EP9 – Nurses are involved in staffing and scheduling based on established guidelines, such as the ANA's Principles for Nurse Staffing, to ensure that RN assignments meet the needs of patient populations.

Provide two examples, with supporting evidence, from different practice settings when input from clinical nurses was used to modify RN staffing assignments and/or adjust the schedule to compensate for a change in patient acuity, patient population, resources or redesign of care.

Introduction:

Shift managers play a pivotal role on every shift, managing a dynamic process of continuous evaluation and re-evaluation of staffing adequacy and patient assignment. They use their clinical experience to serve as a resource to everyone on the unit. UVA uses the ANA's Principles for Nurse Staffing as the foundation for staffing guidelines. (Exhibit EP9.a: PCS Policy A01 Assignment for Inpatient Staffing)

Using these fundamental rule sets and their clinical judgment, shift managers are empowered to make adjustments as needed to ensure care delivery is safe and as cost effective as possible.

Example 1: 6 West – Acute Care Neuroscience and Neuro Intermediate Care Unit; Changes in Staffing to Accommodate Intermediate Care Patients (Population)

ANA Principles of Nurse Staffing – Principle Addressed:

Principles Related to Registered Nurses and Other Staff- The specific needs of the population served should determine the appropriate clinical competencies required to the registered nurse practicing in that area.

6 West is a unit with a combination of acute care (6W) and intermediate beds (NIMU). This mixed-population environment requires the shift manager to fully understand the needs of every patient, as well as the care demands that are placed on the nurses caring for them. The competencies for the interventions and technological care required for this specialty population are specific and not available outside of the Neuro ICU and 6 West Intermediate Care units.

On February 24, 2014, Carla Rothmann, BS, RN, CNRN, Clinician II, was the 6 West shift manager for the 0700-1900 shift. The unit census and acuity dropped enough to allow Grace Benolirao, BSN, RN, Clinician II, to float to 5 Central at 1900. Exhibit EP9.b is a screenshot from our scheduling software system indicating the planned float to 5 Central. (Exhibit EP9.b: Screenshot Benolirao Planned Float To 5C)

At 1845, 15 minutes prior to the end of the shift, Rothman was notified of an admission coming to the Neuro Intermediate Care Unit from the Emergency Department: an 82-year-old man with a new intracerebral hemorrhage and hypertension. Based on the information received from the nurse in the ED, Rothman evaluated the evolving care needs of the patient population on 6 West. The incoming patient was on a nicardipine drip, which required blood pressure management every 15 minutes. This patient needed the advanced neurological assessment skills of nurses certified in administering the NIH stroke scale.

In order to ensure safe and appropriate staffing ratios for the NIMU, which are 1:3, an additional nurse was needed. However, Rothman knew that pulling Benolirao back from 5 Central would be detrimental to 5 Central. She decided to call in Sheeba Joy, BSN, RN, Clinician II, who earlier in the week had signed up for an on-call opportunity. Exhibit EP9.c is a scheduling system screenshot of the Daily Editor view showing the change in assignment. (Exhibit EP9.c: Screenshot SJoy schedule change) Sheeba's flexibility allowed Grace to float to 5 Central as planned.

Rothman's shift was over and Ruth Clements, RN, CNRN, Clinician II, arrived as the 1900-0700 shift manager on 6 West. In the first hour of her shift, Clements was notified of another NIMU admission that would bring their intermediate population census up to four from three. This patient was a 59-year-old man with Stage IV lymphoma with progressive weakness and possible Guillain-Barre Syndrome. NIMU nurses use specific assessment tools for patients with Guillain-Barre Syndrome. This assessment includes respiratory vital capacity, diplopia, muscle weakness, swallowing and other cardinal features.

This NIMU admission meant that two competent and experienced NIMU nurses were needed to manage these intermediate care patients. At approximately 2000, Clements notified 5 Central that at 2300, Benolirao would be needed back in her home unit. This gave 5 Central several hours to address their acute care staffing needs and decide on a course that would meet the staffing need with minimal budgetary impact. Exhibit EP9.d: shows the scheduling system screenshot of Benolirao's return to 6 West. (Exhibit EP9.d: Screenshot Benolirao Back To 6W)

The staffing and scheduling adjustments made autonomously by these shift managers are typical examples of the critical decisions and thoughtful consideration needed to safely and efficiently manage the staffing demands of the mixed population environment.

