and educational and required meetings considered hours worked?	
4. Is time spent on-call or on standby while on hospital premises considered hours worked?	
5. Does the staffing plan allow for some fluctuation in nurse availability by shift and day, based on variations in census and patient are requirements?	
6. Does the plan provide options for nurses when staffing arrangements are inadequate, such as authorization to call agency nurses if needed?	
7. Is a skills mix evaluation performed whenever an outside agency nurse is retained?	
8. Are criteria for voluntary and mandatory overtime delineated, and are occurrences noted on an overtime approval form?	
9. Does the plan outline corrective actions to be taken when staffing parameters are not satisfied?	
Plan Distribution and Posting	
1. Is a copy of the staffing plan and any subsequent changes provided to each member of the hospital's nursing staff free of charge?	
2. Is a notice posted in a conspicuous location informing the public that the staffing plan is available and explaining how to obtain a copy?	
3. Is the following information posted on each unit: annual staffing plans, patient census, shift-based and total clinical staff numbers, and the name of the nursing supervisor on duty?	
Plan audit and review	
1. If negative trends in inpatient care outcomes or nurse well-being emerge, does the staffing plan dictate more frequent data review and creation of an action plan to address the problem(s)?	
2. Does the staffing plan require the measurement of the following nursing sensitive indicators, among others? - Nosocomial infections - Patient falls - Pressure ulcer rate - Pain assessment and intervention - Restraint use - Peripheral intravenous infiltration - CAUTIs - CLABSIs - Failure to rescue events - 30-day mortality - Longer hospital stays	
3. Are actual staffing levels evaluated periodically, using patient outcomes and benchmarking data?	
4. Is the use of mandatory overtime regularly evaluated?	
5. Are efforts made to reduce the need for overtime by improving staffing policies?	
6. Are the following nurse staffing trends evaluated on an ongoing basis? - Utilization of supplemental staffing - Nurse job satisfaction, including such critical areas as working conditions, compensation and benefits	

Staffing Plan Checklist(s)

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Unit-Specific Staffing Plan Review Checklist - 2015

Unit: _____

- ☐ Scope of Service
  - Patient population served
  - Types of procedures performed
  - Hours of operation
  - Units of service budget references (hospital days, number of cases, case length, etc)

- ☐ Identification of individual patient needs in order to create meaningful care
- ☐ Nurse staffing is based on specialized qualifications and competencies of nursing staff
- ☐ Minimum number of staff
- ☐ Skill mix of caregivers (RNs, LPNs, CNAs)
- ☐ Patient acuity
- ☐ Admission, discharge and transfer activity in 24 hours
- ☐ Process for evaluating admissions, transfer, discharges – recognize the capacity of the nursing staff to provide safe patient care
- ☐ Reference to national specialty guidelines and outside benchmarking is not the sole determination for staffing model

Comments:

Unit-Specific Staffing Plan Review Checklist - 2015

Unit: _____

- ☐ Plan has, as its primary consideration, the provision of safe patient care and an adequate nursing staff, to the extent possible
- ☐ Plan is based on an accurate description of individual and aggregate patient needs and requirements for nursing care
- ☐ Plan includes at least an annual quality evaluation process, to determine whether the staffing plan is appropriately and accurately reflecting patient needs over time
- ☐ Plan is based on the specialized qualifications and competencies of the nursing staff
- ☐ Plan ensures that the skill mix and the competency of the staff meet the nursing care needs of the patient
- ☐ Plan is consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations, such as, but not limited to, The American Association for Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN)
- ☐ Plan recognizes differences in patient acuteness
- ☐ Plan includes a formal process for evaluating and initiating limitations on admission or diversion of patients to another unit when, in the judgment of the direct care registered nurse, there is an inability to meet patient care needs or a risk of harm to existing and new patients.
- ☐ Plan establishes minimum numbers of nursing staff personnel, including licensed nurses and certified nursing assistants on specified shifts, with no fewer than one registered nurse and one other nursing care staff member on duty in a unit when a patient is present.
- ☐ UBNPC review of the plan documented in unit's UBNPC minutes. Minutes include information regarding what unit data was reviewed with the plan, and the changes that were made to the plan with the rationale for those changes. If no changes to staffing plan, state this in the UBNPC minutes and rationale for no changes, i.e. "monitoring data from staffing plan reviewed and felt no changes indicated."
- ☐ Plan acknowledges care delivery components.

