Policy Title:	Staffing Plan/Acuity Based Assignment Decision Making Tool		
Location:	Housewide	**Policy Section:**	Provision of Care
Policy Number:	PC 251	**Next Review Date:**	1/2015
Original Effective Date:	10/2008	**Reviewed Date:** **Revised Date:**	 1/2012

I. PURPOSE:

To provide guidelines for maintaining adequate levels of nursing staff for each patient care unit.

II. POLICY:

Unit specific competencies, licensure requirements, and methods of patient care delivery are utilized in coordinating the placement of personnel throughout the hospital.

A. Scheduling will be the responsibility of the Unit Manager. The Staffing Office will facilitate when requested by Manager, House Supervisors.

B. Unit staffing needs are based on census, skill mix, staffing education/experience, and patient acuity.

C. Staff may be added or deleted to a unit to meet patient acuity and department needs. Staff may be assigned additional patients or fewer patients based on the complexity of the patient.

D. All nursing employees are to provide the Staffing Office with their current telephone number. Employees without telephones should arrange to have a message telephone number available. Each employee is responsible for the current maintenance of this information.

E. Employees must follow the Human Resource Department policies relating to time and attendance.

III. PROCEDURE/GUIDELINES:

A. Schedules / Staffing Procedure:

1. Time schedules are completed for 4-week time frames, posted two (2) weeks prior to the beginning of each schedule and submitted to the Staffing Office in advance. The Staffing Office notifies the Department Director of dates for posting the work schedule.
2. Staffing will be reviewed on an ongoing basis regarding the following:
   a) Unit needs based on census and patient acuity.
   b) Supplemental staff will be added as necessary, utilizing on-call personnel, regular staff, or agency personnel with prior approval from Department Manager, Director, and/or Chief Nursing Officer.
   c) Competency standards of the unit must be met by all staff.
3. The Unit Clinical Supervisor, with the exception of the O.R. will review staffing for the next 24 hours by 0900 and 2100 every day with the House Supervisor at bedboard. The Department Manager and/or Clinical Supervisor will review the weekend staffing each Friday. The Perioperative Services Director / designee will review staffing for each applicable departments for the next day and for the weekend staffing each Friday.

B. Staffing Issues Resolution:

1. If the Department Director/Clinical Supervisor anticipates problems with staffing or has a special request, the Clinical Supervisor should contact the Staffing Coordinator or House Supervisor.
   a. Any “no shows” after 10 minutes into the shift should be followed up with a phone call to the Staffing Coordinator. The Clinical Supervisor shall follow up with the House Supervisor/Department Director.

b. The Clinical Supervisor will notify the Staffing Coordinator and/or House Supervisor of any changes in the staffing list necessitated by "no shows" or other last minute staffing situations.

C. Staff Schedule Review Procedure:

The Clinical Supervisor / designee shall review the staffing rosters for adequate staffing. The variances are then adjusted by:

1. Flexing/reassigning staff based on patient acuity/unit/ department needs.
2. Additional staff is contacted in the following order:
   a) Per diem
   b) Part-time staff
   c) On-call staff
   d) Full-time staff, not working
   e) Staff on duty who volunteer to work extra hours
   f) Agency nurses
   g) Travelers and/or Local Per diem Agency
3. In the event that the patient acuity exceeds staffing levels the Clinical Supervisor, Department Director, House Supervisor, Medical Director and/or Administrative Representative will:
   a) Request that physicians reassess their patients to determine if they can be triaged or discharged.
   b) Clinical Supervisors/ House Supervisors/ Unit Managers/ Department Directors will take patient assignments appropriate to their clinical competencies.

D. **Acuity Emergency Department Triage:**

Defined as the means by which persons seeking emergency medical care are prioritized according to urgency of illness or injury.

