Staffing Request and Documentation Form (SRDF) Summary Report - May 2014 - April 2015

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Executive Summary

This report provides a summary of the Staffing Request and Documentation Forms (SRDF) reviewed by the Oregon Nurses Association (ONA) from May 1, 2014 through April 30, 2015. The SRDF forms were completed by staff nurses, or charge nurses, to document the occurrence of an inappropriate staffing event on a specific shift and unit. This report includes analysis of 937 SRDFs submitted and highlights several key observations as noted below.

Summary of the total number of SRDFs submitted:

- Twenty-seven facilities are represented
- There was a 2.6 percent year-over-year increase of total SRDFs submitted

Summary of factors related to SRDF submissions:

- 77 percent of the SRDFs were submitted from an eight-hour shift
- 49 percent were submitted from a day shift and 33 percent were submitted from night shifts
- Nearly 36 percent of the SRDFs were submitted from the Emergency Room (13.2 percent), ICU (12.6 percent), and General Surgical (10.0 percent) units

Summary of identified reasons for requesting additional staff:

- 90 percent note that not having enough staff was a reason for submitting the SRDF
- 61 percent indicate patient acuity and 41 percent indicate that patient intensity being too high were reasons for submitting the SRDF

Summary of consequences of the insufficient staffing event on care tasks:

- 80 percent of pain management, 89 percent of medication, and 91 percent of medical orders and treatments were reported as being delayed or omitted due to insufficient staffing on the unit
- Patient intensity and patient acuity being too high were significantly related to the delay or omission of almost all of the measured care tasks

Summary of patient safety consequences of insufficient staffing

- 72 percent report that the staffing event compromised patient safety and 27 percent indicated that continuity of care was impacted
- There was a 1.4 to 2.1 times greater likelihood that compromised patient safety was reported when not enough staff, patient acuity being too high, and inappropriate staff mix were identified as a reason for submitting the SRDF

Summary of self-care consequences of inadequate staffing event:

- 81 percent reported missed rest breaks, 56 percent reported missed meal breaks, 30 percent indicated voluntary overtime, and 16 percent indicated mandatory overtime
- When patient intensity was indicated, there was at least a 1.4 times greater likelihood that nurses reported voluntary overtime, missing meal breaks, and missing rest breaks

The results from our analyses support the adverse effect of inadequate staffing on delaying or omitting patient care tasks, compromised patient safety, and missed self-care activities.

Background

The negative effects of inadequate staffing in nursing are becoming increasingly apparent. Research supports the negative outcomes of inadequate staffing on lower quality of patient care (Aiken et al., 2002), increased medical errors, infections, and patient injury (Hall et al., 2004), and higher patient mortality (Clarke & Aiken, 2003). Moreover, insufficient staffing affects nurses by placing greater demands and expectations for nurses to shoulder a greater patient load (Wicker & August, 1995), work at a faster rate (Beglinger, 2006), and work overtime (Hall et al., 2004). Research shows that inadequate staffing negatively affects nurse wellbeing such as increasing job strain, emotional exhaustion (i.e., burnout), and depression (Aiken et al., 2002; Greenglass et al., 2003; Jamal & Baba, 1992; Leiter & Laschinger, 2006).

