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How to Write a Better Charter & Staffing Plan

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Disclosures

The presenters/planners of this CNE activity declare no conflicts of interest and will provide the best available evidence for this content, presenting information fairly and without bias.

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Objectives

- Identify charter best practices
- Gain better understanding of how to develop a robust staffing plan
- Examine staffing plans and determine where revisions are needed

Charters

333-510-0105(6)

The Staffing Committee must develop a written charter that documents the policies and procedures of the staffing committee. At minimum, the charter must include:

- How meetings are scheduled
- How members are notified of meetings
- How agendas are determined
- How input from hospital nurse specialty or unit staff is submitted
- Who may participate in decision making
- How decisions are made
- How the staffing committee shall monitor, evaluate, and modify the staffing plan over time

*Plus, other deficiencies noted not related to the OARs

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How meetings are scheduled

- Who schedules the meetings?
- When are the meetings?
- How long are the meetings?
- How many meetings per year? (Minimum, at least quarterly)

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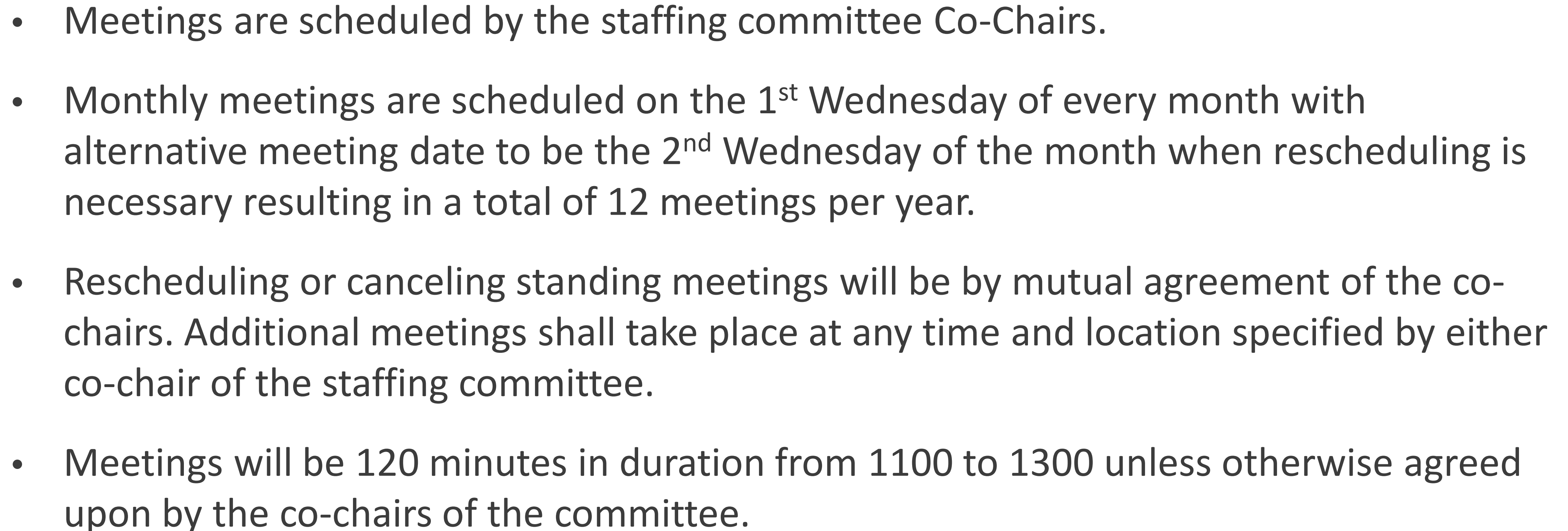
Example



How members are notified of meetings

- Are you being notified by email? In person? Postcard? Smoke signal?
- Who is responsible for sending the notification?
- When does the notification get sent?

Example

- Staffing Committee members are notified of meetings by an emailed meeting invitation sent by either co-chair at the beginning of each calendar year for all regularly scheduled monthly meetings.
- One week before each scheduled meeting a reminder email will be sent out by either co-chair to all committee members.