Example / Practice Setting 2: Acute Care Pediatrics – Changes in Patient Assignment to Accommodate Changing Patient Acuity

ANA Principles of Nurse Staffing – Principle Addressed:

Staffing decisions should be based on the number and needs of the individual healthcare consumer, families and population served.

UVA Children's Hospital is composed of a pediatric intensive care unit, a neonatal intensive care unit and three acute care pediatric units. The acute care units are covered by a single staffing group that is adept at managing the unique and challenging bed flow within the Children's Hospital. Within the acute care pediatric units, the acuity of the patients covers a wide range. Because the units are not disease-specific, any patient may be cared for in any bed. This allows maximum flexibility, but also requires the nurses to be adept at adjusting to the potential change in acuity at any time.

From 0700-1900, two shift managers are assigned to cover the three acute care units and do not carry a patient assignment. They attend the Children's Hospital bed briefing at 0800 and then the hospital-wide bed briefing at 0815 and 1430 to present their census and staffing projections. In addition, they coordinate admissions and discharges with the Bed Coordination Center and communicate frequently with the Pediatric ICU, Neonatal ICU and Pediatric Emergency Department to determine best patient placement to meet patients' clinical demands. This often requires decisions regarding placing patients on adult units, if appropriate, and potential scheduling changes. On-the-spot huddles are held between the Children's Hospital shift managers and physicians as needed to ensure that careful communication and coordination is occurring. Staffing decisions and assignments related to patient acuity or changing conditions are the responsibility of the shift manager.

On January 31, 2014, Terra Bailey, MSN, RN, Clinician II, was assigned to four patients, including a 13-year-old palliative care oncology patient on 7 West from 0700 to 1900. (Exhibit EP9.e: 7 West Clairvia Schedule 1/31/14) The patient's condition began to deteriorate sooner than anticipated. The patient required more aggressive pain control and the family needed emotional support during this difficult time. Bailey saw that the situation would require more of her than her current assignment would allow. The patient's care needs increased in severity, intensity and complexity, and Bailey consulted with the shift manager, Sue Cullen, BSN, RN, Clinician III, to request a change in assignment that would allow her time to stabilize the patient and attend to the challenging emotional needs of the family. Exhibit EP9.f includes two screenshots from Epic showing notes that Bailey wrote about her patient's progressing condition. (Exhibit EP9.f: Notes Documenting Progressing Condition)

Cullen, as shift manager, had been evaluating staffing and was preparing to cancel a nurse who was due to come in at 1100. With this change in patient acuity, she decided

instead to keep that nurse and adjust Bailey's assignment. Cullen and Bailey agreed that they would re-evaluate the situation at 1400.

At 1100, the incoming nurse, Erin Luther, RN, Clinician II, assumed care of Bailey's other three patients. This allowed Bailey to provide one-on-one end-of-life care for several hours. She spent time with the family, comforted the child, coordinated pain control measures and stabilized the situation. Exhibit EP9.g is the assignment sheet from this shift showing the change in patient assignment time frames. (Exhibit EP9.g: 7 Acute Assignment Sheet, PHI Redacted)

Cullen consulted with Bailey as planned, to evaluate the care needs of the palliative care patient; together, they determined that the child did not need one-on-one care beyond the 1500 hour, but that he might warrant close monitoring and the availability of quick intervention pending further changes in his condition. Palliative care doesn't necessarily require one-on-one nursing, but in the event that the patient's status worsens and death is imminent, the nurse would need to be readily available to support the family and keep the patient comfortable. The team agreed that if this occurred, the other nurses would take over the remainder of Bailey's assignment, and the charge nurse and palliative care nurse practitioner would be there to support her with end-of-life and postmortem care.

With a plan in place, Bailey picked up an additional patient who was low acuity at 1500. This made possible a fiscally responsible unit staffing adjustment, but also allowed her to continue to provide the level of care the child and his family needed.