Cover Page

The following is the nurse staffing plan for Summit Pacific Medical Center submitted to the Washington State Department of Health in accordance with Revised Code of Washington 70.41.420.

CEO Attestation Form

I, the undersigned with responsibility for Summit Pacific Medical Center, attest that the attached staffing plan and matrix was developed in accordance with RCW 70.41.420 for 2022 and includes all units covered under our hospital license under RCW 70.41. This plan was developed with consideration given to the following elements (please check):

- ☐ Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;
- ☐ Level of intensity of all patients and nature of the care to be delivered on each shift;
- ☐ Skill mix;
- ☐ Level of experience and specialty certification or training of nursing personnel providing care;
- ☐ The need for specialized or intensive equipment;
- ☐ The architecture and geography of the patient care unit, including but not limited to placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;
- ☐ Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations;
- ☐ Availability of other personnel supporting nursing services on the patient care unit; and
- ☐ Strategies to enable registered nurses to take meal and rest breaks as required by law or the terms of an applicable collective bargaining agreement, if any, between the hospital and a representative of the nursing staff.

This staffing plan was adopted by the hospital on: October 10, 2022 with changes to reflect CNA and ED Tech additions and clarify RN staffing to incorporate staggered shifts and Swing Bed patients.

As approved by Josh Martin, CEO

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Signature

Nurse Staffing Plan Purpose

This plan was developed for the management of scheduling and provision of daily staffing needs for the hospital, and to define a process that ensures the availability of qualified nursing staff to provide safe, reliable and effective care to our patients. This plan applies to all parts of the hospital licensed under RCW 70.41.

Nurse Staffing Plan Principles

- Access to high-quality nursing staff is critical to providing patients safe, reliable and effective care.
- The optimal staffing plan represents a partnership between nursing leadership and direct nursing care staff.
- Staffing is multifaceted and dynamic. The development of the plan must consider a wide range of variables.
- Data and measurable nurse sensitive indicators should help inform the staffing plan.

*These principles correspond to *The American Nursing Association Principles of Safe Staffing.*

Nurse Staffing Plan Policy

- The nurse staffing committee (committee) is responsible for the development and oversight of the nurse staffing plan to ensure the availability of qualified nursing staff to provide safe, reliable and effective care to our patients.
- The committee's work is guided by its charter.
- The committee meets on a regular basis as determined by the committee's charter.
- The committee's work is informed by information and data from individual patient care units. Appropriate staffing levels for a patient care unit reflect an analysis of:
    - Individual and aggregate patient needs;
    - Staffing guidelines developed for specific specialty areas;
    - The skills and training of the nursing staff;
    - Resources and supports for nurses;
    - Anticipated absences and need for nursing staff to take meal and rest breaks;
    - Hospital data and outcomes from relevant quality indicators; and
    - Hospital finances.

  *The American Nurses Association does not recommend a specific staffing ratio, but rather to make care assignments based on acuity, patient needs and staff competencies.

- The analysis of the above information is aggregated into the hospital's nurse staffing plan. Each individual patient care unit may use the Nurse Staffing Committee Checklist to guide their work.
- Staff continuously monitor individual and aggregate patient care needs and make adjustments to staffing per agreed upon policy and collective bargaining agreement (if applicable).
- The committee will perform a semiannual review of the staffing plan. If changes are made to the staffing plan throughout the calendar year, an updated staffing plan will be submitted to DOH.
- The hospital is committed to ensuing staff are able to take meal and rest breaks as required by law, or collective bargaining agreement (if applicable). The committee considers breaks and

strategies to ensure breaks when developing the plan. A global break policy may be used, or individual patient care units may have discretion in structuring breaks to meet specific needs while meeting the requirements of the law. Data regarding missed or interrupted breaks will be reviewed by the committee to help develop strategies to ensure nurses are able to take breaks.

Nurse Staffing Plan Scope

Acute care hospitals licensed under RCW 70.41 are required by law to develop a nurse staffing plan. The plan must cover areas of the hospital that: 1) are under the hospital's license (RCW 70.41) and 2) where a nurse(s) provides patient care (i.e., "patient care unit").