How agendas are determined

- Who is responsible for creating the agenda?
- How can a member submit agenda topics for consideration?
- When will routine work of the committee, such as charter reviews and approvals and staffing plan reviews and approvals, be added to the agenda?

Example

Committee co-chairs determine each month's agenda no less than seven calendar days prior to the committee meeting.

These standing items shall remain on the agendas unless both co-chairs agree to any changes:

a) January - Review and vote of charter

b) February - Review and vote of Medical Unit's staffing plan

c) March - Review and vote of Surgical Unit's staffing plan

d) April - Review and vote of ICU's staffing plan

e) May - Review and vote of ED's staffing plan

f) June - Review and vote of Birth Center's staffing plan

g) July - Review and vote of OR and PACU's staffing plans

***If at any time a unit's SP needs to be reviewed and voted on prior to their regularly scheduled annual review, either rep. member of the committee from the unit shall notify either co-chair no < 7 calendar days prior to the meeting.**

How input from hospital nurse specialty or unit staff is submitted

Be careful of general language like, “NSC members will collaborate/communicate/work with unit nurses.”

- How are the committee members expected to communicate with their represented units?
- How do committee members bring any comments from their units to the committee?
- Can any NSM, not just those on the committee, submit input? How would they do that?

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Example

- Staff nurses may submit input on agenda topics through any committee representative member who will then bring it to either co-chair's attention for consideration and inclusion on the agenda.
- Committee members are expected to communicate on a regular basis, not less than quarterly, with nurse staffing members in their department group in order to solicit potential agenda items.
- Each committee member will have access to email each nurse staffing member in the department group that they represent.
- The hospital will create and maintain email distribution lists for each department group. Co-chairs will receive a courtesy copy of these emails for support and tracking purposes.

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Who may participate in decision making?

- How does the committee ensure equal numbers of direct care and management staff are voting?
- When there is an unequal number, how do you decide who does not vote?
- If alternates are used, how it is decided that the alternate votes instead of the primary?
- If members represent more than one unit, do they get more than one vote?

Example

- Once a quorum has been established, the committee must determine the voting eligibility of each member.
- Only an equal number of hospital nurse leaders and direct care staff may vote.
- If there is a need for voting members to abstain due to unequal committee numbers, volunteers will be solicited, if there are no volunteers then the correlated Co-Chair will determine the voting member who shall abstain.

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How decisions are made

How does the committee vote?

Example

- Any member may make a motion to vote on an issue.
- A member, other than the moving member, may second the motion to initiate a vote.
- A vote shall be taken utilizing color-coded cards with green indicating a “yes”, yellow indicating “abstention” and red indicating a “no” vote.

How the staffing committee shall monitor, evaluate and modify the staffing plan over time

This section of the law not a focus for OHA's surveys in 2017

Each plan should be reviewed at least annually

- What things will the committee consider when reviewing the plan?
- How will the committee decide if the plan needs to be modified? What would the modification process look like?
- HPPD

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Example

Department specific staffing plans will be monitored, evaluated, modified and approved no less than once per year.

An Annual Reporting Calendar will be developed by the co-chairs prior to January 1 of each calendar year.

The Annual Reporting Calendar shall include dates for each department to submit the following information to either co-chair:

- A draft of their staffing plan for consideration and voting on by the committee
- A summary of data from the past year related to the patient outcomes the staffing plan identifies as being relevant to monitor
- Any complaints the department has received in the last year related to nurse staffing, including any complaints by direct care nursing staff that they believe the department is engaging in a pattern of requiring staff to work overtime for non-emergent care
- A summary of the number of hours of nursing care provided compared with the number of patients served during a 24-hour period over the last year
- The aggregate number of hours of voluntary and/or mandatory overtime worked by nursing staff in the last year
- A summary of the number of shifts in which the department's staffing differed from what was required by their staffing plan

Any other requests for information that the committee feels is relevant for the review of the department's staffing plan should be made to either co-chair no less than 30 calendar days prior to the scheduled review of that department's plan.

Other deficiencies noted not related to the OARs

- Charter needs to be voted on and approved by NSC! Minutes should reflect this vote.
- Charter should have the date of last approval
- Make sure the charter is consistent in its rules and language within itself and consistent with other policies and procedures.
- If the committee is using alternate members, this needs to be further defined in the charter. What is the alternate's role and expected duties? When would the alternate vote instead of the primary?

