2021

The following is an updated nurse staffing plan for Trios Health, submitted to the Washington State Department of Health in accordance with Revised Code of Washington 70.41.420. The following nurse staffing plan replaces the nurse staffing plan previously submitted to the Washington State Department of Health.

Nurse Staffing Coalition
April 30, 2021

I, the undersigned with responsibility for Trios Health, attest that the attached staffing plan and matrix was developed in accordance with RCW 70.41.420 for2020, and includes all units covered under our hospital license under RCW 70.41. This plan was developed with consideration given to the following elements:

√ Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;
√ Level of intensity of all patients and nature of the care to be delivered on each shift;
√ Skill mix;
√ Level of experience and specialty certification or training of nursing personnel providing care;
√ The need for specialized or intensive equipment;
√ The architecture and geography of the patient care unit, including but not limited to placement of patient rooms, treatment areas, nursing stations, medication preparation areas, and equipment;
√ Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations;
√ Availability of other personnel supporting nursing services on the patient care unit; and
√ Strategies to enable registered nurses to take meal and rest breaks as required by law or the terms of an applicable collective bargaining agreement, if any, between the hospital and a representative of the nursing staff.

This staffing plan was adopted by the hospital on: April 30, 2021

As approved by _____

John Solheim, CEO

Nurse Staffing Plan Purpose

This plan was developed for the management of scheduling and provision of daily staffing needs for the hospital, and to define a process that ensures the availability of qualified nursing staff to provide safe, reliable and effective care to our patients. This plan applies to all parts of the hospital licensed under RCW 70.41.

Nurse Staffing Plan Principles

- Access to high-quality nursing staff is critical to providing patients safe, reliable and effective care.
- The optimal staffing plan represents a partnership between nursing leadership and direct nursing care staff.
- Staffing is multifaceted and dynamic. The development of the plan must consider a wide range of variables.
- Data and measurable nurse sensitive indicators should help inform the staffing plan.

*These principles correspond to *The American Nursing Association Principles of Safe Staffing.*

Nurse Staffing Plan Policy

- The nurse staffing committee (committee) is responsible for the development and oversight of the nurse staffing plan to ensure the availability of qualified nursing staff to provide safe, reliable and effective care to our patients.
- The committee's work is guided by its charter.
- The committee meets on a regular basis as determined by the committee's charter.
- The committee's work is informed by information and data from individual patient care units. Appropriate staffing levels for a patient care unit reflect an analysis of:
    - Individual and aggregate patient needs;
    - Staffing guidelines developed for specific specialty areas;
    - The skills and training of the nursing staff;
    - Resources and supports for nurses;
    - Anticipated absences and need for nursing staff to take meal and rest breaks;
    - Hospital data and outcomes from relevant quality indicators; and
    - Hospital finances.

  *The American Nurses Association does not recommend a specific staffing ratio, but rather to make care assignments based on acuity, patient needs and staff competencies.

- The analysis of the above information is aggregated into the hospital's nurse staffing plan. Each individual patient care unit may use the Nurse Staffing Committee Checklist to guide their work.
- Staff continuously monitor individual and aggregate patient care needs and make adjustments to staffing per agreed upon policy and collective bargaining agreement (if applicable).
- The committee will perform a semiannual review of the staffing plan. If changes are made to the staffing plan throughout the calendar year, an updated staffing plan will be submitted to DOH.
- The hospital is committed to ensuring staff are able to take meal and rest breaks as required by law, or collective bargaining agreement (if applicable). The committee considers breaks and strategies to ensure breaks when developing the plan. A global break policy may be used, or individual patient care units may have discretion in structuring breaks to meet specific needs while meeting the requirements of the law. Data regarding missed or interrupted breaks will be reviewed by the committee to help develop strategies to ensure nurses are able to take breaks.

Nurse Staffing Plan Scope

***Acute care hospitals licensed under RCW 70.41 are required by law to develop a nurse staffing plan. The plan must cover areas of the hospital that: 1) are under the hospital's license (RCW 70.41) and 2) where a nurse(s) provides patient care (i.e., "patient care unit").**

The following areas of the hospital are covered by the nurse staffing plan:

- Emergency Department
- Ambulatory Care Unit
- GI Lab
- Cardiac Cath Lab

- Perioperative Services
- 2N Medical Unit
- 3N Surgical Unit
- Intensive Care Unit
- Infusion Center
- Family Birthing Center
- Special Care Nursery
- Pain Clinic

Nurse Staffing Plan Critical Elements

The following represents critical elements about the nurse staffing plan:

Staffing schedules are based on projected patient census and acuity demands. Adjustments to the schedule are made based on fluctuations in census, activity, and/or acuity, utilizing additional staff as necessary and available. Additional staff is called in by the Nursing Department Leadership or House Supervisor.