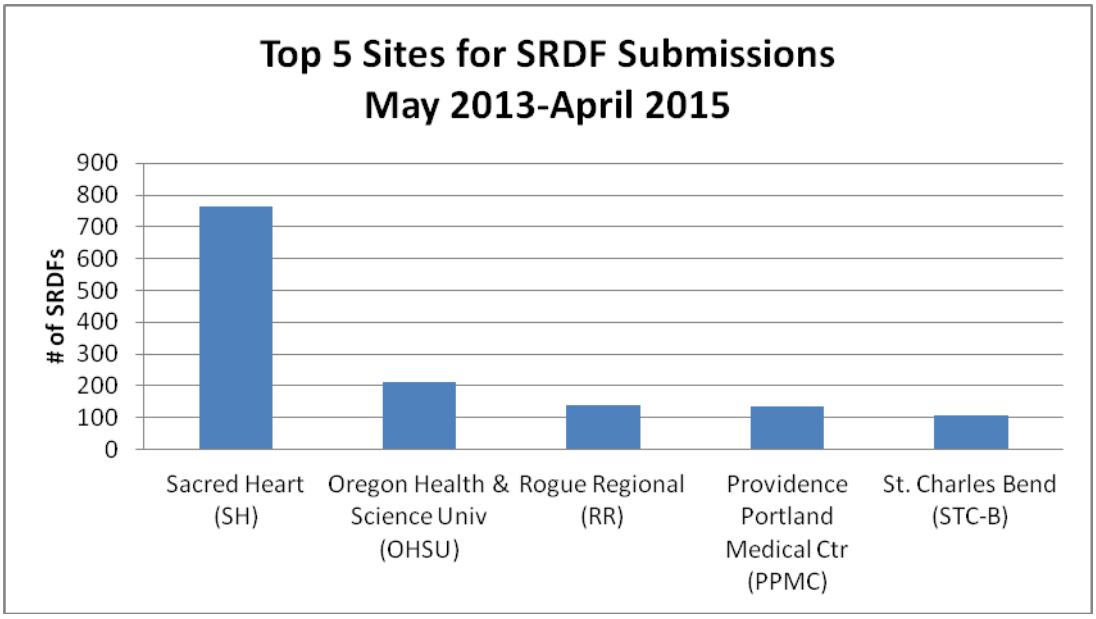
Staffing Request Documentation Forms (SRDF), are submitted after a request for additional staffing resources is communicated up through the chain of command at a facility. SRDFs are filled out by staff nurses, or charge nurses, to document the occurrence of an insufficient staffing event. Copies of the SRDF are distributed to the appropriate management personnel at the facility, the Oregon Nurses Association (ONA), and the individual or groups of individuals who submit the form keep a copy. Once ONA staff receives the form, it is logged into a spreadsheet, and an acknowledgement email is sent to each of the individuals who sign the form. The next steps require ONA staff to follow specific protocol to transfer the information from the report into a database. First, quantitative data is extracted and transferred to a coding sheet by a trained coder. The data are then transferred from coding sheet into statistical database for analysis. Information written in the additional comments section of the form is also transcribed into a separate database for further analysis. The data from this process are what are analyzed and reported in this document. The analysis included 937 SRDFs submitted by nurses from 25 different facilities from May 1, 2014 to April 30, 2015.

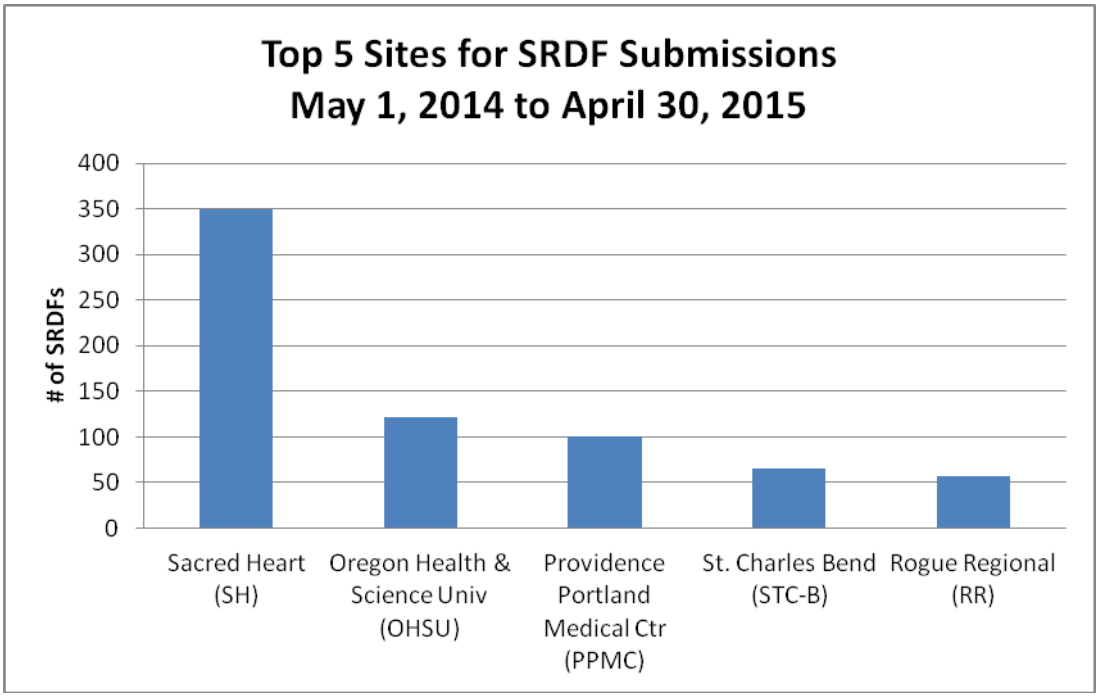
We would like to acknowledge that more SRDFs may be submitted than are actually analyzed in this report. There are two reasons why a SRDF may not qualify for inclusion in this report. First, sometimes several SRDFs are submitted for the same insufficient staffing event. In this case, we examine the different reports to verify that the event being reported on is truly the same to insure that the event is only reported once. Second, SRDFs that are missing significant data regarding who was notified in the reporting chain about the insufficient staffing event are removed from the analysis. We have instituted these two controls as a way to increase the validity of the information being reported.