Example

X. Recordkeeping

a. An administrative assistant shall be assigned to document the business of the Staffing Committee in official meeting minutes. The staffing committee must document meeting proceedings by keeping written meeting minutes that include, but are not limited to, the following information:

- The name and position of each staffing committee member in attendance
- The name and position of each observer or presenter in attendance
- Motions made
- Outcomes of votes taken
- A summary of staffing committee discussions

*Action items – all action items will include who is responsible, what the action is and when the action is to be completed. Co-chairs will be notified by email when an action item is completed

Staffing Plans

ORS 333-510-0105, ORS 333-510-0110, ORS 333-510-0115

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Must be based on the specialized qualifications and competencies of the nursing staff and provide for the skill mix and level of competency necessary to ensure that the hospital is staffed to meet the health care needs of patients (E630).

What doesn't work?

- Don't use generic language.
- Don't put non-RNs into staffing plans unless you have a waiver.
- Be careful when outlining delegation of tasks (NSMs you delegate should have the appropriate qualifications and competencies).

What does work?

- List the qualifications and competencies for each NSM.
- Clarify what kind of nursing staff are filling which roles.
- If qualifications and competencies are different for floating staff, this needs to be included.

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Example

- No shift will have more than 50% of RNs be new graduates
- All RNs shall have the competencies and qualifications listed in these attached hospital policies:
  - General Nursing Competencies - required within 3 months from hire date
  - ICU RN Competencies - required within 3 months from hire date for RNs with more than 1 year of ICU experience OR within 1 year from hire date for new graduate RNs.
  - CNA2s competencies- required within 3 months from hire date.

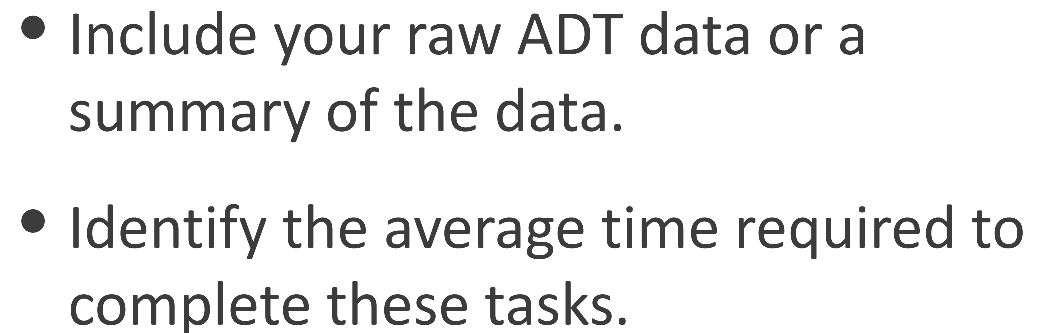
*The Staffing Committee must approve and vote on any policy that will be utilized in a staffing plan as well as any policies that has had changes made to it. In addition, the policies must have a review date listed on them.

Must be based on a measurement of hospital unit activity that quantifies the rate of admissions, discharges and transfers for each hospital unit and the time required for a direct care registered nurse belonging to a hospital unit to complete admissions, discharges and transfers for that hospital unit (E632).

What doesn’t work?

- Don’t keep old data in the plan (unless it is pertinent).
- Don’t put only half of the required data (Need both A/D/T data as well as time to complete these).

What does work?



- Include your raw ADT data or a summary of the data.
- Identify the average time required to complete these tasks.

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Example

- Medical-Surgical unit had an average of 8 discharges, 5 admissions, and 2 transfers in a 24-hour period. See attached A/D/T raw data from 2017.

- On average, admissions, discharges, and transfers take 30 minutes to complete. For that reason, after any ADT activity a RN will not be given any additional ADT activity for 30 minutes unless RN consents.

Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses (E634).

What doesn't work?

- Symptoms
- Chief complaints
- Nursing services provided

What does work?

- Diagnoses!