Basic nurse staffing patterns have been established by each nursing unit. These patterns are based on historical staffing data, patient days, nursing hours per patient day required to deliver safe nursing care, budget information, quality improvement data, acuity, ages of patients served, specialty qualifications, staff competencies, technologies used as well as patient satisfaction data.

The utilization of skill mix is made in accordance with laws governing nursing practice and the scope of the Nurse Practice Act for the State of Washington. The following skill mix and nurse staffing patterns are defined by each unit. Physician clinics have established staffing levels.

Low Census

Nursing staff members may be placed on low census and/or on call, according to policy, if scheduled staffing exceeds the need. On call requires the nurse to remain available for immediate recall to duty at the hospital during the nurse's regularly scheduled shift. Low census without call releases the nurse from further duty at any time during the nurse's regularly scheduled shift. The determination is made to either low census or low census on call a nurse based on patient acuity, staff skill mix and competency of nursing staff members.

Meal and Break Coverage:

Trios Health is committed to ensuring that our staff receive rest break and meal breaks. The goal for the Charge Nurses is to have a lighter patient load (or no patient load if at all possible) in order to collaborate with team members to cover breaks and lunches. The nurse assigned to go for his/her break will report off to the Charge and/or Resource Nurse (a role within the staffing matrix-not additional) who will assume responsibility for the group of patients assigned to the nurse taking a meal or rest break. Rest breaks and meal break will either be assigned at the beginning of a shift by the Charge Nurse or have sign-up sheets each shift. Clear communication by the staff nurse with the Charge Nurse when he/she cannot take a scheduled meal or rest break is imperative to ensure all staff receive breaks in a timely manner. Some departments may have a more prescribed assignment of break coverage due to case load/timing such as cardiac catheterization lab, endoscopy, OR and PACU. Reason for missed or interrupted meal or rest breaks are documented by the charge nurse. If a rest break or meal break is interrupted and an employee is able to take a complete rest or meal break at the earliest reasonable time during which the employee is required to receive a rest break, the rest break or meal break is considered to have been taken.

Department Specifics:

Emergency Department
The Emergency Department is staffed with a minimum of three RNs 24 hours per day, seven days a week. One RN is assigned as Charge/Triage Nurse. Additional staff are utilized based on census and acuity, including secretarial clerical support and technicians. Ancillary departments also add to the interdisciplinary patient care team. Staffing ratios for the Emergency Department can range from 1:1 to 1:4 depending on acuity. For periods of time, trauma activations, STEMI

activations and stroke activations are 2:1 and some nurses will exceed the 1:4 ration to meet department demand, but this is not a general staffing practice. Emergency Department nurses respond to other departments when Codes (code blue and rapid response team) are called. Generally, start times of various shifts mirror the yearly average patient volume per hour of presentation. Some changes are made to accommodate seasonal fluctuations. Each shift will have a designated Charge Nurse to facilitate throughput, answer EMS calls and to overhead page activations and code calls within the unit and on the floors. Each shift will have a Triage Nurse or direct bedding is utilized to facilitate eyes on patients presenting to the department. Lunch and breaks are scheduled and tracked by the Charge Nurse on each shift. A sheet is posted at the nurse's station and is submitted to the Director daily with the staffing sheet. If lunches or breaks are missed, the reasons are documented on this sheet.