Total Number of SRDFs Submitted by Site

Analysis and Interpretation: A total of 937 SRDFs were coded between May 1, 2014 through April 30, 2015. This represents a 2.6 percent year-over-year increase in submissions. Sacred Heart and OHSU remain the top two sites for the number of SRDF submissions.

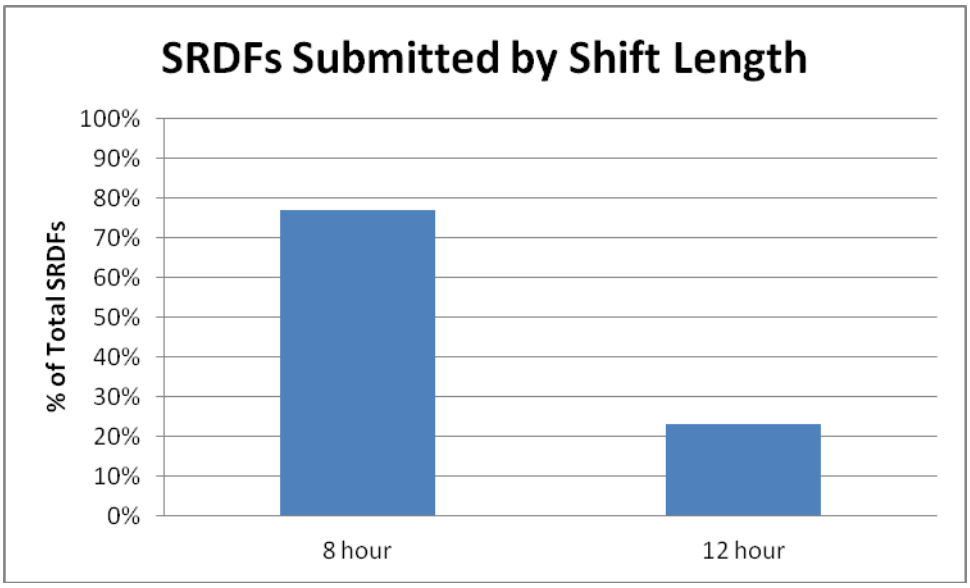
	May 1, 2013 – April 30, 2014	**May 1, 2014 – April 30,2015**	**Total**
Sacred Heart (SH)	413	350	763
Oregon Health & Science Univ (OHSU)	89	122	211
Rogue Regional (RR)	84	57	141
St. Charles Bend (STC-B)	42	66	108
Sky Lakes (SKY)	40	5	45
Providence Medford (PMMC)	35	32	67
Providence Portland Medical Ctr (PPMC)	34	101	135
Pacific Communities (SPCH)	28	11	39
Providence St V (APRN) (STV)	28	18	46
McKenzie-Willamette (MCW)	25	16	41
Providence Willamette Falls (PWFH)	24	19	43
Bay Area (BA)	21	22	43
Columbia Memorial (CMH)	10	32	42
Tuality (TCH)	9	34	43
Albany Samaritan (AGH)	9	5	14
Good Shepherd (GSH)	6	0	6
Providence Milwaukie (PMIL)	4	3	7
SAMCO (SAO)	4	4	8
Coquille (CVH)	2	2	4
St. Alphonsus (SAB)	2	1	3
Peace Harbor (PH)	2	0	2
Grande Ronde (GRH)	1	1	2
Samaritan Lebanon Comm Hosp (SLCH)	1	1	2
St. Charles Redmond (STC-R)	0	23	23
Providence Seaside (PSH)	0	2	2
Mercy Medical (MMC)	0	9	9
Good Samaritan Regional Med Ctr (GSM)	0	1	1
Total	**913**	**937**	**1849**

