Nurse Staffing Report

Facility Name: OHSU Hospital and Clinics

Report Publication Date: December 22, 2017

**DISCLAIMER:** This report was provided to the hospital administrator and both co-chairs of the hospital-wide nurse staffing committee prior to publication.

The hospital has 30 business days from the date it was provided to the hospital administrator and both co-chairs of the hospital-wide nurse staffing committee to submit a Plan of Correction to address deficiencies cited in the report. The Plan of Correction will be added to the published copy of the Nurse Staffing Survey Report after the Plan of Correction is approved by the Oregon Health Authority.

If you need this information in an alternate format, please call our office at (971) 673-0540 or TTY 711.
December 21, 2017

Joe Ness
Hospital Administrator
OHSU Hospital and Clinics
3181 SW Sam Jackson Park Road
Portland, OR 97239-3011

Adam Foster
Nurse Staffing Committee Co-Chair
OHSU Hospital and Clinics
3181 SW Sam Jackson Park Road
Portland, OR 97239-3011

Mariah Hayes
Nurse Staffing Committee Co-Chair
OHSU Hospital and Clinics
3181 SW Sam Jackson Park Road
Portland, OR 97239-3011

RE: Nurse Staffing Survey
Nurse Staffing complaint #s OR13575, OR12723 and OR12536

Dear Mr. Ness, Mr. Foster and Ms. Hayes:

On November 7, 2017 our office completed a nurse staffing survey and nurse staffing complaint investigation at your facility. The survey revealed one or more violations of the Oregon Administrative Rules for Nurse Staffing Services.

Enclosed is the Report for that visit. You must complete and sign the Plan of Correction and return it to our office within thirty (30) business days of your receipt of this letter. Please keep a copy for your files. The Plan of Correction must include the following information for each deficiency cited:

1. A detailed description of how the hospital plans to correct the specific deficiency identified;
2. The procedure(s) for implementing the plan for the specific deficiency;
3. A timeline or date by which the hospital expects to implement the corrective actions;
4. The description of monitoring procedure(s) that the hospital will perform to prevent a recurrence of the specific deficiency identified; and
5. The title of the person who will be responsible for implementing the corrective actions described.

A Plan of Correction Guidance document is also enclosed for your convenience.

Please note that the hospital administrator's signature and the date signed must be recorded on Page 1 of the Report/Plan of Correction form.

If you have any questions you may contact our office at (971) 673-0540.

Sincerely,

Nurse Staffing Survey Team  
Oregon Health Authority  
Public Health Division  
Health Care Regulation and Quality Improvement

Enclosures: Nurse Staffing Report  
Plan of Correction Guidance Document

If you need this material in an alternate format, please call (971)673-0540 or TTY 711
E 000  Initial Comments

This report reflects the findings of a full nurse staffing survey that was initiated onsite on 09/25/2017 and concluded on 11/07/2017.

The hospital was evaluated for compliance with the Oregon Administrative Rules for hospital Nursing Services Staffing set forth in OAR Chapter 333, Division 510. The deficiencies identified during the survey follow in this report.

The survey also included an unannounced, onsite nurse staffing complaint investigation of complaint #OR13575. There was insufficient evidence to substantiate the allegation contained in the complaint.

In addition, this report reflects the findings of an unannounced, onsite nurse staffing complaint investigation of complaint #s OR12536 and OR12723. The complaint investigation was initiated on 05/31/2017 and concluded on 06/02/2017. The allegations contained in the complaints were found to be substantiated. The deficiencies identified during the complaint investigation are incorporated into this report.

The following abbreviations, acronyms, and definitions may be used:

4A - 4A Inpatient Transplant Urology Plastics Unit
5B - A hospital unit
6A - 6A South Pre-op & Post-op Unit
9K - A hospital unit
10D HCR - A hospital unit
14A - A hospital unit
AACN - American Association of Critical-Care Nurses
AC - Acute Care
ACLS - Advanced Cardiac Life Support
**Health Care Regulation and Quality Improvement**

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<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>(14-1008)</td>
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<td>11/07/2017</td>
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**NAME OF PROVIDER OR SUPPLIER**

**OHSU HOSPITAL AND CLINICS**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3181 SW SAM JACKSON PARK ROAD
PORTLAND, OR 97239

### (X4) ID PREFIX TAG

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- ACNM - Acute Care Nurse Manager
- ASPAN - American Society of PeriAnesthesia Nurses
- ASPSN - Unknown
- AVWHONN - Association of Women's Health, Obstetric and Neonatal Nurses
- BLS - Basic Life Support
- Chemo or chemo - Chemotherapy
- CHO - Community Hematology/Oncology Outpatient Infusion Clinics
- CN - Charge Nurse
- CNA - Certified Nursing Assistant
- CNE - Chief Nurse Executive
- CNO - Chief Nursing Officer
- CTRC - Clinical Trial Research Center
- DCH - Doernbecher Children's Hospital
- DCHOR - Doernbecher Children's Hospital Intraoperative Unit
- EKG - Electrocardiogram
- EMU - Epilepsy Monitoring Unit
- Eval - Evaluation
- GI - Gastrointestinal
- HBNSC - Hospital-Based Nurse Staffing Committee
- hr./hrs. - hour/hours
- I&O - Intake & Output
- IMC - Intermediate Care
- L&D - 12C Labor and Delivery Unit
- LDR - Labor and Delivery
- LPN - Licensed Practical Nurse
- MOT - Mandatory Overtime
- MRSN - Unknown
- Neuro - Neuro Unit
- NIH - National Institute of Health
- NM - Nurse Manager
- Nocs - Nights
- NSC - Nurse Staffing Committee
- NSM - Nursing Staff Member
- NSP - Nurse Staffing Plan
- OHSU - Oregon Health & Sciences University
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<th>(X5) COMPLETE DATE</th>
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| E 000             | Continued From page 2  
OLC - Unknown  
ONS - Oncology Nursing Society  
Onc - Oncology Unit  
OR - Operating Room  
OT - Overtime  
PACU - Post-Anesthesia Care Unit  … | E 000         |                                                                                                           |                   |
| E 600             | OAR 333-510-0045 (1) Nurse Staffing Complaint Notice  
(1) On each hospital unit, a hospital shall post a complaint notice that:  
(a) Summarizes the provisions of ORS 441.152 to 441.177;  
(b) Is clearly visible to the public; and  
(c) Includes the Authority's complaint reporting phone number, electronic mail address and website address. | E 600         |                                                                                                           |                   |

This Rule is not met as evidenced by: Based on observation and interview it was determined the hospital failed to ensure it posted the complaint notice with all required information.
**E 600** Continued From page 3

Findings include:

1. During tour of the hospital with the Director of Regulatory Affairs and the CNO on 09/26/2017 beginning at 1100 the nurse staffing complaint notice observed posted in the staff entry area of 6A and in the public entry area of 6A lacked the electronic mail address and website address for the Oregon Health Authority. The notice observed posted in public entry area of 6A also included an inaccurate physical address for the Oregon Health Authority.

2. During tour of the hospital with the Director of Regulatory Affairs and the CNO on 09/26/2017 beginning at 1110 the nurse staffing complaint notice observed posted in the entry area of 4A lacked the electronic mail address and website address for the Oregon Health Authority.

3. During tour of the hospital with the Director of Regulatory Affairs and the CNO on 09/26/2017 beginning at 1120 the nurse staffing complaint notice observed posted in nurses' station of L&D lacked the electronic mail address and website address for the Oregon Health Authority.

4. During tour of the hospital with the Director of Regulatory Affairs and the CNO on 09/26/2017 beginning at 1130 the nurse staffing complaint notice observed posted in the DCHOR lacked the electronic mail address and website address for the Oregon Health Authority.