Comments:

Plan presented to Hospital Staffing Committee by:
Name: _____ Date: _____ Name: _____ Date: _____
On behalf of unit UBNPC

Plan reviewed by:
Name: _____ Date: _____ Name: _____ Date: _____
On behalf of the Hospital-Based Nurse Staffing Committee(HBNSC)
Cc: Nurse Manager, UBNPC Chair, Hospital Staffing Committee

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Staffing Plan Checklist(s)

Org: *(Unit's Org. #)*	**Unit Manager:** *(Nurse Manager's Name)*
Unit: *(Unit's Name)*	**Unit Base Chair:** *(Staff RN's Name)*
Fiscal Year (FY): *(Ex. 2015/2016)*	**Date:** *(Today's Date)*

PATIENT POPULATION *(Patients' Served in Unit)*	ACUITY & CARE LEVEL DESCRIPTION	INTENSITY OF UNIT & CARE (Highest/Lowest)	ENVIROMENTAL FACTORS	ESSENTIAL STAFFING	MEASUREMENT METHODS
o Description of patient population including common diagnoses. Include description of unit specific patients that can ONLY come to your unit (i.e chemo patient, vent patient, Remodulin, specific cardiac drips, etc).	o Admission/Discharge/Transfer rate (manager can request this info). Generalized staffing ratios for your unit throughout each shift (ie. days vs. nights, swing shift, etc)	o How do you address patient acuity on your unit? o Include any acuity tools as attachment o IMC criteria? o Isolation o How to determine patient ratio1:1, 1:2, 1:3, etc.	o Description of your unit- # of beds, how many private vs. semi private, how many nurses stations, are the teams located on unit? o Vocera usage? Other communication techniques (ex: ED uses cell phone for charge) o Small description of patient rooms o Call light capabilities, types of alarms, lock down capability?	o Specialized qualifications of staff (ACLS, VAD certified, chemo certified, etc) o Skill mix (# of RNs, CNA, tech, etc) o Minimum number of staff needed to operate unit (attach any grids, staffing guides, etc) o Any evidenced based practice standards (ASPAN, CCRN, etc). o Process for evaluating limitations on admissions, or diversion of patients to other units. o Chain of resolution o Meal/break coverage plan	o Measurement methods to evaluate staffing plan success. o Only incorporate those that you are actually measuring on a unit level (less is more). o Include clinical and non-clinical measurements. o Annual review of staffing plan included as part of UBNPC.

This staffing plan includes, as its primary consideration, the provision of safe patient care and adequate nursing staff to the extent possible.
This staffing plan is based on accurate descriptions of individual an aggregate patient needs and requirements for nursing case.

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Core Measures and Additional Tracking

Quality / core measures

- **Patient Falls**
- **CAUTI**
- **CLABSI**
- **VAP Rates**
- **Press Ganey/NDNQI Scores**
- **CMS core measures**
  - Stroke
  - Heart Failure
  - Acute MI
  - SCIP
  - Pneumonia
  - Pressure Ulcers
- **Employee Surveys**
- **Patient Surveys**
- **Medication Errors**
- **Missed Nursing Care**
- **Staffing Request Documentation Forms (SRDF)**
- **Facility reporting forms**
- **Unusual Occurrence Reports (UOR)**
- **Patient Safety Incident (PSI)**

Tracking additional data

- **Nurse Practice councils**
- **Unit Base Councils**
- **Unit daily reports**
- **Kronos / Timekeeping**
  - **Track MOT/VOT**
    - **Unit and system wide**

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Thank you!

Contact ONA Nursing Practice Consultants:

Jordan Ferris, BSN, RN, CMSRN
ferris@oregonRN.org

Tonya Tittle, MSN, RN
tittle@oregonRN.org

practice@oregonrn.org