Example

The primary diagnoses seen on this unit are:

- Essential hypertension (HTN)
- Acute on chronic and new diagnoses congestive heart failure (CHF)
- ST elevation and non-ST elevation myocardial infarction (STEMI/NSTEMI)
- Unstable angina
- Cardiac arrhythmias

Based on these diagnoses, the following grid identifies the minimum number of staff needed to care an be used to determine base staffing requirements. This unit is staffed with RNs and CNA2s.

Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations (E636).

What doesn’t work?

- Don’t *not* include staffing standards if your specialty organization has any.
- Don’t cite staffing standards that do not exist!
- Don’t forget to cite your sources.

What does work?

- Include a year or version of the specialty staffing standards.
- If there are no standards for your specialty, document that.

Example

- ASPAN American Society of Peri Anesthesia Nurses. Practice Recommendation 1 – Patient Classification/Staffing Recommendations (2017)
  - A Position Statement on Acuity Based Staffing for Phase I (2016)
- AWHONN – Guidelines for Professional Nurse Staffing for Perinatal Units (2010)
- AACN – Synergy Professional Practice Model (2011)
- APNA – Staffing Inpatient Psychiatric Units: A call for new staffing models (2011)
- ENA – Staffing and Productivity in the Emergency Department (2015)

Must recognize differences in patient acuity and nursing care intensity (E638).

What doesn't work?

- General statements
- Addressing acuity but not intensity
- Addressing acuity and intensity but not how staffing will be adjusted

What does work?

- Detail how acuity and intensity are determined
- Detail how staffing will be adjusted based on acuity and intensity
- Attach an acuity tool to your plan

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Example 1

Patient Acuity and Intensity

Nursing assignments will be based on the Workload Acuity Score in EPIC.

The charge nurse if responsible for making patient assignments based on the acuity numbers generated in EPIC at 0200 and 1400.

Dayshift RN Max Acuity/Intensity Score: 16

Nightshift RN Max Acuity/Intensity Score: 19

The workload acuity score may change throughout the shift. If during the shift, the total acuity/intensity score of a nurse's assignment exceeds the maximum acuity number it does not place the nurse's group out of compliance. However, it does exempt that nurse from assuming care of new patients.

Admissions are automatically an acuity number of 3 for the first 2 hours and will be reassessed for an acuity/intensity number for the next shift.

EPIC Workload Acuity Score	Acuity/Intensity Number
0-15	1
16-25	2
26-45	3
46-65	4
66-85	5
85 +	6

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Example 2

8E Acuity Tool

Instructions: using the indicators below, identify each patient's acuity level. The sample descriptors are on the back.
+/- may be used (example: 3+ or 2-)
Notify Charge Nurse of patients' acuity by 1500/0300 for accurate assignment.

Level 1 Acuity Patient has 3 -4 of the following indicators	**Level 2 Acuity** Patient has 3 -4 of the following indicators	**Level 3 Acuity** Patient has 3 -4 of the following indicators	**Level 4 Acuity** Patient has >2 of the following indicators plus (4-6) indicators from levels 2 &/or 3
• A&O x 3, able to make decisions, communicates clearly • Independent in ADL's • Emotionally stable, adequate coping skills, collaborates w/staff • Knowledge of disease process, tx, and teaching plan • Family support • Saline lock • 1 tx/proc. Per shift • Ready for DC home w/no equipment or Home Health • Pain mgmt. (PO <4/day) • CDU patients	• Communicates clearly & appropriately for age & ability (some delay) • Needs assist w/ADL's (set-up) • SBA w/transfer • 1:1 sitter • Difficulty making important decisions • Mildly compromised communication (mumbles/slurred speech at times) • Minimal assist w/ basic physical tasks (FWW/cane/crutches but steady gait; Min-asst w/hygiene /grooming) • Stable surgical pt's after immediate post-op monitoring periods, now most in self-care phase, participating in education • Able to control behaviors • Pain mgmt. (PO 4-6/day) • Comfort Care • IV Fluids	• A&O x 2; easily reorients. • Forgetful • Cannot make important decisions independently • Mod. compromised communication (mumbles/slurred speech/whispers) • Moderate assist in ADL's • Unsteady gait and uses FWW/cane/crutches to ambulate • Needs DC Planning assistance • Problems w/elimination (incontinent, diarrhea, frequent N/V) • Fall risk Moderate (one person assist to ambulate, assistive device) • Complex, urgent admit (i.e., rush to OR, GI bleed, etc) • 2-3 lines /drains/tubes • Isolation • Requiring frequent suctioning • First 24 hrs patients w/ Epidurals/PCA/Hep gtt • Frequent IV analgesia every 4-6 hours • Unstable surgical patients after immediate post-op monitoring period (BP not WDL, O2 2-3 LPNC, brady-/tachycardia, decrease in LOC/mentation, decrease in U/O • Pt. requiring blood (product) transfusion • Emotionally labile, inadequate coping skills, unable/refuse to collaborate w/staff	• A&O x 1 Confused, • Moderate to severe memory loss, cannot be re-oriented • Restraints • Unable to make decisions • 2 person assist with transfer/positioning • Max assist w/ ADL's • Feeder, difficulty swallowing (aspiration risk) • Severely compromised communication • Unable to control behaviors that might cause harm/injury/fall (1:1 monitoring) • Compromised respiratory status RR >30 min, oxygen sat <88% with supplemental oxygen. • Very Frequent IV analgesia (every 2 hrs) or > 5 IV/PO combination analgesia needs per 8 hr shift • No family /social support • Complex Admit (i.e., rush to OR, GI Bleed, etc.). • May Require Service Recovery (quality management)

