Mount Hood Medical Center ICU Nursing Staffing Plan

<table>
<tr><td>Date of Review: December 14, 2016</td><td></td><td>Additional Details/Law Requirements</td></tr>
<tr><td>Patient Population</td><td>☒ Adult/Geriatric ☐ Pediatric ☐ Neonate
☒ Cardiac Telemetry ☒ Critical Care ☐ Emergency ☒ Medical Surgical ☐ NICU
☒ Step-down ☐ Womens & Newborn</td><td>Adult critically ill medical & surgical patients; including but not limited to, neurological, cardiac, pulmonary, renal, metabolic & infectious conditions with hemodynamic instability, and post-operative. Also, acute medical, surgical and telemetry patients awaiting transfer to appropriate acute care units (SB 469 pg 4, lines 27-29).</td></tr>
<tr><td>Patient Factors based on typical unit population type</td><td>Admission/Discharge/Transfers per shift:
Day ☐ High ☒ Average ☐ Low Night ☐ High ☐ Average ☒ Low
Acuity ☒ High ☐ Average ☐ Low</td><td>SB 469 pg 4, line 37 and page 5, lines 5-7</td></tr>
<tr><td>Average Daily Census</td><td>
<table>
<tr><td>2014</td><td></td><td></td><td>2015</td><td></td><td></td><td>2016</td><td></td><td></td></tr>
<tr><td>January</td><td>*</td><td></td><td>January</td><td>8</td><td></td><td>January</td><td>7</td><td></td></tr>
<tr><td>February</td><td>*</td><td></td><td>February</td><td>6</td><td></td><td>February</td><td>7</td><td></td></tr>
<tr><td>March</td><td>*</td><td></td><td>March</td><td>7</td><td></td><td>March</td><td>6</td><td></td></tr>
<tr><td>April</td><td>7</td><td></td><td>April</td><td>6</td><td></td><td>April</td><td>6</td><td></td></tr>
<tr><td>May</td><td>5</td><td></td><td>May</td><td>6</td><td></td><td>May</td><td>6</td><td></td></tr>
<tr><td>June</td><td>6</td><td></td><td>June</td><td>8</td><td></td><td>June</td><td>7</td><td></td></tr>
<tr><td>July</td><td>5</td><td></td><td>July</td><td>7</td><td></td><td>July</td><td>7</td><td></td></tr>
<tr><td>August</td><td>5</td><td></td><td>August</td><td>5</td><td></td><td>August</td><td>7</td><td></td></tr>
<tr><td>September</td><td>6</td><td></td><td>September</td><td>7</td><td></td><td>September</td><td>7</td><td></td></tr>
<tr><td>October</td><td>8</td><td></td><td>October</td><td>5</td><td></td><td>October</td><td></td><td></td></tr>
<tr><td>November</td><td>8</td><td></td><td>November</td><td>7</td><td></td><td>November</td><td></td><td></td></tr>
<tr><td>December</td><td>7</td><td></td><td>December</td><td>7</td><td></td><td>December</td><td></td><td></td></tr>
<tr><td>TOTAL AVG</td><td>6.3</td><td></td><td>TOTAL AVG</td><td>6.6</td><td></td><td>TOTAL AVG</td><td>6.6</td><td></td></tr>
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</td><td>The nurse manager determines core unit staffing levels by incorporating such factors as average daily census over a year-to-year rolling report and HPPD. Based on these factors the current core is 5 total RNs scheduled to work per shift. Although this ‘core’ level equates to all nurses that are staffed for any given day, the actual number of nurses working on a given shift fluctuates dependent on many factors. (See following sections).</td></tr>
<tr><td>Unit Hours per Patient Day</td><td>HPPD: 20.08</td><td></td></tr>
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<td>Unit Matrix
(minimum staffing)</td>
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Core staffing for the ICU is 4 12 hour RNs per shift, and normal ICU staffing is based on a 1:2 RN to patient ratio. Each shift is staffed with a Charge RN who responds to codes, rapid response calls and makes patient assignments to Staff RNs. This Charge RN will be staffed even if the unit census is zero. A minimum of one Charge RN and one Staff RN will be staffed for one or more patients (SB 469 pg 4 lines 38-41). Additional staff RNs who are scheduled but not needed due to census are placed on-call for the shift or cancelled.

The Charge RN works collaboratively with Staff RNs, and uses their expert judgement, along with the following staffing matrix and acuity guidelines to make patient assignments to the staff nurses. The charge RN may work outside of this formula if he or she feels that the unit or patient needs are not being met.