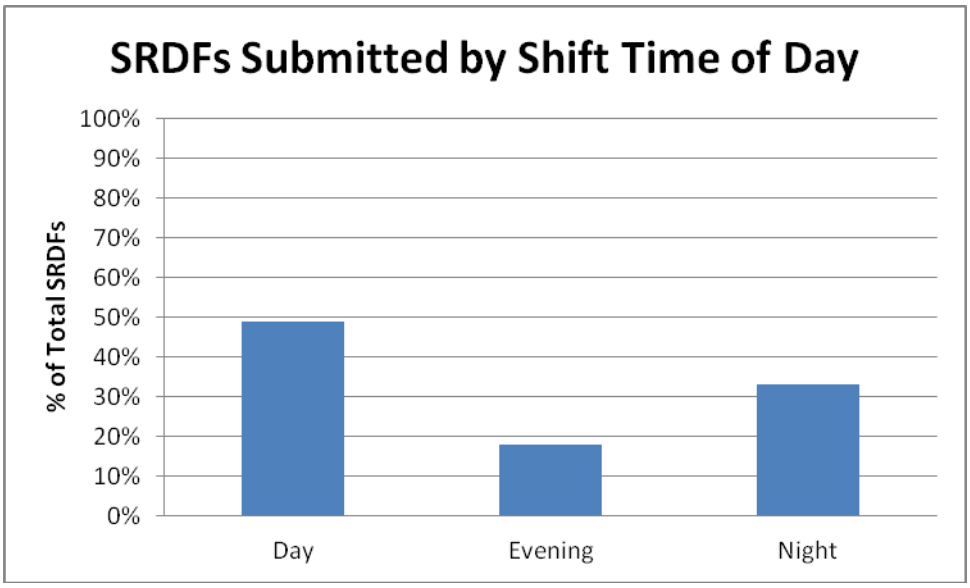

Top 5 Sites for SRDF Submissions
May 2013-April 2015
# of SRDFs
900
800
700
600
500
400
300
200
100
0
Sacred Heart (SH)
Oregon Health & Science Univ (OHSU)
Rogue Regional (RR)
Providence Portland Medical Ctr (PPMC)
St. Charles Bend (STC-B)