The following areas of the hospital are covered by the nurse staffing plan: Acute Care Unit (ACU), Emergency Department, Outpatient Procedure Unit

2022 Staffing Unit Plan Overview

Department: **Emergency Department (ED)**

Date: 7-1-2022 Indicate: Both Annual and Semi-Annual Review as the annual was sent in December of 2021 but did not show on DOH site.

Author: Tori Bernier, CNO

Nursing Department Overview

Emergency Department patients range from 1:1 to 1:3-4 ratio depending on acuity and intensity.

- Average daily census: 55
- Average number of admits/ discharges/transfers: 55/45/10
- Average length of stay: 2.5 hrs generally but 12 hrs or greater for transfers

Key Quality Indicators

Patient falls, falls with injury, scanning of patient and medications, medication errors, patient satisfaction and ED throughput, boarding hours per day, LWOBS

Staffing matrix for Patient Census for planned ADC of 55

The Emergency Department is an outpatient department, within a rural Critical Access Hospital (CAH) that has a staffing model based on a variable dally patient census. The Emergency Department utilizes a dally staffing grid to indicate staff assignments and roles for their shift The daily staffing grid is based on historical arrival rates of patients and can change based on new arrival data throughout the year. The Charge Nurse prepares a new staffing grid each day and makes staff assignments according to patient needs and staff training, competency, training, and experience. The Emergency Department Charge Nurse is available to assist with patient care and take a patient assignment. House Supervisors are available to assist with patient care nightly and all day on weekends.

(Insert matrix for each area of the hospital identified under 'Nurse Staffing Plan Scope. A matrix may vary by type of unit or shift. Designated shifts or start times and number of RNs per shift/start time by census or cases are common and core elements found in a staffing matrix.

ED Staggered Staffing Plan:

AM Shift (Staggered Staffing)

Census	RN	ED techs	Other	Notes
0600 0-10	1 CN, 1- 2 RNS	2		Patient census varies each day
900 10-15	0-1 RN			Patient census varies each day
1100 15-20 (optional)	0-1 RN			Patient census varies each day
1500 20-25 (optional)	0-1 RN			Patient census varies each day
0600	House Supervisor on Weekends-optional			0900, 1100 or 1500 RN are optional depending on census: Core Staff = 2 RNs

PM Shift (Staggered Staffing)

Census	RN	ED techs	Other	Notes
1800 0-25	1 CN, 1-2 RNS as well as staggered RNs	2		Patient census varies each day: Core Staff = 2 RNs
1800	House Supervisor			Optional

<u>Matrices are developed as a guide for shift-by-shift unit-based staffing decisions and are adjusted up or down based on patient factors and skill-mix of hospital staff.</u>

The above staffing plan is contingent upon the follow supports/ considerations.

The ED is supported by laboratory, diagnostic imaging, respiratory therapy, house supervisors, and Acute Care Unit RNs who are cross trained to float. Census can fluctuate based on divert status of other local hospitals, inability to receive an accepting hospital and/or available transportation to another hospital. Alternate care sites within the hospital with staff from ED or other units help offset the fluctuations, boarding and surges. RNs, leaders and Techs can fill the HUC role. SPMC has implemented Patient Safety Companions as BH Sitters as well as utilizing clinic or Urgent Care staff. RNs stabilize Trauma patients as a Level IV center. ED staff support Code Blue across the facility. Pharmacist and staff are available daily with off-site pharmacists on off hours.

Which situations require staffing variation?

Multiple 1:1 patients, Holding Critical Care patients (boarders) , unanticipated Increase/Decrease in patient volumes (variable staffing model), call outs without replacement after all attempts to fill.

Chain of Command/ Staffing Decision Tree

Charge nurse is expected to collaborate with leadership to discuss shift to shift and assignment adjustments based on acuity and intensity. The unit manager or house supervisor or on call administration is available 24/7. The decision is made jointly with the Administrator on Call approval.

Meals and rest breaks

Charge nurse is available to provide breaks for staff who are unable to break themselves. At times the 1500 or 1100 RN is helping with breaks. House Supervisors, when on site, also help with breaks and meals. Daily break and meal assignments are listed on the daily sheet.