5. During observation on 09/27/2017, photos taken of notices posted at 5 CHO clinics reflected that the notices lacked the electronic mail address and website address for the Oregon Health Authority.
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| E 600 |            | Continued From page 4  
6. In NSM interviews completed between 09/25/2017 and 10/02/2017, 321 of 582 respondents indicated that information about nurse staffing laws was not posted at the hospital or they did not know where it was posted. | E 600 |            |                                                                                                  |               |
| E 602 |            | OAR 333-510-0045 (2) Anti-Retaliation Notice  
(2) A hospital shall also post an anti-retaliation notice on the premises that  
(a) Summarizes the provisions of ORS 441.181, 441.183, 441.184 and 441.192;  
(b) Is clearly visible; and  
(c) Is posted where notices to employees and applicants for employment are customarily displayed.  
Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185  
Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185  This Rule is not met as evidenced by:  
Based on interview it was determined the hospital failed to ensure it posted the anti-retaliation notice in places where employees and applicants for employment would be likely to view and read it.  
Findings include:  
1. During interview with the Director of Regulatory Affairs on 09/26/2017 beginning at 1135, he/she stated that all applicants for employment apply online. | E 602 |            |                                                                                                  |               |
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<td>E 602</td>
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<td>2. During interview with the Director of Regulatory Affairs on 09/26/2017 beginning at 1700, he/she stated there was no anti-retaliation notice posting online where employees or applicants could view it.</td>
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<td>E 604</td>
<td>OAR 333-510-0045 (3) Nurse Staffing Documentation</td>
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<td>(3) A hospital shall keep and maintain all records necessary to demonstrate compliance with ORS 441.152 to 441.177. These records shall: (a) Be maintained for no fewer than three years; (b) Be promptly provided to the Authority upon request; and (c) Include, at minimum: (A) The staffing plan; (B) The hospital nurse staffing committee charter; (C) Staffing committee meeting minutes; (D) Documentation showing how all members of the staffing committee were selected; (E) All complaints filed with the staffing committee; (F) Personnel files for all nursing staff positions that include, at minimum, job descriptions, required licensure and specialized qualifications and competencies required for the individual’s assigned nurse specialty or unit; (G) Documentation showing work schedules for nursing staff in each hospital nurse specialty or unit; (H) Documentation showing actual hours worked by all nursing staff; (I) Documentation showing all work schedule variances that resulted in the use of replacement nursing staff; (J) Documentation showing how many on-call hours, if any, required nursing staff to be on the hospital premises;</td>
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(K) Documentation showing how many required meeting, education and training hours, if any, were required of nursing staff;
(L) The hospital's mandatory overtime policy and procedure;
(M) Documentation showing how many, if any, overtime hours were worked by nursing staff;
(N) Documentation of all waiver requests, if any, submitted to the Authority;
(O) Documentation showing how many, if any, additional hours were worked due to emergency circumstances and the nature of those circumstances;
(P) The list of on-call nursing staff used to obtain replacement nursing staff;
(Q) Documentation showing how and when the hospital updates its list of on-call staff used to obtain replacement nursing staff and how the hospital determines eligibility to remain on the list;
(R) Documentation showing the hospital's procedures for obtaining replacement nursing staff, including efforts made to obtain replacement staff;
(S) Documentation showing the hospital's actual efforts to seek replacement staff when needed;
(T) Documentation showing each actual instance in which the hospital implemented the policy described in OAR 333-510-0110(2)(g) to initiate limitations on admission or diversion of patients to another hospital; and
(U) All staffing committee reports filed with the hospital administration following a review of the staffing plan.

Stat. Auth.: ORS 413.042, 441.155, 441.169, 441.173 & 441.185
Stats. Implemented: ORS 441.155, 441.169, 441.173 & 441.185
This Rule is not met as evidenced by:
Based on interview and review of NSP documentation 3 of 5 specialties or units (4A, L&D and 6A); and review of documentation in 8 of 14 personnel records (NSM 2, 4, 5, 12, 16, 44, 45 and 46), it was determined that the hospital failed to maintain documentation showing the specialized qualifications and competencies for NSMs as required by subsection (c)(F).

Findings include:

1. Review of personnel records for 4A CNA NSM 2, with a hire date of 02/06/2017, reflected no documentation of "4A Unit Orientation." During interview with the 4A nurse manager on 09/29/2017 at 1515, he/she stated that the "4A Unit Orientation" included review of "CNA Shift Responsibilities" document with the employee. There was no documentation reflecting that had been done. The "CNA Shift Responsibilities" document included approximately 65 items including, but not limited to: "Answer call lights promptly ... skin care and turning/position changes as directed by RN ... Complete documentation ... Chart VS and I&O ... Rounds on patients every hour ... Incontinent patients ... Fall risks ... Empty Foley catheters and drains - record output ... Verify call light within reach ... Signs/Symptoms to Report to the Nurse ... Irregular pulse ... Labored breathing ... Any bleeding, especially bright red ... Chest pain or shortness of breath."

2. Review of personnel records for 4A RN NSM 5, with a hire date of 02/06/2017, reflected no documentation of "Hospital Required Education: ... Environment of Care ... Broadening Cultural
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<td>E 604</td>
<td>Continued From page 8 Competence ... Cardiovascular health ... Creating a quiet, safe, healing environment ... Workplace violence prevention and response ...&quot; Further, the records reflected no documentation of a &quot;Unit-specific minimum requirement&quot; titled &quot;Permacath flushing for Accessing and Deaccessing Dialysis Catheters.&quot;</td>
<td>E 604</td>
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<td>3. Similar findings were identified for 4A RN NSM 4.</td>
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<td>4. During interview with the 4A nurse manager on 09/29/2017 at the time of review, he/she confirmed findings 1, 2 and 3.</td>
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<td>5. Review of personnel records for L&amp;D RN NSM 12, with a hire date of 06/27/2011, reflected no documentation of required &quot;Hospital Required Education: ... Cardiovascular Health ... Pneumatic Tube System ... Population Served and Venous Thromboembolism (VTE) Staff Education.&quot;</td>
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<td>6. Similar findings were identified for L&amp;D RN NSM 16.</td>
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<td>7. During interview with the L&amp;D nurse manager on 09/29/2017 at the time of review, he/she stated that the required education referred to in finding 5 &quot;should have been done already.&quot;</td>
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<td>8. Review of personnel records for 6A RN NSM 45, with a hire date of 07/25/2016, reflected that the &quot;Orientation Evaluation Checklist&quot; was signed and dated on the last page as &quot;Completed&quot; on 09/15/2016. The checklist included 80 &quot;performance criteria&quot;. Instructions on the checklist directed the preceptor to &quot;initial and date each box individually.&quot; None of the 80 spaces were initialed or dated under the columns titled &quot;Preceptor Eval, Initials &amp; Date&quot;. Evaluation of the</td>
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<td>E 604</td>
<td>Continued From page 9</td>
<td>performance criteria were not recorded in 75 of the 80 spaces, including, but not limited to: &quot;Care of Epidural&quot;; &quot;Care of Lumbar Drain&quot;; &quot;Completes Pre-op checklist&quot;; and &quot;Describes safe medication administration standards/policies...&quot;</td>
<td>E 604</td>
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<td>9.</td>
<td>Review of personnel records for 6A RN NSM 46, with a hire date of 05/02/2016, reflected that the &quot;Orientation Evaluation Checklist&quot; was signed and dated on the last page as &quot;Completed&quot; on 06/24/2016. However, the NSM’s level of performance for the performance criteria of &quot;Verbalizes the emergency communication process for urgent airway and Code Blue&quot; and &quot;Completes hands on defibrillator training with unit supervisor&quot; was documented as &quot;Novice.&quot; The checklist reflected that &quot;Novice&quot; was defined as &quot;requires close supervision.&quot; The space for re-evaluation of these performance criteria by the preceptor was blank.</td>
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<td>10.</td>
<td>Similar findings were identified for 6A RN NSM 44.</td>
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<td>11.</td>
<td>During interview with 6A nurse manager and NSC direct care co-chair on 09/29/2017 at the time of review, they confirmed findings 8, 9 and 10.</td>
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<td>12.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 217 of 582 respondents indicated that replacement staff assigned to their unit did not have the necessary competencies and skills to work in the unit or they did not know if the replacement staff had the necessary competencies and skills to work in the unit.</td>
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<td>13.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 78 of 582</td>
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## Summary of Deficiencies

**E 604** Continued From page 10

Respondents indicated that in the past year they have been scheduled to work with patients for whom they do not have current competencies.

**E 612** OAR 333-510-0105 (4) (a) Nurse Staffing Committee Req.

1. The staffing committee shall be comprised of an equal number of hospital nurse managers and direct care staff. Direct care staff members shall be selected as follows:
   a. The staffing committee shall include at least one direct care registered nurse from each hospital nurse specialty or unit as the specialty or unit is defined by the hospital to represent that specialty or unit;

This Rule is not met as evidenced by:

Based on interview, review of the NSC charter, and review of the NSC roster undated, it was determined that the hospital failed to ensure the NSC was clearly comprised of equal numbers of nurse managers and direct care staff that represented all specialties/units where nursing services were provided:

* The NSC was not clearly comprised of equal numbers of hospital nurse managers and direct care staff; and
* At least one RN from each hospital specialty or unit was not included in the NSC membership.