Medical and Surgical Units (2North Medical and 3N Surgical)

There must be at least two RNs on each shift. Other skill mix utilized consists of nursing assistants certified (NAC) with support from secretarial staff (US). Ancillary departments also add to the interdisciplinary patient care team. Staffing is based on census, staffing matrix, acuity and patient care needs. Staffing will flex depending on census and complexity of care. The staffing for Med/Surg is 1:5 RNs/1:10 NACs on day shift with the addition of a unit secretary from the census of 12 and higher. The staffing for Med/Surg is 1:6 RNs/1:12 NACs on night shift. Primary care RN teams, consisting of an RN without NAC assignment, is a nurse to patient ratio of 1:4 on day shift. Primary care RN teams, consisting of an RN without NAC assignment, is a nurse to patient ratio of 1:5 on night shift. Each shift will have a designated Charge Nurse. Day shift Charge RNs should not be assigned a patient team but they may take patients transitionally to facilitate throughput or if they deem they have the ability to accept a patient(s) while meeting the responsibilities of the Charge RN role. Night shift Charge Nurse patient assignment should be no greater than 2 and they may also take a patient assignment transitionally or if they deem they have the ability to take an additional patient(s). The Charge Nurse duties may include but not limited to: act as a resource to staff, respond to emergencies, overhead page activations and code calls throughout the facility. Meal and breaks will follow the process outlined above under heading "Meal and Break Coverage."

Perioperative Services:

Pre-Anesthesia

At least one RN, supplemented by a CNA when warranted by patient volume. Breaks and meal breaks are scheduled between patient visits.

Operating Room

One RN is assigned as Charge Nurse. The circulator must be an RN. The scrub may be an RN, LPN or surgical technician. Additional support staff include a scheduler and anesthesia assistant, as well as OR environmental services employees. Case scheduling and complexity of cases determine the daily assignments including the specific complement of staff assigned to each case. Breaks and lunches are assigned by the OR Supervisor or the Charge Nurse. If a scheduled break time falls during a case the Charge will assign a nurse to relieve the RN scheduled for break.

Post Anesthesia Care Unit (PACU)

At least two RNs must be staffed in PACU at all times of operation. One RN must be Phase I competent. Charge Nurse assigns breaks and meal breaks based on the anticipated time between arriving cases from OR.

Ambulatory Care Unit

The ACU is open Monday thru Friday from 5:45 a.m. to 7:00 p.m. and on Saturday and Sunday from 6:30 a.m. to 7:00 p.m. Schedules include 8 hour and 12 hour shifts.

At least two RNs must be in the unit during hours of operation. One RN is assigned as Charge Nurse. Other personnel utilized include CNAs and HUCs. Staffing is based on acuity, staffing matrix, and nursing hours adjusted for rapid turnover of outpatient beds. Overall, the ACU will have a nurse-patient ratio of 1:3 or 1:4 and our core staffing model will be 7-11 RNs supported by a CNA/HUC and a Scheduler (Monday-Friday). On Saturdays and Sundays, there will be two RN's to provide patient care. Staffing will flex up or down as needed based on daily volume and complexity. There is a posted signup sheet at the nurse's station. Meal and breaks will follow the process outlined above under heading "Meal and Break Coverage."

Endoscopy

One RN and a second RN or GI tech is assigned to Endoscopy Monday through Friday 7:00am-3:30pm. One RN and a second RN or GI tech will cover call after 3:30pm weekdays and on weekends.

Cardiac Cath Lab

Two Cath Lab trained RNs shall be assigned to the Cath Lab Monday through Friday 7:00am-3:30pm. Four Cath Lab trained Special Procedures Techs shall be assigned to the Cath Lab, Monday through Friday 7:00am-3:30pm. For Monday through Friday 3:30pm-7:00am, and on weekends/holidays, 1 RN and 2 Special Procedures Techs will be on call for unforeseen, emergency cases. Generally the staffing mix for one patient/case will be 1 RN and 2 Special Procedures Techs. Meal and breaks will follow the process outlined above under heading "Meal and Break Coverage."

Intensive Care Unit (ICU)/ Intermediate Care Unit (IMC)/Pediatrics

There are to be at least two qualified RNs on each shift. Two ICU trained RNs shall be assigned to ICU when Intensive Care Status patients are present. One Pediatric trained nurse shall be assigned when pediatric patients are present. Special circumstances may support augmentation with additional ancillary staff. The staffing ratio for ICU RN staff to patients is 1:2. The staffing ratio for Pediatric RN staff to patients is 1:4. Intermediate Care RN staff to patient ratio is 1:4. Pediatric/IMC total care (no NAC assigned to help with a nurse's assigned team of patients) assignment will be 1:3. Each shift will have a designated Charge Nurse and the goal is they will not be assigned any patients in order facilitate throughput. The charge nurse may take up to two patients transitionally but should not be preassigned more than one new admission patient prior to the start of shift. The Charge Nurse Duties may include but not be limited to: respond to emergencies, answer overhead page activation and code calls throughout the house and act as a resource to staff. There is a posted signup sheet at the nurse's station. Meal and breaks will follow the process outlined above under heading "Meal and Break Coverage."