Level of Experience, specialty certifications or training of the nursing staff

BLS, ACLS and PALS upon hire and TNCC within a year.

Architecture and geography

The 10 bed ED utilizes 9 rooms and uses one room for triage currently. Plans are in place to move the Triage RN to the waiting room to better evaluate patients as they enter the building and give one more exam/treatment area. Screener remains at the entrance to ED waiting area. Registration is also in waiting area. One medication preparation and Pyxis room in the department. Two storage and one dirty utility room is present on unit. The Nurse Station is located centrally in the unit with the patient rooms along each side of the station.

National or professional guidelines

Emergency Nursing Association guidelines are used as well as Trauma, Stroke and Cardiac response guidelines.

Feedback and evaluation

Review survey results with staff at staff meetings, shift huddles, and via email: Beginning Unit Based Teams (UBT) and combining Staffing for more participants.

Staff participation in nurse staffing survey? With high traveler utilization and new staff coming on board, we have not had many responses to surveys. We utilized 12 hr meetings with all staff in January through February to solicit ideas, needs and issues. The list was compiled and will be addressed in the UBTs.

Themes of the results: Staffing stabilization and decrease travelers, Admission times to ACU, Respiratory Therapy and training on ventilators, alignment of schedules for RN to CNA and HUC assignments/delegation. Adding a 3rd RN to ACU to facilitate breaks and lunches as well as assistance available to cover sick calls. Implementation of shift safety huddles and MESSS reports to the Daily Operation Briefs as a way of communicating safety items or concerns.

Work plan proposed: Respiratory Therapist program began, and ventilator training completed. Daily Methods, Equipment, Staffing, Safety, Supplies (MESSS) information passed on shift to shift and to the manager who then writes the updates or problem solving on the MESSS for all to get updates. Huddle boards ordered for all units for safety and general communication and process improvements. Hiring more staff with experience as possible, starting the Nurse Residency Program and bringing foreign nurses who will become hires, keeping highly qualified travelers with the least disruption, and decreasing as hired RNs.

If recommendation were made in the last staffing plan, how did you utilize them and what impact has it made? We added the third nurse to ACU, hired RTs and more phlebotomy help in both departments.

2022 Staffing Unit Plan Overview

Department: **Acute Care Unit (ACU)**

Date: 7/1/2022 Indicate: Both Semi-annual review and Annual review

Author: Tori Bernier, CNO

Nursing Department Overview

Patients on the ACU are medical patients who are considered medical level. Some cardiac and insulin drips are performed by trained personnel. Patients can range from a 1:3 to 1:5-6 ratio with swing bed patients being 1:8 depending on intensity.

- Average daily census: 7
- Average number of admits/ discharges/transfers: 3/3/1
- Average length of stay: 4 days

Key Quality Indicators

30 Day readmissions, Patient harms: CAUTI, CLABSI, Wounds, Falls and Falls with injury, medication scanning rates, ED to ACU admission times

Staffing matrix for Patient Census for planned ADC of 6-10

The Acute Care Unit is a 10-bed observation, inpatient and swing bed unit within a rural Critical Access Hospital (CAH). It has a staffing model based on a variable daily patient census. The ACU utilizes a staffing grid to indicate staff assignments and roles for their shift. The Charge Nurse prepares a new staffing grid each day and makes staff assignments according to patient needs and staff training,

competency, and experience. The Charge Nurse is expected to assist with patient care and have assignments when only 2 RNs present.

Staffing Plan Matrix Acute Care Unit

AM Shift 12 hrs 0600-1830

Census	RN's	CNA	HUC	Notes
0 - 5-6 0-8 with Swing Bed	1	1	1	HUCs and CNAs have, historically had staggard and variable shifts. In 2022 leadership is aligning shifts for patient safety, delegation, and assignments
5-6 - 10	2-3	1	1	
				3rd RN is optional core staffing is 1 RN and CNA

PM Shift 12 hrs 1800-0630

Census	RN's	CNA	HUC	Notes
0 – 5-6 0-8 with Swing Bed	1	1	1	HUCs and CNAs have, historically had staggard and variable shifts. In 2022 leadership is aligning shifts for patient safety, delegation, and assignments
4-6	2-3	1	1	
				3rd RN is optional core staffing is 1 RN and CNA

Matrices are developed as a guide for shift-by-shift unit-based staffing decisions and are adjusted up or down based on patient factors and skill-mix of hospital staff.