**Findings include:**

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**STATE OF OREGON**

**STATE FORM**

**6UPU11**

If continuation sheet 11 of 54
**Health Care Regulation and Quality Improvement**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CLA ID NUMBER:** 14-1008  

**X2 MULTIPLE CONSTRUCTION**  
A. BUILDING:  
B. WING  

**X3 DATE SURVEY COMPLETED:** 11/07/2017

**NAME OF PROVIDER OR SUPPLIER:** OHSU HOSPITAL AND CLINICS  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3181 SW SAM JACKSON PARK ROAD, PORTLAND, OR 97239

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| E 612         | Continued From page 11  
1. Review of a document titled "Hospital-Based Nursing Staff Committee (HBNSC)" dated "June 2017" reflected the composition of the hospital's NSC. The roster contained NSC members' names, of which 10 were identified as nurse manager members, and 8 were identified as direct care members.  
2. Review of the NSC roster dated "June 2017" included a non-RN direct care member who represented "Case Management, Poison Center & units not covered by other clusters." The roster did not reflect which "units" were not covered, and it did not indicate whether a direct care RN represented those units. The NSC roster also reflected that direct care NSC member positions were 'open' for the following units: 10D HRC, Apheresis, GI Adult, Nursing Resource Management, Vascular Access Team; and 12A, 12C, and 13C.  
3. Review of the NSC Charter reflected "...the committee is comprised of an equal number of nursing staff members and nurse managers...individual units are represented in clusters by the respective elected (nursing staff members) and selected (nurse manager) representatives...The cluster 'member-at-large' is filled by a CNA/LPN member representing OHSU CNAs/LPNs and a nurse manager representing UA RNs..." It was not clear what was meant by "UA" RNs. The charter did not include that the NSC would include at least one direct care RN from each hospital specialty or unit.  
4. During interview with the NSC co-chairs on 09/26/2017 at the time of NSC charter review, they stated the direct care non-RN who represented "member-at-large" cluster represented all specialties/units that do not
**E 612** Continued From page 12

already belong to a cluster, and would represent any new specialties/units that open in the future. They acknowledged during interview that the NSC roster reflected unequal numbers of nurse managers and direct care staff members.

5. In NSM interviews completed between 09/25/2017 and 10/02/2017, 408 of 582 respondents indicated that they did not know who represented their unit on the NSC. 510 of 582 NSMs indicated that they did not participate or did not know if they participated in the selection of NSC members.

**E 618** OAR 333-510-0105 (5) Nurse Staffing Committee Req.

(5) The staffing committee shall have two co-chairs. One co-chair must be a hospital nurse manager elected by a majority of the staffing committee members who are hospital nurse managers. The other co-chair must be a direct care registered nurse elected by a majority of the staffing committee members who are direct care staff.

Stat. Auth.: ORS 413.042, 441.151 & 441.154

Stats. Implemented: ORS 441.154

This Rule is not met as evidenced by:

Based on review of the NSC charter it was determined that the hospital failed to ensure the NSC co-chairs were selected in accordance with these rules.

Findings include:

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**STATE OF OREGON**

**STATE FORM**
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<th>E 618 Continued From page 13</th>
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<td>1. Review of the NSC Charter titled &quot;Hospital-Based Nursing Staff Committee&quot; dated &quot;June 2017&quot;, reflected &quot;The Committee has two chairs: one co-chair is a direct care registered nurse elected by the nursing staff in the committee ... One co-chair is a hospital nurse manager selected by the CNO...The co-chairs do not represent a specific area but are representatives for the entire organization.&quot; This selection is not in accordance with these rules: * The nurse manager co-chair is selected by the CNO and not elected by a majority of the NSC nurse manager members.</td>
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<td>E 620 QAR 333-510-0105 (6) Nurse Staffing Committee Req.</td>
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<td>(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:</td>
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<td>(a) How meetings are scheduled;</td>
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<td>(b) How members are notified of meetings;</td>
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<td>(c) How agendas are determined;</td>
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<td>(d) How input from hospital nurse specialty or unit staff is submitted;</td>
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<td>(e) Who may participate in decision-making;</td>
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<td>(f) How decisions are made; and</td>
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<td>(g) How the staffing committee shall monitor, evaluate and modify the staffing plan over time.</td>
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<td>Stat. Auth.: ORS 413.042, 441.151 &amp; 441.154 Stats. Implemented: ORS 441.154</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

This Rule is not met as evidenced by:
Based on interview and review of the NSC charter, it was determined that the hospital failed to ensure the NSC had developed and approved a charter that was current, accurate, and included or clearly stipulated the following:
* How meetings are scheduled;
* How members are notified of meetings;
* How agendas were determined;
* How decisions were made;
* How input from specialty or unit staff is obtained; and
* How the staffing committee shall monitor, evaluate and modify the staffing plan over time.

Findings include:

1. Review of the document titled "OHSU Hospital-Based Nurse Staffing Committee" charter dated "June 2017" reflected:
   * The NSC charter did not state how meetings are scheduled, how members would be notified of meetings, how agendas were determined or how input from hospital nurse specialty or unit staff is submitted.
   * The NSC charter did not clearly stipulate a process for voting or decision-making. It stated only, "... substantive decisions are arrived [at] following open, respectful discussions and confirmed consensus." It was unclear what was considered "substantive" and it did not include how decisions were made that were not substantive.
   * The NSC charter did not clearly describe how decisions are made. The charter stated only, "Quorum is considered 50% +1 of the members with a parity of management and direct care representatives." It was unclear how parity would be achieved as 50% +1 would be an odd number.
Continued From page 15

2. During interview with NSC co-chairs on 09/26/2017 beginning at 1405, they confirmed finding 1.

3. In NSM interviews completed between 09/25/2017 and 10/02/2017, 363 of 582 respondents indicated they had not participated in the development of the NSP for the unit they worked on.

4. Review of the document titled "OHSU Hospital-Based Nurse Staffing Committee" dated "05/2017" reflected "The hospital may not modify or change the policy or plans unilaterally without the approval of the HBNSC. However, the hospital may, through its Quality Assurance activities, modify the plan only to improve patient care; the HBSNC will be apprised of these changes and why they are necessary."

5. During interview with NSC nurse manager co-chair of the nurse staffing committee on 05/31/2017 at 1500, he/she stated changes that Quality Assurance may want to make, or something the hospital may want to push through, are brought to the committee. He/she stated that he/she "could see how someone can read [the charter language referring to Quality Assurance] that way."

(7) Staffing committee meetings must be conducted as follows:
(a) A meeting may not be conducted unless a quorum of staffing committee members is present;
(b) Except as set forth in subsection (c) of this
E 622 Continued From page 16

section, a meeting must be open to all hospital nursing staff as observers and to any other individual as either observer or presenter by invitation of either co-chair of the staffing committee;
(c) Either co-chair of the staffing committee may temporarily exclude all non-members from a meeting during staffing committee deliberations and voting; and
(d) Each staffing committee decision must be made by majority vote; however, if a quorum consists of an unequal number of hospital nurse managers and direct care staff, only an equal number of hospital nurse managers and direct care staff may vote.
Stat. Auth.: ORS 413.042, 441.151 & 441.154
Stats. Implemented: ORS 441.154

This Rule is not met as evidenced by:
Based on interview and review of NSC charter it was determined that the hospital failed to ensure that the NSC conducted business in accordance with this rule:
* There was no assurance that only an equal number of nurse manager members and direct care staff members had participated in voting;
* A NSC meeting was conducted when a quorum of members was not present; and
* There was no assurance that the meeting is open to all hospital nursing staff as observers and to any other individual as either observer or presenter by invitation of either co-chair of the staffing committee.

Findings include:
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<td>E 622</td>
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1. Review of NSC meeting minutes dated 04/05/2017 identified 16 individuals in attendance but lacked clear position information to indicate whether each individual was an RN, a non-RN, a nurse manager, a direct care NSM, a primary member, an alternate member or an observer. The minutes reflected "March meeting minutes present for approval. No vote, due to quorum not available." However, the minutes also reflected 5 pages documenting discussion at the meeting from 1500 to 1700. *"Adjourned" at 1702. There was no assurance that the meeting was conducted with a quorum of NSC members.

2. Review of "OHSU HBNSC Voting Record" dated 04/05/2017, reflected a vote was taken to approve March 2017 HBNSC meeting minutes. The voting record reflected 1 nurse manager member and 2 direct care members voted "yea." No other votes were cast. There was no documentation to reflect that voting by an equal number of nurse manager members and direct care staff members had occurred.

3. Review of NSC meeting minutes dated 05/03/2017 reflected "March minutes approved". The voting record for approval reflected 1 individual "abstained", and 3 individuals "voted in favor." There was no further record of who voted. There was no documentation to reflect that voting by an equal number of nurse manager members and direct care staff members had occurred.

4. Review of NSC meeting minutes dated 05/3/2017 reflected "April minutes approved". The voting record for approval of April minutes reflected 2 nurse managers voted "yea" and 4 direct care RNs voted "yea". There was no documentation to reflect that voting by an equal
E 622 Continued From page 18

5. Review of NSC meeting minutes dated 09/06/2017 reflected "Staffing plan vote: Current Plan approved with a 7 to 5 vote ..." It reflected "Current Plan" followed by names of 7 individuals without identifying the position or title of those individuals; and "New Plan" followed by names of 5 individuals without identifying the position or title of those individuals. There was no documentation to reflect that voting by an equal number of nurse manager members and direct care staff members had occurred.