Must establish minimum number of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts (E640) and must provide that no fewer than one registered nurse and one other nursing staff member is on duty in a unit when a patient is present (E642).

What doesn't work?

- Don't include non-nursing staff in your grid unless you have a waiver.
- Don't consider non-nursing staff when identifying minimum staff for one patient, unless you have a waiver.

What does work?

- Embed a grid with specific NSMs
- Grid has to say what staffing is with one patient
- Minimum staffing should be maintained when nursing staff are off the floor (for example, on a break).

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Example

MINIMUM STAFFING		
Patients	RNs	CNA2s
1-3	1	1
4-6	2	1
7-9	3	1
10-12	4	2
13-15	5	2

Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgement of a direct care registered nurse or a nurse manager, there is an inability to meet patient care needs or a risk of harm to patients (E644).

What doesn't work?

- Don't include general language that fails to outline a real process or procedure.

What does work?

- Attach a hospital policy and procedure on diversion and limitation on admission of patients.
- Ensure the chain of command can start with a direct care nurse.

Example

Process:

- Any RN may initiate
- RN contacts Charge Nurse
- Charge Nurse contacts House Supervisor & Nurse Manager
- If this process is unable to meet patient care needs, the House Supervisor and/or Nurse Manager will escalate the concern to the CNO or designee.

Must consider tasks not related to providing direct care, including meal breaks and rest breaks (E646).

What doesn't work?

- Rebranding the buddy system
- Say that you can take up to 12 patients - implied or otherwise

What does work?

- Maintain your staffing plan even when staff members on their meals and breaks.
- Include a detailed meals and breaks plan: Who is the NSM reporting off to? How is the plain maintained? How are meals and breaks being documented?

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Example

- 3 RNs are used for meals and breaks
- Times are assigned
- Charge nurse utilized as 4th backup
- RNs give brief report to Resource RN
- Tasks are limited to what can be done in allotted time
  - Meds
  - Blood draws
  - Etc.

DAY SHIFT LUNCH/BREAK SCHEDULE

Caregiver Name	Break time	Lunch Time (45 MIN)	Break Time	Offered	Taken	Refused (caregiver initial)
RN 1	0820	1100	1600			
RN 2	0820	1100	1600			
RN 3	0900	1100	1620			
RN 4	0840	1200	1620			
RN 5	0840	1200	1640			
RN 6	0920	1200	1640			
RN 7	0900	1300	1700			
RN 8	0900	1300	1700			
RN 9	0940	1330	1720			
RN 10	0920	1400	1720			
RN 11	0920	1400	1740			
RN 12	1000	1430	1740			
RN 13 (RESOURCE RN 1)	1000	1500	1800			
RN 14 (RESOURCE RN 2)	1020	1500	1800			
RN 15 (RESOURCE RN 3)	1300					

Questions?

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Contact Us!

For more information contact

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Thank you!