The above staffing plan is contingent upon the follow supports/ considerations.

ACU benefits from collaboration with the hospitalist and ED provider as needed. ACU also relies on diagnostic imaging, laboratory and phlebotomists, Licensed Independent Social Worker, Clinical Documentation Supervisor, House Supervisors on nights and weekends, Assistant Nurse Manager, Manager and Director (all leadership having ED and ACU responsibility and can assist as needed at bedside or as HUC). ED RNs and CN to assist with unstable patients and those patients are transferred to ED for ongoing care and transfer to higher level, ED RNs are cross trained to support ACU as needed,

Food and Nutrition Services with meals brought to the rooms, Respiratory Therapy for EKGs, oxygen, and treatments. Pharmacist and staff available daily with off-site coverage on off hours.

Which situations require staffing variation?

Multiple 1:3 patients, ED patients (boarders) , overflow patients, Increase/Decrease in patient volumes (variable staffing model)

Chain of Command/ Staffing Decision Tree

Charge nurse is expected to collaborate with leadership to discuss shift to shift and assignment adjustments based on acuity and intensity. The unit manager or house supervisor or on call administration is available 24/7. The decision is made jointly with the Administrator on Call approval.

Meals and rest breaks

Charge nurse is available to provide breaks for staff who are unable to break themselves. Leadership or House Supervisors may also provide breaks as needed.

Level of Experience, specialty certifications or training of the nursing staff

BLS, ACLS upon hire.

Architecture and geography

ACU has 10 large, single occupancy, patient rooms circling a centralized nurse station. Computers are in each room with scanning capabilities, one medication room, two storage rooms and one dirty utility are also centrally located. Hospitalists, Assistant Nurse Manager and the Licensed Independent Social Worker offices are located in the unit. One conference room for daily rounds and meetings and an activity room for swing bed patients are located in the unit. ACU is directly across the hall from ED for patient movement and assistance from ED RNs and Providers.

National or professional guidelines

Association for Medical Surgical Nursing

Feedback and evaluation

Review survey results with staff at staff meetings, shift huddles, and via email: Beginning Unit Based Teams (UBT) and combining Staffing for more participants.

Staff participation in nurse staffing survey? With high traveler utilization and new staff coming on board, we have not had many responses to surveys. We utilized 12 hr meetings with all staff in January through February to solicit ideas, needs and issues. The list was compiled and will be addressed in the UBTs.

Themes of the results: Staffing stabilization and decrease travelers, Admission times to ACU, Respiratory Therapy and training on ventilators, alignment of schedules for RN to CNA and HUC assignments/delegation. Adding a 3rd RN to ACU to facilitate breaks and lunches as well as assistance available to cover sick calls. Implementation of shift safety huddles and MESSS reports to the Daily Operation Briefs as a way of communicating safety items or concerns.

Work plan proposed: Respiratory Therapist program began, and ventilator training completed. Daily Methods, Equipment, Staffing, Safety, Supplies (MESSS) information passed on shift to shift and to the manager who then writes the updates or problem solving on the MESSS for all to get updates. Huddle boards ordered for all units for safety and general communication and process improvements. Hiring more staff with experience as possible, starting the Nurse Residency Program and bringing foreign nurses who will become hires, keeping highly qualified travelers with the least disruption, and decreasing as hired RNs.

If recommendation were made in the last staffing plan, how did you utilize them and what impact has it made? We added the third nurse to ACU, hired RTs and more phlebotomy help in both departments.