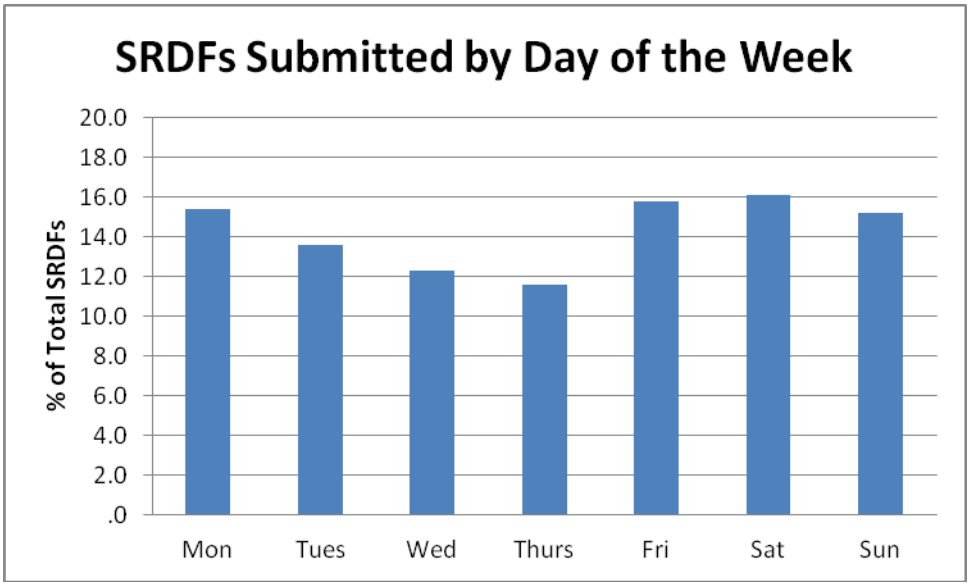

Top 5 Sites for SRDF Submissions
May 1, 2014 to April 30, 2015
# of SRDFs
400
350
300
250
200
150
100
50
0
Sacred Heart (SH)
Oregon Health & Science Univ (OHSU)
Providence Portland Medical Ctr (PPMC)
St. Charles Bend (STC-B)
Rogue Regional (RR)

Analysis of Potential Factors Related to the Number of SRDFs Submitted

Analysis: We examined several potential factors that could be related to the number of SRDFs submitted including shift length (eight versus twelve hour), time of day of the shift (day, evening, or night), day of the week, month of the year, and unit type. We observed that 77 percent of the SRDFs were submitted on eight-hour shifts. We also found that 49 percent of the SRDFs were submitted during the day shift followed by 33 percent on the night shift and 18 percent on the evening shift. Additionally, a greater percent of SRDFs submitted on Fridays (15.8 percent) and Saturdays (16.1 percent) compared to the rest of the week. Finally, over one third of the SRDFs submitted were from the Emergency Room (13.2 percent), ICU (12.6 percent), and General Surgical (10.0 percent) units.




SRDFs Submitted by Shift Time of Day
% of Total SRDFs
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Day
Evening
Night


SRDFs Submitted by Day of the Week
% of Total SRDFs
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
.0
Mon
Tues
Wed
Thurs
Fri
Sat
Sun

Percent of SRDFs Submitted by Unit Type

Unit	% of Total SRDFs Submitted
Emergency Room	13.2%
ICU/CCU/CMICU/NICU	12.6%
General Surgical	10.0%
General Medical	7.6%
Mother/Baby, Family Birth Center, Nursery	7.4%
Oncology	7.2%
Recovery Room/PACU	5.9%
Other	5.3%
Combined Medical Surgical	4.2%
Labor and Delivery	3.5%
Short Stay	3.2%
Post-cardiac/Step Down/Telemetry	3.2%
Inpatient Psychiatry/Behavioral Health Unit	2.9%
Orthopedics	2.2%
Operating Room/Surgery	2.2%
Neurology	1.5%
IV Therapy	1.3%
Temporary Care/Unit Overflow	1.2%
Rehabilitation/Longterm Care	1.2%
Pediatrics	1.1%
Emergency/Psychiatric	0.8%
Home Health	0.7%
Combined Orthopedics/urology	0.3%
Outpatient Infusion	0.3%
Endoscopy Lab	0.3%
Diabetes/Renal	0.2%
Special Procedures	0.2%
Respiratory Care	0.1%
Jail/prison	0.0%

Analysis of the Reasons for Reporting

Analysis: On 90 percent of the submitted SRDFs insufficient number of staff was indicated. Patient acuity being too high for the current staffing level was identified on 61 percent SRDFs and 41 percent of the SRDFs reported that patient acuity intensity was too high for the amount of staff on shift.

We examined the written responses for reports where "other" was selected as the reason for reporting. Throughput (i.e., turnover, admissions, transfers, and discharges) was mentioned on several SRDFs as a potential reason for reporting the insufficient staffing event. Adding throughput or a response related to turnover will be considered on future versions of the SRDF. On future updates to the SRDF having more than a 1:1 patient-to-nurse ratio was also reported several times. Finally, there were several responses that should have been categorized as inappropriate staff mix because the issue was related to inexperienced staff on the unit that did not have the appropriate skill set or knowledge of policies to perform the necessary duties (i.e., students and nurses in orientation).