<table>
<tr><td>Census</td><td># of Staff</td></tr>
<tr><td>____ 2:1 patients x2</td><td>____ RN</td></tr>
<tr><td>____ 1:1 patients x1</td><td>____ RN</td></tr>
<tr><td>____ 1:2 ICU patients /2</td><td>____ RN</td></tr>
<tr><td>____ M/S/tele patients /3</td><td>____ RN</td></tr>
<tr><td>____ Total census > 3 add free charge RN</td><td>____ RN</td></tr>
<tr><td></td><td>____ Total staff</td></tr>
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<tr><td>Nurse to Patient Ratio</td><td>Acuity factors</td></tr>
<tr><td>2:1</td><td>Massive transfusion protocol, newly admitted intensivist patient if necessary, unstable CRRT</td></tr>
<tr><td>1:1</td><td>Hypothermia protocol, CRRT, TPA patient, organ donation preparation, hemodynamically unstable requiring multiple pressors being titrated up or interventions/assessments q15 mins, proning, postoperative intubated patients, persistently agitated patients at risk of self-harm or harm to others, anticipated trips off unit</td></tr>
<tr><td>1:2</td><td>Typical ICU patient assignment</td></tr>
<tr><td>1:3</td><td>Medical/surgical/telemetry patients awaiting transfer to appropriate acute care unit</td></tr>
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<td>
ICU Staff: RNs in the ICU are ACLS/BLS certified and have completed Legacy required mandatory education for critical care nurses, including a 12-week critical care consortium. CCRN certification is recommended. Some RNs have completed additional education/training to care for certain patient populations (CRRT, Icy Cath, etc.…). The unit strives to have a safe and appropriate mix of expert and novice RNs (Kendall-Gallagher & Blegan, 2009) (SB 469 pg 4 line 30-34). Additionally, a CHT is staffed on Mondays through Fridays from 0700-1100 to provide assistance with patient care and clerical duties during these busy hours.

Additional Staff: If the core ICU nursing staff is unable to safely provide care for the patients in the unit, the following are employed:

Legacy Critical Care resource pool RNs
Nurses from other hospital departments (Cath lab, PACU, medical specialties) cross-trained to ICU
Voluntary overtime and incentive shifts offered to ICU staff

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	The charge RN will take into account the following, using the AACN Synergy model, when making assignments: • Experience, skill mix, competencies, and specialized qualifications of nursing staff • Patient acuity, stability, complexity, vulnerability, resiliency, predictability, and ability to participate in decision making • Continuity of care, patient/family requests • Resource availability Census and acuity fluctuations due to admissions, discharges and transfers (ADT), procedures/trips, and patient condition are managed by Charge and Staff RN collaboration with the house supervisor and in real time by the following: • Staffing each shift with an open assignment for admission • Increase or decrease in staff RNs, utilizing on-call RNs, resource pool, cross-trained RNs as needed • The Charge RN may assume care of a patient while additional staff RNs are being obtained • The house supervisor or ICU manager may assume patient care while additional staff RNs are being obtained Since ADT levels vary widely day to day and during any given shift in the ICU environment, churn factors are difficult to calculate. Therefore, with regards to ADT related fluctuations in workloads, decisions regarding real-time staffing levels are left up to the expertise of the unit charge nurse. All staffing levels are ultimately guided by patient and staff safety, and as previously stated, the unit charge RN has the ability to utilize these afore stated methods to ensure safe standards are maintained.	**Provision of rest/meal breaks (SB 469 pg. 5):** The following are strategies employed in order to facilitate the provision of rest and meal breaks, as well as to cover for RNs who are off the unit for procedures/tests: • Staff RNs provide coverage for one another on a rotating basis, as long as the remaining number of staff present is sufficient to provide safe care • The free Charge RN provides coverage for RNs off the unit • Cross trained RNs are called upon to provide coverage • The house supervisor can provide coverage • On-call nurses can be called in to provide coverage In the extremely rate and unlikely event that safe and adequate staffing, as defined in this plan, cannot be obtained, the SCCM guidelines for Admission, Discharge, and Triage are used and the need addressed by emergently transferring the least critically ill patient/s to an accepting Legacy ICU **(SB 469 pg. 4 lines 42-45).**
Environmental Factors	**Unit Size – 10 Patient rooms** **Room occupancy** ☒ Single ☐ Multiple The ICU at Mount Hood has ten rooms; all of which are sufficient in size and equipment to treat most patients. Rooms 1 and 10 are larger in size and are usually reserved for patients who may require more or larger scale equipment such as a Hemodialysis machine or a Bariatric Bed. Rooms 1, 4, 7, and 10 have ceiling hoist (lift) systems for patients who are fully	There is a physician /pharmacist workstation which has 3 fixed computers as well as an X-ray viewing station. Most needed equipment, supplies and medications are located within

	or mostly dependent on caregivers for all repositioning. There is one fixed computer in each room for charting and electronic medication verification. There are 4 fixed computers in the main nursing station, as well as 2 portable computer workstations	designated areas, as well as unused patient rooms. An outer hallway storage closet is also utilized for extra equipment storage.
Evaluation Metrics	Safe staffing compliance levels are measured by decreased rates of: >Hospital-related mortality >Hospital acquired pneumonia >Nosocomial infections >Bloodstream infections and other adverse events. >Decreased risk of hospital-related death and shorter lengths of stay. >Hours of mandatory or volunteer overtime worked by nursing staff	Measurement methods include: >Legacy approved audit tools for adherence to Protocols and Procedures. >Safety committee evaluations. >Administrative review. The staffing committee will review the plan at least yearly and at any other date/time specified by the majority of voting members of the committee **SB 469 Section 5**
Evidence based staffing standards or guidelines	Society of Critical Care Medicines (2015). *Critical Care Delivery: The Importance of Process of Care.* CCMJOURNAL Vol 43:7 Association of Critical Care Nurses (2016). *The AACN Synergy Model for Patient Care*. http://mini.aacn.org/wd/certifications/content/synmodel.pcms?menu=certification Kendall-Gallagher, D., & Blegen, M. A. (2009). Competence And Certification Of Registered Nurses And Safety Of Patients In Intensive Care Units. *American Journal of Critical Care : An Official Publication, American Association of Critical-Care Nurses*, *18*(2), 106–114. http://doi.org/10.4037/ajcc2009487	**SB 469 page 4 lines 35-36**