Family Birthing Center (FBC)

A minimum of six RN/LPN trained Labor and Delivery/Post-Partum of which one should be a Special Care Nursery RN for high risk deliveries if only single RN required in Special Care Nursery. Minimum of one (1) trained scrub tech in house at all times. Nurse to patient ratios for the FBC range from 1:1 to 1:3 depending on acuity of patient. Ratios are based on the AWHONN recommendations. Each shift will have a designated Charge Nurse to facilitate the flow of the department, provide primary care for triage and antepartum testing, assist with cesarean sections and emergencies, be a staff resource and be baby nurse at deliveries if resource nurse is unable to attend as primary baby nurse. Each shift will have a Resource nurse to be designated as baby nurse for routine deliveries, provide break coverage and to be backup for triage and OP testing. Meal and breaks will be scheduled and tracked by the charge nurse on each shift. If lunches or breaks are missed, the Charge nurse will document the reason on the staff assignment sheet. There is a posted signup sheet at the nurse's station. Meal and breaks will follow the process outlined above under heading "Meal and Break Coverage." They will be planned and tracked by the charge nurse each shift and documented on the daily assignment sheet for each person. If meals or breaks are missed the charge nurse will document the reason on the daily assignment sheet.

Special Care Nursery (SCN)

A minimum of two Primary SCN RNs required to be in house for minimum staffing with one (1) infant in SCN. Second RN is available for high risk deliveries and can be floated to FBC as part of their core staffing. Ancillary departments such as Respiratory Therapy are considered part of the patient care team. Nurse to patient ratios for the SCN can range from 1:1 to 1:3 and are based on the AWHONN recommendations. Each shift will have a designated charge nurse to facilitate the flow of the department and be a resource. Meal and breaks will follow the process outlined above under heading "Meal and Break Coverage." They will be planned and tracked by the charge nurse each shift and documented on the daily assignment sheet for each person. If meals or breaks are missed the charge nurse will document the reason on the daily assignment sheet.

Infusion Center (IC)

The Infusion Center will offer outpatient services to Trios Medical Group (TMG) Oncology and Hematology patients. Patients are scheduled for chemotherapy and immunotherapy infusions/injections, symptom management, growth factors, central line blood draws and flushes, iron infusions, phlebotomy, and other services as needed.

Outpatient oncology nursing includes treatment administration, patient and family teaching, psychosocial support, patient counseling, care of central lines, pumps, patient assessments, toxicity management and facilitating referrals for community resources and support. Outpatient oncology nursing also requires the nurse to have a comprehensive understanding of oncology, immunology, community health, rapid assessment skills, as well as expert competency in outpatient treatment regimens and their side effects, leadership as direct caregiver, and collaborator. The outpatient oncology nurse must possess strong consistent clinical judgment, confidence in decision making, and has to respond to high volumes of patients while dealing with issues that are not always predictable. Clinical decisions have to be made with less data.

Acuity levels vary by severity of patient illness, the complexity of nursing service required, and the complexity of the treatment regimen. The nurse to patient ratio for patients actively receiving chemotherapy is 1:4. Some infusions may require 1:1 patient care for a length of time. The patient turn-over rate in the outpatient setting is high. Staffing will flex up or down as needed based on daily volume

Pain Clinic

The Pain Clinic manages outpatient chronic pain patients. Patients are referred by their primary care provider for an evaluation for pain management. Some are candidates for pain management procedures such as nerve blocks, steroid injections, medial/lumbar branch blocks and radiofrequency ablation to name a few.

Staffing includes two Registered Nurses and one radiology technician. One RN is designated as the pre-procedure and post-procedure nurse. The other assists physician during moderate/procedural sedation. The radiology technician runs the C-Arm machine.

Lunch breaks are scheduled between 12:30-1:00, when patients are not scheduled for a procedure. 15-minute breaks will be coordinated as described about under “Meal and Break Coverage.”

Float Team

The float team includes RN and unlicensed sitter positions. Assignments and patient ratio is dependent on the department to which they are assigned for the shift. Meal and Rest Breaks will follow the assigned department’s process.