Reasons for Reporting	% Indicating this was an issue
Not Enough Staff	90%
Patient Acuity too High	61%
Patient Intensity too High	41%
Inappropriate Staff Mix	32%
Other	23%

Analysis of the Care Task Consequences of Inadequate Staffing

Analysis and Interpretation: An example of what is meant by the impact of insufficient staffing on care tasks is captured in the following comment from a submitted SRDF**,** "Meds given up to 2-3 hours late, AM assessments not completed until afternoon, no breaks or lunches for some nurses, and/or orders completed late." When an adverse staffing event occurred, nurses reported between 80 percent and 93 percent of the time that a care task was either delayed or omitted. Pain management was the least delayed or omitted task, but it was only fully completed 20 percent of the time within the expected time frame. The least completed task was documentation, which was completed only 7 percent of the time within the expected time frame. The adverse staffing characteristics of patient intensity and patient acuity were significantly related to the delay or omission of almost all of the measured care tasks. In fact, when patient intensity was indicated as the reason for the inadequate staffing event, there was a 2.3 times greater likelihood that medical medications were delayed or omitted. When it was indicated that patient acuity was too high, there was at least a 2.6 times greater likelihood that medical orders and hygiene were delayed or omitted.

Consequences	% Delayed/Omitted	% Completed
Pain Management	80%	20%
Hygiene	86%	14%
Admission, Transfer, Discharge	86%	14%
Observation, assessment, monitoring	87%	13%
Medications	89%	11%
Psychosocial support	89%	11%
Support, information	90%	10%
Medical orders/treatments	91%	9%
Teach home/self care	91%	9%
Documentation	93%	7%

Analysis of Patient Safety Consequences of Inadequate Staffing

Analysis and Interpretation: An example of what is meant by the impact of insufficient staffing on patient safety and unit outcomes is captured in the following comment from a submitted SRDF, “I feel that this weekend we knowingly put patients in a potentially unsafe situation. I am putting my license in jeopardy. I will not work in a situation like this again and I’m having serious thoughts about looking elsewhere for employment.” We found that 72 percent of the nurses indicated that patient safety was compromised due to the inadequate staffing event and 27 percent reported that it affected continuity of care. Not enough staff, patient acuity, and inappropriate staff mix were significantly related to reports of compromised patient safety. Patient acuity being too high, patient intensity being too high, and inappropriate skill mix were significantly related to reported issues with continuity of care. When not enough staff, patient acuity being too high, and inappropriate staff mix were indicated, there was between a 1.4 to 2 times greater likelihood that compromised patient safety was reported. Indications of patient acuity being too high, patient intensity being too high, and inappropriate skill mix were related to at least a 1.5 times greater likelihood of continuity of care being compromised.

Consequences	% Yes	% No
Compromised safety	72%	28%
Continuity of care	27%	73%

Analysis of the Self-Care Consequences of Inadequate Staffing

Analysis and Interpretation: An example of what is meant by the impact of insufficient staffing on self-care is captured in the following comment from a submitted SRDF**,** "No one got breaks except the CNA. I had to call the Director of Shift Operations to come to the floor so that we could retrieve food from cafeteria - for safety. RNs didn't get 15 minute breaks legally allotted to Q4hrs. Forced to eat at nurse's station while charting." Nurses reported missing rest breaks 81 percent of the time and missing meal breaks 56 percent of the time on the submitted SRDFs. Patient intensity being too high had the strongest relationship with the self-care outcomes. When patient intensity was indicated as the reason for the SRDF submission, there was at least a 1.4 times greater likelihood that nurses reported voluntary overtime, missing meal breaks, and missing rest breaks. When not enough staff, patient acuity being too high, and patient intensity being too high were reported nurses had at least a 1.4 times greater likelihood to skip meal breaks. Finally, when patient acuity and intensity were indicated as the reason for the SRDF submission, nurses had at least a 1.8 times greater likelihood for skipping rest breaks.

Consequences	% Yes	% No
No rest break	81%	19%
No meal break	56%	44%
Voluntary overtime	30%	70%
Mandatory overtime	16%	84%

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