6. Similar findings regarding unclear documentation of voting were identified in the NSC meeting minutes for 06/07/2017 and 08/02/2017.

7. During interview with NSC co-chairs on 09/26/2017 at the time of review, they confirmed findings 1 through 6 and acknowledged that voting records were unclear.

8. Review of the NSC charter titled "OHSU Hospital-Based Nurse Staffing Committee" dated "June 2017", reflected "Meeting Frequency and Observers...Non-constituents/outside OHSU guests may observe and attend a HBNSC meeting only with prior approval by both committee co-chairs."

9. During interview with NSC nurse manager co-chair on 05/31/2017 at 1500, he/she confirmed the NSC charter as written required both committee co-chairs' approval for guest observers to attend NSC meetings.
Continued From page 19

OAR 333-510-0105 (8) Nurse Staffing Committee Req.

(8) The staffing committee must document meeting proceedings by keeping written meeting minutes that include, but are not limited to, the following information:

(a) The name and position of each staffing committee member in attendance;
(b) The name and position of each observer or presenter in attendance;
(c) Motions made;
(d) Outcomes of votes taken;
(e) A summary of staffing committee discussions; and
(f) Instances in which non-members have been excluded from staffing committee meetings.

Stat. Auth.: ORS 413.042, 441.151 & 441.154
Stats. Implemented: ORS 441.154

This Rule is not met as evidenced by:

Based on interview and review of NSC committee meeting minutes for the last 6 months it was determined that the hospital failed to ensure that NSC minutes included:

* The name and position of each NSC member in attendance;
* The name and position of each observer or presenter in attendance;
* The motions made; and
* The outcomes of votes taken.

Findings include:

1. Refer to findings identified under Tag E622, OAR 333-510-0105(7), that reflects a lack of clear and specific documentation regarding NSC voting.
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<td>2. NSC meeting minutes for 04/05/2017 identified 16 individuals in attendance but lacked clear position information to indicate whether each individual was an RN, a non-RN, a nurse manager, a direct care NSM, a primary member, an alternate member or an observer.</td>
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<td>3. During interview with NSC co-chairs on 09/26/2017 at the time of NSC review, they stated the attendees reflected in the 04/05/2017 meeting minutes were 6 nurse managers, 5 observers, 3 direct care RN members, 1 direct care non-RN member and 1 direct care co-chair. They acknowledged the documentation of attendance was incomplete and unclear.</td>
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<td>4. Similar findings regarding lack of documentation of attendees' positions were identified in meeting minutes for 05/03/2017, 06/07/2017, 08/02/2017 and 09/06/2017.</td>
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<td>5. NSC meeting minutes for 04/05/2017, 05/03/2017, 06/07/2017, 08/02/2017 and 09/06/2017 reflected NSC approvals and votes, but lacked documentation of motions made to move forward with a vote.</td>
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<td>OAR 333-510-0110 (1) Nurse Staffing Plan Req.</td>
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<td>(1) Each hospital shall implement a written hospital-wide staffing plan for nursing services that is developed and approved by the hospital nurse staffing committee established in accordance with ORS 441.154 and OAR chapter 333 division 510 rules.</td>
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This Rule is not met as evidenced by:
Based on interview, review of NSC documentation, and review of NSP documentation for 9 of 9 specialties or units (4A, L&D, CHO, DCHOR, 6A, 5B, 9K, 14A and 10D-HRC), it was determined that the hospital failed to implement a hospital-wide NSP developed and approved by the NSC in accordance with these rules:
- Not all hospital specialties and units were incorporated into the NSP;
- NSPs were not all fully developed or complete; and
- NSPs were not all approved by the NSC using valid voting procedures.

Findings include:
1. Refer to findings identified under Tags E630, E632, E634, E636, E638, E640, E642, and E646 that reflect that NSPs were not fully developed or complete.
2. Review of an untitled 5-page document reflected a listing of 114 specialties/units identified by the hospital where nursing services are provided. The list indicated for each specialty/unit whether the specialty/unit had a NSP in place. The list reflected 47 of 114 specialties/units did not have a NSP in place. The specialties/units without a NSP included, but were not limited to: "DCH Peritoneal Dialysis"; "Wound/Ostomy/Continence"; "DCH Palliative Care"; "Wound Care Center"; "DCHU/Immunology Infusion"; and "Surgical Oncology".
3. During interview with NSC co-chairs on
E 628 Continued From page 22

09/26/2017 and 09/29/2017 at the times the list of specialties/units was reviewed, they confirmed there were numerous specialties/units that provide nursing services that did not have NSPs developed and implemented.

4. Review of 11 NSC meeting minutes for the last 12 months reflected the NSC failed to review and approve NSPs for most specialties/units during that time. Only two specialties/units’ NSPs were brought before the NSC during 11 meetings:
   * NSC meeting minutes for 04/05/2017 reflected the PANDA unit brought a "handout ... outlining staffing plan." The minutes reflected discussion of a "trial" staffing plan. There was no documentation of any action or vote by the NSC regarding the PANDA NSP at that meeting or any subsequent meetings.
   * NSC meeting minutes for 09/06/2017 reflected unit 9N’s nurse manager and UBNPC co-chairs presented 9N’s NSP to the NSC to "benefit from some outside eyes on their staffing plan." The NSC voted and approved continuation of 9N’s existing NSP. There was no documentation of any action or vote by the NSC regarding the revisions to the 9N NSP.

5. During interview with 6A nurse manager on 09/29/2017 at the time of NSP review, he/she confirmed that the 6A NSP dated "2017-2018" had not been approved by the NSC. He/she stated that the 6A NSP was approved by the UBNPC 2 months prior to the survey.

6. During interview with CHO director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed that the CHO NSP dated "09/06/2016" included language not approved by the NSP. They stated language pertaining to the number of patient treatments and procedures per
Continued From page 23

RN was "not approved" as it was "not part of the NSP" in September 2016 when the NSP was approved. They further stated they were not clear how it was changed after it was approved and posted on the shared website as a Word document.

7. Review of undated document titled "Kaizen Charter: PACU to Acute Care Transfer of Care" reflected "Problem Statement: There are variations in practices and standards on how a patient gets transferred from PACU to acute care." Included in the document is an outline of a "Trial Plan." Three dates are listed under the "Trial Plan" with bulleted points for each date: "Monday, January 30 - Acute care goes to PACU to pick up the patient"
* "4A, 14A, 5B, 9K;"
* "Monday, February 6 - PACU Deliver to Acute Care"
* "not enough staff in PACU even with upstaffed by 2 RNs (mandatory OT, missed breaks..."
* "Time off unit comparable (15-20 min on average)"
* "Wednesday - Feb 15 - Acute Care goes to PACU to pick up the patient."
* "4A, 14A, 5B, 9K;"
* "Time away from the unit increased with this trial;"
* "Regardless, with the current staffing model, there's a cutoff time when there's not enough nurses in both the PACU and AC Floors."

There was no evidence that the trial NSP was reviewed and approved by the NSC prior to implementation by the hospital.

8. Review of 4A NSP titled "OHSU: 4A... Unit Specific Staffing Plan" dated "05/01/2016"; 5B NSP titled "OHSU HBNSC Unit Staffing Plan...
Unit: 5B" dated "06/16/2016"; 9K NSP titled...
**E 628** Continued From page 24

"OHSU HBNSC Unit Staffing Plan ... Unit: 9K" dated "05/23/2017" revealed no language related to a trial staffing plan for transfer of patients from PACU.

9. During interview with AC nurse manager on 05/31/2017 at 1200, he/she stated the pilot staffing plan for taking RNs off their unit while transferring a patient to an acute care unit from PACU was not in the staffing plans for 4A, 5B and 9K.

10. During interview with 14A and 5B nurse manager on 05/31/2017 at 1515, he/she stated, "I don't think [the trial staffing plan] in [unit staffing plans], trials have never been put into nurse staffing plans."

11. During interview with AC nurse manager on 06/01/2017 at 1430, he/she stated, "No, we did not receive approval from the nurse staffing committee for the trial," for RNs to leave their units to transfer patients from PACU to 4A, 5B or 9K.

12. In NSM interviews completed between 09/25/2017 and 10/02/2017, 208 of 582 respondents indicated that in the past year they observed a failure to implement the written NSP in their unit.

13. In NSM interviews completed between 09/25/2017 and 10/02/2017, 365 of 582 respondents indicated that the hospital's current NSP was not sufficient to meet the needs of the patients.