1. Categories:

   All patients presented to the ED are to be evaluated upon arrival, and triaged/assigned a priority of care by the nurse based upon the findings of a visual and verbal assessment, severity of pain, respiratory and neurological status. The categories of priority of care are:

Urgency Category	Acuity	Examples
Category I	Emergent	Cardiac arrest, active seizure, major trauma, respiratory distress, major burn, psychiatric patient who is a threat to himself or others
Category II	Urgent	Open fracture, severe pain, minor burn, acute abdomen, sickle cell crisis
Category III	Nonurgent I	Closed fracture, laceration/contusions, sprains, noncardiac chest pain
Category IV	Nonurgent II	Rash, constipation, impetigo, abrasion, URI, UTI
Category V	Nonurgent III	Routine physical, minor bruises, cold

2. Definitions:

   Category I:

   Patients in this category require immediate attention with maximal utilization of resources. Unless appropriate medical and/or surgical intervention occurs the patient may die or suffer irreversible damage to limbs or sensory organs. Examples include cardiac arrest, tension pneumothorax, airway obstruction, multiple trauma, massive GI bleed, or status epilepticus. A

psychiatric example is a patient who is suicidal or homicidal and agitated without control over impulses.

Category II:

Patients in this category have a potential threat to life or limb or are suffering extreme pain. Generally, they will become unstable and deteriorate if not treated quickly. Examples include chest pain with likelihood of acute myocardial infarction, high-risk overdose, asthma attack with respiratory compromise, or a patient who is suicidal or homicidal struggling to control impulses, and perhaps threatening flight.

Category III:

Patients in this category must be seen by a physician within 1 hour, if possible, because their pain, severe symptoms, or risk profiles indicate the probability of deterioration without intervention. Examples include some fractures, abdominal pain with vomiting and fever, severe back pain with radiation, lacerations with tendon, nerve or large vessel involvement, or a patient entertaining thought of suicide or homicide but in control of impulses.

Category IV:

Patients in this category have acute injuries or medical problems, but are comfortable enough to wait greater than one hour to see a physician. Symptoms and risk factors for serious disease do not indicate a probability of deterioration. Examples of patients in this category would be those with puncture wounds, minor soft tissue injury, mild abdominal pain, and most lacerations. A psychiatric patient (not acutely symptomatic) who is returning for an appointment or seeking medication.

Category V:

Patients in this category do not have a classic medical emergency and do not need the specialized services of an emergency department. These patients do not require immediate treatment. In some cases these patients seek emergency department treatment due to limited understanding of the function of an emergency department, health insurance problems, child care or other social factors. Examples include uncomplicated upper respiratory infections, chronic dermatitis.

E. **Women's Services:**

Registered Nurse / Patient Ratio	Care Provided
Intrapartum	
1:2	Patients in labor
1:1	Patients in second stage of labor
1:1	Patients with medical or obstetric complications
1:2	Oxytocin induction or augmentation of labor
1:1	Coverage for initiating epidural anesthesia
1:1	Circulation for cesarean delivery
Antepartum-Postpartum	
1:6	Antepartum and postpartum patients without complications
1:2	Patients in postoperative recovery
1:3	Antepartum and postpartum patients with complications but in stable condition
1:4	Newborns and those requiring close observation
Newborns	
1:6-8	Newborns requiring only routine care
1:3-4	Normal mother – newborn couple care or breastfeeding care
1:3-4	Newborns requiring continuing care
1:2-3	Newborns requiring intermediate care
1:1-2	Newborns requiring intensive care

1:1	Newborns requiring multisystem support
1:1 or greater	Unstable newborns requiring complex critical care

F. **Medical Surgical**

(Example) Acuity Based Assignment Decision Making Tool Guide. Targeted goal is 15 points or less per assignment, excluding the ED and L&D.

1. **General Medical Surgical Care – maybe any of the following or other (1–Point) (Example)**
   a. New Admit that can independently perform ADLs
   b. Makes needs known
   c. Makes decisions
   d. May have some indwelling tubes
2. **Simple to Moderate General Medical Surgical Care- maybe any of the following or other (2–Points) (Example)**
   a. General medical or general surgical patient
   b. Walk with assistance
   c. Makes needs known
   d. General Medical Surgical/Telemetry patients
   e. May receive subsequent doses of chemo (is not receiving chemo for the first time)
   f. Blood administration
   g. New onset of diabetes
   h. General isolation (does not include TB)
3. **Complex Care, maybe any of the following or other (3- Points) (Example)**
   a. Active Chest Pain with elevated Troponin
   b. Confused/issues with cognition…requires representation
   c. Restrained (may require restraints for safety)
   d. Multiple IV meds, includes IVPB, IVP, (more than 9 per shift)
   e. First Dose of Chemo
   f. Pressors
   g. DKA
   h. TB isolation
   i. L2K with medical issue as primary and psych as secondary
4. **Moderately Complex Care – maybe any of the following or other (7– Points) (Example)**
   a. Intubated
   b. On multiple medication drips, titration drips, paralytics, narcotic drips
   c. Total care
5. **Severely Complex (15–Points) (Example)**
   a. CRRT
   b. IABP
   c. Intubated paralysed patient with open chest on IABP with VAD
   d. Ruptured AAA that may have active bleeding out
   e. Immediate s/p procedure patients that bypass PACU

