ARTICLE 18 – NURSING CARE DELIVERY

18.4 Staffing System. The Medical Center and registered nurses will act in compliance with the Oregon Hospital Nurse Staffing Law; ORS 441.151 to 441.177 and ORS 441.179 to 441.186. The Medical Center Nurse Staffing Committee shall be responsible for the development and implementation of a written Medical Center-wide staffing plan for nursing services. The staffing plan shall be developed, monitored, evaluated and modified by the Staffing Committee consistent with ORS 441.155, all changes in structure proposed by the Medical Center that (1) support the staffing plan, (2) affect direct patient care on the individual units and (3) have an impact on multiple units, (4) or change the unit direct patient care staffing matrix will be discussed and reviewed by the Staffing Committee prior to implementation.

18.4.1 Staffing plan. Pursuant to ORS 441.155; the staffing plan shall:

(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;

(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;

(c) Must be based on total diagnoses for each hospital unit and the nursing staff required to manage that set of diagnoses;
(d) Must be consistent with nationally recognized evidence-based standards and guidelines established by professional nursing specialty organizations;

(e) Must recognize differences in patient acuity and nursing care intensity;

(f) Must establish minimum numbers of nursing staff, including licensed practical nurses and certified nursing assistants, required on specified shifts, provided that at least one registered nurse and one other nursing staff member is on duty in a unit when a patient is present;

(g) Must include a formal process for evaluating and initiating limitations on admission or diversion of patients to another hospital when, in the judgment 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;

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

(i) May not base nursing staff requirements solely on external benchmarking data.

In accordance with these legal requirements there shall be an appropriate complement of non-nursing ancillary and support staff to maintain a safe workplace for nurses, other staff, and patients. Staffing plans shall determine

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nurse staffing levels that account for the appropriate numbers of non-nursing ancillary and support staff.

Staffing plans must include a mechanism to measure patient acuity and nursing work intensity. A patient acuity and workload intensity tool shall be adopted by the UBPC in accordance with the process for adoption of a staffing plan as outlined in Article 18.4.4. This tool will be included with the staffing plan for approval by the Nurse Staffing Committee.

The Employer will maintain appropriate staffing levels on each unit, supported by the acuity and intensity tool outlined above, for the duration of the shift.

18.4.2 Minimum Safe Staffing Standards

18.4.2.1 The Employer agrees that the following minimum safe standards will apply and that a staffing plan will not result in a nurse being assigned more patients than provided in this Article.

18.4.2.2 Direct care nurses shall not be assigned more patients than the following at any point for any shift, including while relieving other nurses during their meal or break for all adult and pediatric units:

a) Emergency Department:
   - One nurse to three (1:3) non-trauma or noncritical care patients with acuity adjustment to a higher ratio as needed for acute psychiatric patients both adult and pediatric
   - One nurse to one (1:1) trauma or critical care patient
   - One triage nurse or minimum of two nurses during peak times
   - Two nurses to one (2:1) trauma patient as determined by the UBPC

b) Intensive Care Unit, [Trauma/Surgical ICU, Medical ICU, or other Critical/Intensive Care Unit]:
   - One nurse to two patients (1:2)

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- One nurse to one patient (1:1)
- Two nurses to one (2:1) when appropriate as identified by the unit staffing plan
- Neonatal ICU: ratios as determined by AWHONN, American Academy of Pediatrics, American College of Obstetrics

c) Labor and Delivery: in accordance with Association of Women's Health Obstetrics Neonatal Nurses (AWHONN) standards

d) Mom/Baby:
- One registered nurse to six patients (1:6) in postpartum. In this context, the mother and the baby are each counted as separate patients. This would mean, for example, one registered nurse to three mother-baby couplets (1:3) in accordance with AWHONN standards.

e) Main Operating Room: One registered nurse to one patient (1:1) in accordance with AORN standards

f) Endo (in patient and out patient), Cath Lab: One registered nurse to one (1:1) patient in accordance with professional standards;
   a. Out patient Endo 1:1 during procedure; 1:3 for admit/recovery for stable patients; 1:1 for unstable

g) CVOR: two nurses to one patient (2:1)

h) PACU: One nurse to two patients (1:2), and one nurse to one patient (1:1) in accordance with American Society of Peri-Anesthesia Nurses (ASPAN) standards

i) Medical-Surgical/Oncology/Neurology/Orthopedics/Acute Care of Elderly/Rehabilitation Unit: One nurse to four patients (1:4), One nurse to three patients (1:3) needed for higher acuity.

j) OHVI 4 and OHVI 5 (aka cardiac telemetry unit): one nurse to three patients (1:3)

k) Observation Unit: one nurse to four patients (1:4)

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l) Pediatrics:
   - One nurse to three patients (1:3)
   - One nurse to two patients (1:2) when critical care patients
   - One nurse to one patient (1:1) as determined by acuity

m) Cath Prep/Recovery: one nurse to two patients (1:2) up to one nurse for four patients (1:4) based on ASPAN standards and adjusted for acuity utilizing the identified tool.

n) Behavioral Health: one nurse to five patients (1:5)

o) Short Stay – one nurse to one patient (1:1) for admission, one nurse to three (1:3) pre-op and phase 2. Extended Short Stay one nurse to four patients (1:4).

p) Regional Infusion Center; no more than one nurse to four (1:4) patients

g) Care management: one nurse to twelve patients (1:12).

18.4.3 A hospital may not average the number of patients and the total number of direct care registered nurses and nursing assistants-certified assigned to patients in a unit during any one shift or over any period of time, in order to meet the personnel assignment limits established in this section.