**E 630** OAR 333-510-0110 (2)(a) Nurse Staffing Plan Req  

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**STATE OF OREGON**

**STATE FORM**
(2) The staffing plan:
(a) 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;
Stat. Auth.: ORS 413.042 & 441.155
Stats. Implemented: ORS 441.155

This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 5 of 5 specialties or units (4A, L&D, CHO, DCHOR and 6A), it was determined that the hospital failed to implement a hospital-wide NSP that was developed based on the competencies needed by the nursing staff for each unit, and that provided for the skill mix and level of competency necessary to ensure that patients' needs were met.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18" referred to "qualified staff", "qualified float staff", and "competency of staff is reviewed annually." However, the NSP did not specify or reference what these qualifications and competencies were.

2. During interview with the 4A nurse manager on 09/27/2017 at the time of NSP, he/she confirmed finding 1.

3. Review of the L&D NSP dated "6/22/17"
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<td>E 630</td>
<td>Continued From page 26 reflected &quot;Assess staff qualifications prior to making assignments the charge nurse will review the qualifications of the nurses ... current in unit competencies ...&quot; The NSP did not specify or reference what these qualifications and competencies were.</td>
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4. Review of the CHO NSP dated "09/06/2016" referred to "floor RNs", "Charge RNs", "OLC RNs" and "Triage RNs". However, the NSP did not specify or reference the qualifications and competencies that were required for these positions. The NSP reflected "RN assignment ... will be adjusted by charge RNs according to RN skill level, types of treatment and contributing factors (i.e.: orienting new RNs, etc.)." The NSP broadly referenced "RN skill level" multiple times, however, there was no description of how the qualifications and competencies and skill mix would be evaluated to ensure the needs of patients were met on an ongoing basis.

5. During interview with the CHO Director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed finding 4.

6. Review of the DCHOR NSP titled "OHSU HBOC Single Staffing Plan Checklist" dated "05/30/2017", reflect "Special Qualifications of Staff ... CNOR certification for PeriOp RN." However, during interview with the DCHOR manager and DCH Perioperative Services director at the time of review, they stated "CNOR certification for PeriOp RN was not required. The NSP also included a section under "Staffing Factors" that "Staff Education" included "Mandatory Education", "Annual Competencies" and "Certifications". The NSP did not specify or reference what these qualifications and competencies were.
Continued From page 27

7. During interview with the DCHOR manager and DCH Perioperative Services director on 09/28/2017 at the time of review, they confirmed findings 6 and further stated regarding "CNOR", they were "not sure what that stands for."

8. Review of the 6A NSP dated "2017-2018" included the following references "Pre-op RNs"; "Float RNs"; "Charge RNs"; "new staff"; and CNAs. However, the NSP did not specify or reference the qualifications and competencies that were required for these positions. Regarding qualifications and competencies, the NSP reflected only "Each 6A RN is able to safely care for Pre-op, Phase I, Phase II, and extended care patients"; "All RNs providing Phase I care have completed Peri-Anesthesia orientation and necessary competencies on an annual basis"; and "All RNs providing Phase I care are ACLS-certified."

9. Review of the 6A NSP dated "2017-2018" reflected that regarding skill mix the Charge RN would "Assess number and skill level of RNs ... number of new staff, ensure that new staff have adequate resource assistance ... number of floats; assess skills of floats, those who float frequently and assess their competency." The NSP did not specify how and when the Charge RN would accomplish assessment of skills and competencies for those staff.

10. During interview with the 6A nurse manager and the NSC direct care co-chair on 09/29/2017 at the time of NSP review, the nurse manager stated that "most" charge nurses know the skill level of each staff member. He/she further stated that there was currently no way to track the level of skills and abilities of the staff and they were
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<td>Continued From page 28 working on a system with a new educator.</td>
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<td>OAR 333-510-0110 (2) (b) Nurse Staffing Plan Req.</td>
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(2) The staffing plan:
(b) 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;

This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 5 of 5 specialties or units (4A, L&D, CHO, DCHOR and 6A), it was determined that the hospital failed to implement a hospital-wide NSP that was developed based on measurements of unit activity that quantified the rate of admissions, discharges and transfers for each unit and the time required for a direct care RN to complete those tasks.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18" reflected "admits on average can take 20-40 minutes, discharges can take anywhere from 10 minutes to one hour..." There was no data to support these timeframes.

2. During interview with two 4A nurse managers on 09/27/2017 at the time of NSP review, they stated that unit activities including admissions,
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<td>discharges and transfers had not been measured and quantified. They further stated the timeframes reflected in the NSP were primarily anecdotal.</td>
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<td>3. Review of the L&amp;D NSP dated &quot;6/22/17&quot; reflected that there were no measurements of unit activity included in the NSP.</td>
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<td>4. Review of the CHO NSP dated &quot;09/06/2016&quot; reflected the nursing time allotted for numerous infusions and procedures. There was no data to support these timeframes.</td>
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<td>5. During interview with the CHO director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed finding 5.</td>
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<td>6. Review of the DCHOR NSP dated &quot;05/30/2017&quot; reflected that there were no measurements of unit activity included in the NSP.</td>
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<td>7. During interview with the DCHOR manager and the DCH Perioperative Services director on 09/29/2017 at the time of NSP review, they confirmed finding 6.</td>
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<td>8. Review of the 6A NSP dated &quot;2017-2018&quot; reflected that there were no measurements of unit activity included in the NSP.</td>
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<td>9. During interview with the 6A nurse manager and the NSC direct care co-chair on 09/29/2017 at the time of NSP review, they confirmed that finding 8 and stated they have been trying to gather data on unit activity.</td>
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(2) The staffing plan:
(c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses;

This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 5 of 5 specialties or units (4A, L&D, CHO, DCHOR and 6A), it was determined that the hospital failed to implement a hospital-wide NSP that was developed based on total diagnoses for each unit and the nursing staff required to manage those diagnoses.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18" included a listing of some surgical diagnoses under the headings of "Patient Population" and "Intensity of Care". The 4A NSP did not reflect the nursing staff required to manage those diagnoses.

2. During interview with the 4A director and nurse manager on 09/27/2017 at the time of NSP review, they confirmed finding 1.

3. Review of the L&D NSP dated "6/22/17" included a listing of some diagnoses under the headings of "Maternal Complications" and "Fetal Complications". The L&D NSP did not reflect the nursing staff required to manage those diagnoses.
4. Review of the CHO NSP dated "09/06/2016" included broad categories of diagnoses such as "Hematologic ... Rheumatology ... Infection Disease." The NSP did not reflect the total diagnoses for the unit and the nursing staff required to manage those diagnoses.

5. During interview with the CHO director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed finding 4.

6. Review of the DCHOR NSP dated "05/30/2017" revealed a lack of information related to the total diagnoses for this unit and the nursing staff required to manage those diagnoses.

7. During interview with the DCHOR manager and the Director of Perioperative Services director on 09/28/2017 at the time of NSP review, they confirmed finding 6.

8. Review of the 6A NSP dated "2017-2018" included broad categories of diagnoses such as "Vascular Patients". The NSP did not reflect the total diagnoses for the unit and the nursing staff required to manage those diagnoses.

9. During interview with the 6A nurse manager and the NSC direct care co-chair on 09/29/2017 at the time of NSP review, they confirmed finding 8.
Continued From page 32

evidence-based standards and guidelines established by professional nursing specialty organizations such as, but not limited to: The American Association of Critical Care Nurses, American Operating Room Nurses (AORN), or American Society of Peri-Anesthesia Nurses (ASPAN);

This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 2 of 5 specialties or units (4A, CHO), it was determined that the hospital failed to implement a hospital-wide NSP that was developed to reflect for each unit consistency with current, nationally-recognized standards and guidelines established by professional nursing specialty organizations.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18" reflected only "Evidence Based Practice Standards: MRSN, ASPSN, SUNA." During Interview with three 4A nurse managers on 09/27/2017 at the time of NSP review, they stated they did not know what those acronyms stood for.

2. Review of the CHO NSP dated "09/06/2016" revealed a lack of any reference to current, nationally-recognized standards and guidelines. During interview with CHO director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed this finding.
Continued From page 33

OAR 333-510-0110 (2) (e) Nurse Staffing Plan Req.