House Supervisors

There is one RN House Supervisor 24 hours per day, 7 days per week. Meal and rest breaks will be taken during slow times of the shift. The House Supervisor will notify his/her supervisor immediately if unable to take a meal or rest break.

Nurse Staffing Plan Matrices

The following matrices are to be used in conjunction with the description of ratios in the above departmental narratives.

			Emergency Departmetn Staffing Matrix						
Staff Type	Days 0600	Days 0700	Days 0900	Evenings 1100	Evenings 1500	Evenings 1700	Nights 1700	Nights 1900	# staff
RN(12 hrs)		3	2	1		1	1	4	11
PCT(12hrs)	1				1				2
HUC		1 (10 hrs)				1 (8 hrs)			2
Totals	1	4	2	1	1	2	1	4	15
	Director	Auditor	Trauma/Stroke	Total					
	1	1	1	3					
	8hrs 5 days	8hrs 5 days	10 hr 4 days	26hr 5 days					

2N Medical/3N Surgical Shift Staffing Matrix													
Highlighted Indicates a patient population that could include up to two transitional patients that will discharge from the unit													
*If the Charge RN deems that the unit does not need additonal staff subject to floor acuity to accommodate the patient population during the transition period they will staff according to the lower number.													
	Days						Nights						
# of patients	Charge	Med/ SurgRN	NAC	HUC	Total DAY staff	# of patients	Charge	Med/ Surg RN	NAC	HUC	Total NOC staff	24 hr staff total
1	1	1	0	0	2	1	1	1	0	0	2	4
2	1	1	0	0	2	2	1	1	0	0	2	4
3	1	1	0	0	2	3	1	1	0	0	2	4
4	1	1	0	0	2	4	1	1	0	0	2	4
5	1	2	0	0	3	5	1	2	0	0	3	6
6	1	2	0	0	3	6	1	2	0	0	3	6
7	1	2	0	0	3	7	1	2	0	0	3	6
8	1	2	0	0	3	8	1	2	0	0	3	6
9	1	2	1	0	4	9	1	2	1	0	4	8
10	1	2	1	0	4	10	1	2	1	0	4	8
11	1	3	1	0	5	11	1	2	1	0	4	9
12	1	3	1	1	6	12	1	2	1	0	4	10
13	1	3	2	1	7	13	1	3	1	0	5	12
14	1	3	2	1	7	14	1	3	1	0	5	12
15	1	3	2	1	7	15	1	3	1/2*	0	5/6*	12/13*
16	1	4	2	1	8	16	1	3	1/2*	0	5/6*	12/13*
17	1	4	2	1	8	17	1	3	1/2*	0	5/6*	12/13*
18	1	4	2	1	8	18	1	3	2	0	6	14
19	1	4	2	1	8	19	1	4	2	0	7	15
20	1	4	2	1	8	20	1	4	2	0	7	15
21	1	5	2/3*	1	9/10*	21	1	4	2	0	7	16/17
22	1	5	2/3*	1	9/10*	22	1	4	2	0	7	16/17
23	1	5	3	1	10	23	1	4	2	0	7	17
24	1	5	3	1	10	24	1	4	2	0	7	17
25	1	5	3	1	10	25	1	5	2	0	8	18
26	1	6	3	1	11	26	1	5	2/3*	0	8/9*	19/20*
27	1	6	3	1	11	27	1	5	2/3*	0	8/9*	19/20*
28	1	6	3	1	11	28	1	5	3	0	9	20
29	1	6	3	1	11	29	1	5	3	0	9	20
30	1	6	3	1	11	30	1	5	3	0	9	20

Operating Room Matrix*

Standard Surgical Cases

- 1 RN Circulator/1 patient
- 1 Scrub (either RN or Tech)/1 patient

Complex Surgical Cases (ex: Robotics, Total Hip/Knee, Urology Laser, Neuro/Spine, Trauma)

- 1 RN Circulator/1 patient
- 2 Scrub (either RN or Tech)/1 patient

Non-Anesthetic Provider Cases (Local Anesthesia)

- 1 RN Circulator/1 Patient
- 1 Scrub (either RN or Tech)/1 patient
- 1 RN Local Anesthesia Monitor