G. **Pediatric Acuity Based Staffing**

1. General Pediatric Care: **3 points** (5:1)
   a. IV with continuous fluids

b. IV with intermittent antibiotics < 3
c. Family present to assist with cares
d. Oral feedings
e. Continuous Tube feedings
f. Oral Medications
g. General Isolation (RSV/Rota)

2. Simple to Moderate Care: **4 points** (4:1)
   a. Routine dose of chemotherapy
   b. Post op < 12 hours
   c. Post Procedural sedation
   d. No family members present
   e. Chest tube care
   f. Pt/ parent educational needs
3. Moderately Complex care: **5 points** (3:1)
   a. 1st dose of chemotherapy
   b. IVIG infusion
   c. Chemotherapy requiring vesicant checks
   d. Dialysis Cycler
   e. Continuous beta - antagonist inhalation < 12 hours
   f. Blood Transfusion
   g. New onset diabetic
   h. Every 2 hour vital signs/ accu checks
4. Complex care: **6 points** (2:1)
   a. Continuous beta-antagonist inhalation > 12 hours
   b. Epidural Infusion
   c. Intubated - stable
   d. Dialysis manual
   e. Multiple sedation/vasopressor infusions
   f. DKA/Insulin drip/hourly blood sugars
   g. Fresh Tracheostomy
   h. Every hour vital signs
5. Severely Complex: **15 points** (1:1)
   a. Oscillator - unstable
   b. Organ Donor
   c. Removal of Life support

H. **Neonatal Intensive Care**

1:3-4	Newborns requiring continuing care
1:2-3	Newborns requiring intermediate care
1:1-2	Newborns requiring intensive care
1:1	Newborns requiring multisystem support
1:1 or greater	Unstable newborns requiring complex critical care

I. Where appropriate units may choose to use the attached form for documentation purposes.

NURSING DAILY CENSUS & ACUITY REPORT

DATE: _____

Department:_____PATIENT ACUITY LEVEL

ACUITY LEVEL	7AM	7PM
I.		
II.		
III.		
IV.		
V.		

TIME	ROOM	ADMISSIONS		TIME	ROOM	DISCHARGES	DISPO

TIME	FROM	TO	TRANSFERS IN		TIME	FROM	TO	TRANSFERS OUT

SUMMARY FOR THE DAY:

1. **TOTAL PATIENTS REMAINING AT LAST REPORT:_____** **5. DISCHARGED:_____**
2. **ADMITTED:_____** **6. TRANSFERS OUT:_____**
3. **TRANSFERS INTO UNIT:_____** **7. EXPIRATIONS:_____**
4. **TOTAL IN (ADD LINES 1,2 &3)_____** **8. TOTAL OUT (ADD LINES 5,6,7)_____**

TOTAL PATIENTS REMAINING @ MIDNIGHT (LINE 4 MINUS LINE 8)_____

IV. References:

Van Slyck, A. & Johnson, K.R. (2001) Using Patient Acuity Data to Manage Patient Care Outcomes and Patient Care Costs. Outcomes Management for Nursing Practice, volume 5 Number 1, pages 36-40. http://www.nursingcenter.com

Lang, T.A., Hodge, M., Olson, V., Romano, P., Kravitz, R., (2004) Nurse patient Ratios: A Systematic Review on the Effects of Nurse Staffing on Patient, Nurse Employee, and Hospital Outcomes. Volume 34 (7-8), July/August 2004, pp 326-337. 2004 Lippincott Williams & Wilkins, Inc.