(2) The staffing plan:
(e) Must recognize differences in patient acuity and nursing care intensity;

This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 5 of 5 specialties or units (4A, L&D, CHO, DCHOR and 6A), it was determined that the hospital failed to implement a hospital-wide NSP that was developed to recognize for each unit differences in patient acuity and nursing care intensity.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18" did not clearly reflect how differences in patient acuity and nursing care intensity were recognized and evaluated. For example:
   * The NSP reflect "Patient acuity of IMC is determined with a 4A IMC Screening Tool Form." The form contained a list of conditions with a check box next to each under a section titled "4A IMC Criteria" with directions that "This tool is not an exhaustive list of qualifying diagnoses or interventions. If you believe a patient should qualify for IMC but does not meet the criteria listed on the form, please see 'Intermediate Care Guidelines' found in the 4A Charge Nurse Binder." It was not clear how this tool objectively evaluated individual patient acuity to determine nurse staffing needs.
   * In the column of the NSP titled "Acuity Levels"
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETE DATE</th>
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<tr>
<td>E 638</td>
<td>Continued From page 34 the NSP reflected “Days and Evenings 1:3-4 ... Nights 1:4-5 ...” It was not clear how that reference reflected patient acuity.</td>
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<td>2. During interview with the 4A nurse manager on 09/27/2017 at the time of NSP review, he/she confirmed finding 1.</td>
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<td>3. Review of the L&amp;D NSP dated “6/22/2017” did not clearly reflect how differences in patient acuity and nursing care intensity were recognized and evaluated. The NSP reflected “Acuity &amp; Care Level Description ... Staffing minimums are to be guided by the Recommended Registered Nurse-to-Patient Ratios (AWHONN 2010 Guidelines).” However, it did not reflect how patient acuity would be determined. There was no reference to nursing care intensity.</td>
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<td>4. During interview with the L&amp;D nurse manager and the NSC direct care co-chair on 09/27/2017 at the time of NSP review, it was revealed that there was a &quot;SPARKS&quot; acuity tool that was used to help determine nurse staffing based on patient acuity, but the tool was not referenced in or attached to the L&amp;D NSP.</td>
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<td>5. Review of the CHO NSP dated &quot;06/06/2016&quot; did not clearly reflect how differences in patient acuity and nursing care intensity were recognized and evaluated. The NSP reflected &quot;A Patient Treatment Complexity Tool was developed to determine staffing levels based on the complexity of treatments and patient assignments for each RN. Complexity is the amount of face to face time the nurse spent providing direct care for a patient.&quot; The Complexity Tool consisted of a list of procedures and treatments, each with a corresponding amount of time in minutes allotted. Neither the Complexity Tool nor the NSP</td>
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<td>ID PREFERENCE</td>
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<td>E 638</td>
<td></td>
<td>Continued From page 35 contained objective criteria for adjustment of the Complexity Tool allotted times based on evaluation of individual patient acuity or nursing care intensity.</td>
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<td>6. During interview with the CHO director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed finding 5.</td>
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<td>7. Review of the DCHOR NSP dated &quot;05/30/2017&quot; did not clearly reflect how differences in patient acuity and nursing care intensity were recognized and evaluated.</td>
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<td>*The NSP reflected, &quot;Patient Acuity: Patient Acuity is determined by the Attending Physician. There are three entry levels of care into the DCH Operating Room ... Emergency Procedures ... Urgent/Emergent Procedures ... Schedule Procedures ...&quot; However, the NSP did not specify objective criteria for acuity determinations or how these determinations would impact the staffing in the unit.</td>
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<td>*The NSP reflected, &quot;Each Open OR room is staff (sic) with a minimum of 1 RN and a second RN or Technician: Dental Assistant, Radiology, Respiratory, GI, and/or Surgical. Additional staff needed for acuity or equipment is done by Charge RN. Circulator, Scrub, Surgeon, Anesthesia may request at any time.&quot; It was unclear if the &quot;additional staff&quot; were NSMs. It was unclear how acuity would be considered under these circumstances.</td>
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<td>*The NSP reflected, &quot;Daily Staffing Adjustments ... Charge Nurse and/or manager review next day's schedule to determine staffing needs, case complexity, department requirements, and volumes to determine total staff number required. However, the NSP did not specify objective criteria for acuity determinations or how these determinations would impact the staffing in the</td>
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E 638  
Continued From page 36

unit.
*There was no reference to nursing care intensity.

8. Review of the 6A NSP dated "2017-2018" reflected:
* "All staffing ratios are based on patient needs and following ASPAN Staffing Recommendations, 2015-2017." However, the NSP did not reflect how "patient needs" would be evaluated.
* The NSP referred to the consideration of "patient acuity" but did not specify objective criteria for these determinations.
* The NSP did not reflect how individual nursing care intensity would be evaluated for each patient throughout the pre- and post-op phases.

9. During interview with the 6A nurse manager and NSC direct care co-chair on 09/29/2017 at the time of NSP review, they confirmed finding 8 and state they generally follow ASPAN and no other system is in place that considers individual patient acuity and nursing care intensity in their staffing.

E 640  
OAR 333-510-0110 (2) (f) Nurse Staffing Plan Req.

(2) The staffing plan:
(f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts...
This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 5 of 5 specialties or units (4A, L&D, CHO, DCHOR and 6A), it was determined that the hospital failed to implement a hospital-wide NSP that established minimum numbers of nursing staff required on specified shifts.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18" revealed that it did not clearly reflect minimum numbers of NSMs on each shift. For example: 
   * The NSP reflected "The foundation for our staffing plan is our staffing grid - see attached ... The details of the grid - RN to patient ratio and CNA to patient ratio - are decided upon by our UBNPC and Nurse Manager." Review of the "Unit Staffing Grid" reflected it had no numbers of nursing staff for the unit on specified shifts when there were 1 to 7 patients. There was no explanation for that omission on the grid or in the NSP.
   * The NSP reflected "Reasons to alter staffing numbers from the current 4A grid: ... As determined by the Charge RN, if the floor is considered unusually stable, the floor can be staffed down an RN or CNA." It was no clear when the floor would be considered "stable".

2. During interview with 4A direct and nurse manager on 09/27/2017 at the time of NSP review, they confirmed finding 1 and stated the grid is a "guideline."

3. Review of the L&D NSP dated "6/22/2017"
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>E 640</td>
<td>Continued From page 38 reflected *&quot;... Minimum Staffing for LDR will be 4 RNs (which includes the charge nurse) with a minimum of 2 RNs available on-call ... Baseline staff ... '07-11=10', '11-15=11', '15-19=11', '19-23=10', '23-07=9' ... Weekend Staffing ... '07-19=9 (10 on Sunday due to no on-call) ... '19-07=9 (10 on Sunday) ... Baseline staffing can be flexed down if Estimated Due Date Report (EDD) shows decline in volume.&quot; It reflected a baseline of &quot;staff&quot; that could be flexed down. It was not clear if &quot;staff&quot; were NSMs. *&quot;Minimum staffing ... Charge Nurse and 3 RNs + (2 RNs on-call) ... OB scrub tech 24/7 .../ancillary person with the ability to perform PAS duties.&quot; It was not clear if scrub techs and &quot;ancillary&quot; people were NSMs. * The NSP did not clearly reflect minimum numbers of NSMs on each shift. *&quot;L&amp;D is an RN only care model.&quot; However, during interview with L&amp;D manager on 09/27/2017 at the time of NSP review, he/she stated CNA2s were used on the unit. However, he/she stated CNA2s were not reflected in the NSP. 4. Review of the CHO NSP dated &quot;09/06/2016&quot; revealed that it did not clearly establish minimum numbers of NSMs on each shift. For example: *&quot;Beaverton ... Monday-Friday 8:30 AM to 5:00 PM 4-5 Floor RNs with Charge RN included in to count as 0.5 RN&quot; It was not clear when the minimum number would be 4 and when it would be 5, nor how the 0.5 Charge RN would impact the minimum number. *&quot;Tualatin Monday-Friday 8:30 AM - 5:00 PM ... 3-4 Floor RNs 1 Charge/OLC RN.&quot; It was not clear when the minimum number would be 3 and when it would be 5, nor if the &quot;Charge/OLC RN&quot; was included in the minimum number.</td>
<td>E 640</td>
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5. During interview with CHO director and nurse manager on 09/28/2017 at the time of NSP, they confirmed finding 4.

6. Review of the DCHOR NSP dated "05/30/2017" revealed no evidence of minimum numbers of nursing staff required on specified shifts. There was no evidence that the DCHOR NSP established minimum numbers of NSMs for each shift for this unit.

7. During interview with DCHOR manager and the DCH Perioperative Services director on 09/28/2017 at the time of NSP review, they confirmed the NSP lacked the information identified in finding 6.

8. Review of the 6A NSP dated "2017-2018" revealed that it did not clearly establish minimum numbers of NSMs on each shift. For example:
   * "The goal is to have 12 pre-op RNs at work by 0600 to prepare our average 20-23 first cases."
   * "The goal is to have 21 RNs available to recover patients as needed for our average 45-60 patients and 24-25 OR rooms running concurrently."
   * "Pre-op staffing is generally 1:3-4."
   * "Phase II staffing is generally 1:1-3."

9. During interview with 6A nurse manager and direct care co-chair on 09/29/2017 at the time of NSP review, they confirmed finding 8 and stated that they have a staffing "grid" that they do not always use and it is not attached to or referenced in the NSP.