2022 Staffing Unit Plan Overview

Department: **Outpatient Procedure Services (OPS)**

Date: July 1, 2022 Indicate: Both Semi-annual review and Annual review

Author: Tori Bernier, CNO

Nursing Department Overview

OPS serves patients coming for screening colonoscopies, EGDs and Outpatient Infusion Services, these are not patients who are acutely ill. Patients are scheduled by self-referral or by referral to the Gastroenterologists.

- Average daily census: 1-10 or 12 depending on type of procedures and cancelations
- Average number of admits/ discharges/transfers: 1-10/1-10/0
- Average length of stay: 2-3 hours

Key Quality Indicators

Patient falls, falls with injury, medication scanning rates, medication errors, admit to procedure times, patient satisfaction and cancellations, patient adherence to preparing.

Staffing matrix for Patient Census for planned ADC of 1-10

The Outpatient Procedure Services is an outpatient department that has a staffing model based on a variable dally patient census, type of procedures/infusions and number of procedures/infusions. The Nurse prepares a new staffing grid each day and makes staff assignments according to patient needs and staff training, competency, training and experience. All Outpatient Procedure Nurses and Infusion Nurses are available to assist with patient care. Adjustments to staffing or low census are made based on procedures and patient acuity.

Staffing Plan Matrix: Outpatient Procedure Services

AM Shift

Census	RNs	Endo techs	Infusion RN	Notes
1-10	2-3	1-2	1 RN for 4 10 hr shifts, weekdays	

Matrices are developed as a guide for shift-by-shift unit-based staffing decisions and are adjusted up or down based on patient factors and skill-mix of hospital staff.

The above staffing plan is contingent upon the follow supports/ considerations.

The Outpatient Procedure Services team is supported by Respiratory Therapy, GI Providers and CRNA for anesthesia, laboratory and phlebotomy, ED RN and Provider for unstable patients, diagnostic imaging as needed and the Infusion RN within the unit helps with cases and breaks and the GI RNs help with the Infusion patients.

Which situations require staffing variation?

Sick calls, patient acuity, and procedure number and type.

Chain of Command/ Staffing Decision Tree

Nurse is expected to collaborate with leadership to discuss shift to shift and assignment adjustments based on acuity and intensity. The unit manager or house supervisor or on call administration is available 24/7. The decision is made jointly with the Administrator on Call approval.

Meals and rest breaks

Nurses are available to provide breaks for staff who are unable to break themselves. Infusion and GI help cover and there is a break for lunch between morning and afternoon cases.

Level of Experience, specialty certifications or training of the nursing staff

BLS and ACLS upon hire.

Architecture and geography

The Outpatient Procedure Services (GI and Infusion) consists of five bays for admission, recovery and discharge with the nurse's station in a location to visualize each bay. Two procedure rooms are on the other side of the nurse's station. Medication rooms and a Pyxis in the hallway in front of the procedure rooms are located a short distance from the nurse's station. Office space for scheduler, infusion and GI personnel remains in the department.

National or professional guidelines

Society for Gastroenterology Nursing and Associates

Feedback and evaluation

Review survey results with staff at staff meetings, shift huddles, and via email: Beginning Unit Based Teams (UBT) and combining Staffing for more participants.

Staff participation in nurse staffing survey? With high traveler utilization and new staff coming on board, we have not had many responses to surveys. We utilized 12 hr meetings with all staff in January through February to solicit ideas, needs and issues. The list was compiled and will be addressed in the UBTs.

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If recommendation were made in the last staffing plan, how did you utilize them and what impact has it made? We added the third nurse to ACU, hired RTs and more phlebotomy help in both departments.

Nurse staffing rep: (Vacant, historically was Melissa Smith) No changes from the 2021 except adding the 3rd RN on ACU and bringing RT to SPMC. 1st quarter utilizing FEMA RNs and RTs and transitioned to agency. Working to establish UBTs and incorporate Nurse Staffing into those teams. This was requested by staff in UBT/Staffing meetings held January - February of 2022. October 10, 2022 with changes to reflect CNA and ED Tech additions and clarify RN staffing to incorporate staggered shifts and Swing Bed patients.

Unit manager: Tori L. Bernier RN BSN MBA ____

CNO: Tori L. Bernier RN BSN MBA _________________________________