E 642 OAR 333-510-0110 (2)(f) Nurse Staffing Plan Requirements
E 642. Continued From page 40

(2) The staffing plan:
(f) 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;

This Rule is not met as evidenced by:
Based on interview and review of NSP documentation for 5 of 5 units (4A, L&D, CHO, DCHOR and 6A), it was determined that the hospital failed to implement a hospital-wide NSP that ensured no fewer than one RN and one other NSM be on duty in a unit when a patient is present.

Findings include:

1. Review of the 4A NSP dated "6/1/2017/18", the L&D NSP dated "6/22/17", the CHO NSP dated "09/09/2016", and the 6A NSP dated "2017-2018" lacked information regarding minimum numbers when one patient is present on the unit.

2. During interview with CHO director and nurse manager on 09/28/2017 at the time of NSP review, they confirmed the CHO NSP lacked the information identified in finding 1.

3. During interview with 6A nurse manager and NSC direct care co-chair on 09/29/2017 at the
Continued From page 41

time of NSP review, they confirmed the 6A NSP lacked the information identified in finding 1.

4. Review of the DCHOR NSP dated "05/30/2017" reflected "Each open OR room is staff (sic) with a minimum of 1 RN and a second RN or Technician: Dental Assistant, Radiology, Respiratory, GI, and/or Surgical." It was unclear if the technicians were NSMs.

5. During interview with DCHOR manager and the Perioperative Services director on 09/28/2017 at the time of review, they confirmed the NSP lacked the information identified in finding 5.

OAR 333-510-0110 (2) (h) Nurse Staffing Plan Req.

(2) The staffing plan:
(h) Must consider tasks not related to providing direct care, including meal breaks and rest breaks;

This Rule is not met as evidenced by:
Based on interview, review of NSP documentation for 6 of 6 specialties or units (4A, L&D, CHO, DCHOR, 6A and 10D-HRC), and review of documentation in 26 of 57 NSM timekeeping records (NSMs 3, 4, 8, 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 44, 45, 46, 47, 49, 51, 52, 53, 54, 55, 56, 57 and 58) it was determined that the hospital failed to implement a hospital-wide NSP that was developed to consider for each unit meal breaks, rest breaks, and other tasks not related to direct patient care and that NSMs received breaks as required. The
<table>
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<th>E 646</th>
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<td>NSP did not provide for additional NSMs to maintain the staffing ratios required in the NSP during these tasks, creating the possibility that the units did not meet minimum staffing required for the duration of tasks not related to direct patient care.</td>
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Findings include:

1. Review of the 4A NSP dated "6/01/2017/18" reflected only, "Buddy system is set at the beginning of the day for staff to cover one another for breaks."

2. During interview with two 4A nurse managers on 09/27/2017 at the time of NSP review, they stated that when one RN is on a meal or rest break their RN "buddy" assumes care of their assigned patients in addition to the buddy's own assigned patients. There is no evaluation of whether the NSP is met during these breaks. In addition, they stated that there was no documentation to reflect when NSMs took their meal and rest breaks.

3. Review of the L&D NSP dated "6/22/17" reflected "RNs are encouraged to consolidate their lunch break and one of their 15 minute breaks when feasible. RNs are responsible for finding another RN who can watch their assignment while they are at lunch or on a break. Charge RNs are utilized for meals and breaks when needed." The NSP also reflected "Nurse: Patient ratio examples 1:3 - Lunch and break coverage Charge RN and Covering RN agree on safety of assignment." The NSP did not ensure provision of meal and rest breaks for all NSMs nor ensure staffing was in accordance with the NSP during meal and rest breaks.
Continued From page 43

4. Review of the CHO NSP dated "09/06/2016" reflected only, "No scheduling of patients between 12pm to 1 pm to allow for lunch breaks." In addition, the NSP did not provide for rest breaks before and after meal breaks. The NSP did not ensure provision of meal and rest breaks for all NSMs nor ensure staffing was in accordance with the NSP during meal and rest breaks.

5. During interview with CHO director and nurse manager on 09/28/2017 at the time of NSP review, they stated that on some days a clinic may not have any patients in the clinic from 1200 to 1300 and on those days all NSMs would receive meal breaks at one time. They further stated that in some clinics, NSMs receive meal breaks one or two at a time between patients, or they may "buddy" with another RN to cover their patients while they go to lunch.

6. Review of the DCHOR NSP dated "05/30/2017" reflected only, "Meals and Break Coverage: Assigned break staff scheduled at (0700, 0900, 1100). Night team asks SOR or uses call team if needed." It was unclear if the assigned break staff were NSMs.

7. Review of the 6A NSP dated "2017-2018" reflected "The goal is to have 3-5 RNs utilized as floats during peak hours for covering meals, breaks ..." The NSP also reflected "Employee may opt to skip a meal or break with intention to end shift early, recording a missed break in Kronos." The NSP did not ensure provision of meal and rest breaks for all NSMs nor ensure staffing was in accordance with the NSP during meal and rest breaks.

8. During interview with 6A nurse manager and
### E 646

Continued from page 44

NSC direct care co-chair on 09/29/2017 at the time of NSP review, the nurse manager stated that they do not have a system for documenting the times staff take meal and rest breaks. He/she further stated there is a practice that staff do not take breaks and leave the shift early, but that "process is being reset."

9. Review of the 10D-HRC NSP dated "05/18/2016" lacked information about meal or rest breaks.

10. Review of timekeeping records revealed 26 of 57 NSMs (NSMs 3, 4, 8, 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 44, 45, 46, 47, 49, 51, 52, 53, 54, 55, 56, 57 and 58) did not receive all meal and rest breaks as required. For example:

* Timekeeping records for 4A NSM 4 reflected that a meal break was not received on 06/15/2017 and rest breaks were not received on 06/13/2017, 06/14/2017 and 06/15/2017.
* Similar findings were identified for 4A NSMs 3, 8 and 10.
* Timekeeping records for L&D NSM 20 reflected that a meal break was not received on 08/31/2017.
* Timekeeping records for CHO NSM 24 reflected that a meal break was not received on 07/18/2017 and all rest breaks were not received on 07/17/2017 and 07/18/2017.
* Similar findings were identified for CHO NSMs 23, 25, 26, 27, 28, 29 and 30.
* Timekeeping records for 6A NSM 44 reflected 2 meal breaks were not received during a 17.5-hour shift on 08/24/2017 and 08/25/2017.
* Timekeeping records for 6A NSM 46 reflected rest breaks were not received on 08/25/2017, 08/26/2017 and 08/27/2017.
* Similar findings were identified for 6A NSMs 45, 47 and 49.
E 646  Continued From page 45

* Timekeeping records for 10D-HRC NSM 51 reflected a meal break was not received on
10/20/2016 and 71 other shifts between 10/01/2016 and 05/31/2017. Timekeeping
records for 10D-HRC NSM 51 reflected a rest break was not received on 10/04/2016 and 7
other shifts between 10/01/2016 and 05/31/2017.
* Timekeeping records for 10D-HRC NSM 58 reflected a meal break was not received on
10/03/2016 and 106 other shifts between 10/01/2016 and 05/31/2017.
* Similar findings were identified for 10D-HRC NSMs 52, 53, 54, 55, 56 and 57.

11. During interview with the 4A director and
nurse manager on 09/27/2017 at the time of timekeeping review, they confirmed finding 10 as
related to 4A NSMs.

12. During interview with the DCHOR manager and the DCH Perioperative Services director on
09/28/2017 at the time of timekeeping review, they confirmed finding 10 as related to DCHOR
NSMs.

13. During interview with the 10D-HRC nurse
manager on 06/01/2017 at the time of
timekeeping review, he/she confirmed finding 10 as related to 10D-HRC NSMs.

14. In NSM interviews completed between
09/25/2017 and 10/02/2017, 523 of 582
respondents indicated that the units are short
staffed when a NSM is on a meal or rest break,
that the unit uses a buddy system to cover for
NSMs on meal or rest breaks, or they do not
know whether the unit has the required staffing
when NSMs are on meal or rest breaks.

15. In NSM interviews completed between
**Health Care Regulation and Quality Improvement**

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<th>(X2) MULTIPLE CONSTRUCTION</th>
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<td>14-1008</td>
<td>A. BUILDING:</td>
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<td>B. WING:</td>
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**NAME OF PROVIDER OR SUPPLIER**

OHSU HOSPITAL AND CLINICS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3181 SW SAM JACKSON PARK ROAD
PORTLAND, OR 97239

**DATE SURVEY COMPLETED**

11/07/2017

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<td>09/25/2017 and 10/02/2017, 406 of 582 respondents indicated that in the past year they experienced one or more shifts during which they missed meal and/or rest breaks because there was not sufficient staff to cover that time.</td>
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<td>E 665</td>
<td>OAR 333-510-0130 (1) - (7) Nurse Staffing Member Overtime</td>
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<td>(1) For purposes of this rule &quot;require&quot; means to make compulsory as a condition of employment whether as a result of a previously scheduled shift or hours actually worked during time spent on call or on standby.</td>
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<td>(2) A hospital may not require a nursing staff member to work:</td>
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<td>(a) Beyond the agreed-upon and prearranged shift, regardless of the length of the shift;</td>
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<td>(b) More than 48 hours in any hospital-defined work week;</td>
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<td>(c) More than 12 hours in a 24-hour period;</td>
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<td>(d) During the 10-hour period immediately following the 12th hour worked during a 24-hour period. This work period begins when the nursing staff member begins a shift;</td>
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<td>(e) During the 10-hour period immediately following any agreed-upon and prearranged shift in which the nurse worked more than 12 hours in a 24-hour period.</td>
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<td>(3) Time spent by the nursing staff member in required meetings or receiving education or training shall be included as hours worked for the purpose of section (2) of this rule.</td>
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<td>(4) Time spent on call or on standby when the nursing staff member is required to be at the hospital shall be included as hours worked for the purpose of section (2) of this rule.</td>
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<td>(5) Time spent on call or on standby when the nursing staff member is not required to be at the</td>
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**STATE OF OREGON**

STATE FORM 6UPU11
E 665 Continued From page 47

hospital may not be included as hours worked for the purpose of section (2) of this rule.
(6) Nothing in this rule precludes a nursing staff member from volunteering to work overtime.
(7) A hospital may require an additional hour of work beyond the hours authorized in section (2) of this rule if:
   (a) A staff vacancy for the next shift becomes known at the end of the current shift; or
   (b) There is a potential harm to an assigned patient if the nursing staff member leaves the assignment or transfers care to another nursing staff member.

This Rule is not met as evidenced by:
Based on interview and review of timekeeping documentation for 22 of 49 NSMs (NSMs 1, 4, 6, 7, 8, 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 32, 37, 44, 45, 48, 49 and 50), it was determined that the hospital failed to ensure that NSMs were not required to work:
* Beyond the agreed-upon and prearranged shift;
* More than 48 hours in any hospital-defined work week;
* More than 12 hours in a 24-hour period; or
* During the 10-hour period immediately following the 12th hour worked during a 24-hour period. This work period begins when the nursing staff member begins a shift.
* During the 10-hour period immediately following the shift in which a NSM works more than 12 hours during a 24-hour period. This work period begins when the nursing staff member begins a shift.

Findings include:
E 665 Continued From page 48

1. Review of 4A NSM 10’s timekeeping record for the week of 07/03/2017 at 0000 through
07/09/2017 at 2359 reflected that he/she regularly worked an 8-hour shift. It reflected that he/she worked 9.5 hours on 07/06/2017. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

2. Review of 4A NSM 4’s timekeeping record for the week of 06/12/2017 at 0000 through
06/18/2017 at 2359 reflected he/she worked a total of 49 hours during that week. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

3. Similar findings were identified for 4A NSMs 1, 6, 7 and 8.

4. During interview with 4A director, nurse manager, NSC nurse manager co-chair and
Nursing Finance director on 09/27/2017 at the time of timekeeping review, they stated there was no documentation to reflect whether OT was voluntary or MOT. During the discussion that followed some stated that if the OT was MOT the NSM "would select a MOT Code." However, others stated that the NSM was to submit a form and was not to select a MOT Code. During interview the process for documentation of OT was not clearly described.

5. Review of L&D NSM 20’s timekeeping record for the week of 08/28/2017 at 0000 through
09/03/2017 at 2359 reflected that he/she regularly worked a 12-hour shift. It reflected that he/she worked from 08/31/2017 at 0655 until 06/31/2017 at 2308; NSM 20 returned to work on 09/01/2017 at 0706, less than 10 hours after working more...
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than 12 hours in a 24-hour period. There was no documentation in the timekeeping records reviewed to indicate whether the NSM waived or claimed his/her 10-hour rest period. Further, it reflected that he/she worked 16.22 hours on 08/31/2017. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

6. During interview with L&D manager and Nursing Support Services Manager on 09/27/2017 at the time of timekeeping review, they confirmed finding 5.

7. Review of CHO NSM 24’s timekeeping record for the week of 07/17/2017 at 0000 through 07/23/2017 at 2359 reflected that he/she regularly worked an 8-hour shift. It reflected that he/she worked 8.5 hours on 07/17/2017 and 10 hours on 07/18/2017. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

8. Similar findings were identified for CHO NSMs 23, 25, 26, 27, 28, 29 and 30.

9. During interview with CHO director and nurse manager on 09/28/2017 at 0945, they confirmed findings 7 and 8.

10. Review of DCHOR NSM 32’s timekeeping record for the week of 07/03/2017 at 0000 through 07/09/2017 at 2359 reflected that he/she regularly worked an 8-hour shift. It reflected that he/she worked 12 hours on 07/07/2017. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

11. Similar findings were identified for DCHOR.
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NSM 37.

12. During interview with DCHOR manager and the DCH Perioperative Services director on 09/28/2017 at the time of review, they confirmed findings 10 and 11.

13. Review of 6A NSM 44's timekeeping record for the week of 08/21/2017 at 0000 through 08/27/2017 at 2359 reflected that he/she regularly worked a 12-hour shift. It reflected that he/she worked from 08/24/2017 at 1056 until 08/25/2017 at 0423; NSM 44 returned to work on 08/25/2017 at 1059, less than 10 hours after working more than 12 hours in a 24-hour period. There was no documentation in the timekeeping records reviewed to indicate whether the NSM waived or claimed his/her 10-hour rest period. Further, it reflected that he/she worked 17.5 hours at the shift that began on 08/24/2017. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

14. Review of 6A NSM 48's timekeeping record for the week of 08/21/2017 at 0000 through 08/27/2017 at 2359 reflected that he/she regularly worked a 12-hour shift. It reflected that he/she worked 16 hours on 08/22/2017 and 21.73 hours on 08/23/2017. There was no documentation in the timekeeping records reviewed to indicate whether the OT worked was voluntary or MOT.

15. Similar findings were identified for 6A NSMs 45, 48 and 50.

16. During interview with 6A nurse manager and NSC direct care co-chair on 09/29/2017 at the time of timekeeping review, they confirmed findings 13, 14 and 15.
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<tr>
<td>17.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 99 of 582 respondents indicated that they had been required to work beyond their agreed-upon and prearranged shift in the past year.</td>
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<td>18.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 54 of 582 respondents indicated that they had been required to work during the 10-hour period immediately following the 12th hour worked during a 24-hour period in the past.</td>
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<td>19.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 54 of 582 respondents indicated that they had been required to work during the 10-hour period immediately following a shift in which the respondent work more than 12 hours during a 24-hour period in the past.</td>
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<td>20.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 157 of 582 respondents indicated that they had been required to work for up to an hour after their shift was scheduled to end because of a staffing vacancy in the following shift during the past year.</td>
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<td>21.</td>
<td>In NSM interviews completed between 09/25/2017 and 10/02/2017, 186 of 582 respondents indicated that they had been required to work for up to an hour after their shift was scheduled to end to avoid potential harm to an assigned patient during the past year.</td>
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<th>ID</th>
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<th>OAR 333-510-0130 (8) Nursing Staff Member Overtime</th>
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STATE OF OREGON
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(6) Each hospital must have a policy and procedure in place to ensure, at minimum, that:
(a) Mandatory overtime, when required, is documented in writing; and
(b) Mandatory overtime policies and procedures are clearly written, provided to all new nursing staff and readily available to all nursing staff.

This Rule is not met as evidenced by:
Based on review of the MOT policy and procedure it was determined that the hospital failed to develop a written policy for MOT that ensured:
* Mandatory overtime is documented in writing as required by subsection (8)(a); and
* Mandatory overtime policies are clearly written (8)(b).

Findings:
1. Review of the "Mandatory Overtime" section of the "Comprehensive Staffing Plan" Policy and Procedure dated "9/21/17" did not specify when MOT may or may not be imposed by the hospital.

2. Review of the Policy and Procedure revealed inaccurate, conflicting or ambiguous information regarding MOT.
* The NSP stated that mandatory overtime limits do not apply "When the hospital has made reasonable efforts to contact all qualified nursing staff and nursing services [and] is unable to obtain replacement staff in a timely manner."
* The NSP stated that "The CNE or designee will approve implementation of mandatory overtime per ORS 411.166" which is a not a valid statute
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<td>3. In NSM interview completed between 09/25/2017 and 10/02/2017, 167 of 582 respondents indicated that the hospital did not have, or they did not know if the hospital had a policy on MOT. 156 of 582 respondents indicated that they did not know where the MOT policy is located.</td>
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