Ancillary Staff

- 1 RN Supervisor
- 1 RN Charge (Supervisor may act in this role as volumes dictate)
- 1 Pre-Anesthesia Clinic RN
- 1.5 Scheduler/Biller
- 1 Anesthesia Tech
- 4 Environmental Services Tech (adjusted based on volumes)

On-Call (3:15pm-6:45am Monday pm – Friday am, 3:15pm-7:00am Friday pm – Monday am)

- 1 RN Circulator/1 patient
- 1 Scrub (either RN or Tech)/1 patient

**Staffing reflects AORN staffing guidelines*

PACU Matrix

Phase 1 Level of Care:

- 2 RN's, 1 of whom is an RN competent in Phase 1 post anesthesia nursing, are in the same unit where the patient is receiving Phase 1 level of care.
    - Phase 1 level of care:
        - Class 1:2—1 nurse to 2 patients who are
            - 1 unconscious, stable, without artificial airway, and over the age of 8 years; and 1 conscious, stable, and free of complications.
            - 2 conscious, stable, and free of complications.
            - 2 conscious, stable, 8 years of age and under, with family or competent support staff member present.
        - Class 1:1—1 nurse to 1 patient
            - At the time of admission, until the critical elements are met.
            - Unstable airway.
            - Any unconscious patient 8 years of age and under.
            - A 2nd nurse must be available to assist as necessary.
        - Class 2:1—2 nurses to 1 patient
            - 1 critically ill, unstable, complicated patient.

Critical elements can be defined as:

- Report has been received from the anesthesia professional, questions have been answered, and the transfer of care has taken place.
- Patient has a secure airway.
- Initial assessment is complete.
- Patient is hemodynamically stable.

Examples of an unstable airway include, but are not limited to, the following:

- Requiring active interventions to maintain patency, such as manual jaw lift or chin lift.

Phase 2 Level of Care:

- 2 competent personnel, one of whom is an RN competent in Phase 2 post anesthesia nursing, are in the same room where the patient is receiving Phase 2 level of care. An RN must be in the Phase 2 PACU at all times while a patient is present.
    - Phase II level of care
        - Class 1:3—1 nurse to 3 patients who are
            - Over 8 years of age.
            - 8 years of age and under with family present.
        - Class 1:2—1 nurse to 2 patients who are
            - 8 years of age and under without family or support staff member present.
            - Initial admission of patient post procedure.
        - Class 1:1—1 nurse to 1 patient
            - Unstable patient of any age requiring transfer.

Staffing will reflect ASPAN's "Patient classification/recommended staffing guidelines", and will vary dependent upon surgical volumes.

Cardiac Cath Lab Staffing Matrix

	Staffing			
Day of the Week	RN 0700-1530	RN 1530-0700	Special Procedures Tech 0700-1530	Special Procedures Tech 1530-0700
Monday	2	1 OC	4	2 OC
Tuesday	2	1 OC	4	2 OC
Wednesday	2	1 OC	4	2 OC
Thursday	2	1 OC	4	2 OC
Friday	2	1 OC	4	2 OC
Saturday	1 OC	1 OC	2 OC	2 OC
Sunday	1 OC	1 OC	2 OC	2 OC

OC-on-call

Infusion Center

Staffing varies by day of week due to visit volumes					
Day of the Week	**Charge Nurse** 0700-1730	**RN** 0700-1730	**NAC** 8 hour Shift start times may vary	**Scheduler** 8 hour	**Charge Specialist** 7 hour
Monday	1	2	1	1	1
Tuesday	1	3	1	1	1
Wednesday	1	3	1	1	1
Thursday	1	3	1	1	1
Friday	1	1	1	1	1

Intensive Care Unit Days and Nights (for ICU-level patients only. IMC is staffed at 1:4 nurse to patient ratio).

# of ICU-level patients	Charge	RN	NAC/ HUC
1	1	1	0
2	1	1	0
3	1	2	0
4	1	2	1
5	1	3	1
6	1	3	1
7	1	4	1
8	1	4	1
9	1	5	1
10	1	5	2
11	1	6	2
12	1	6	2
13	1	7	2
14	1	7	2

Staff/Pt Ratio	Family Birthing Center Worksheet	# Pts	#Staff Needed	# Pts Added	Staff Added
	Unit Secretary	N/A	1		
	Charge RN	N/A	1		
	Resource RN	N/A	1		
	Scrub	N/A	1		
	Circulator		1		
	Recovery RN		1		
	SCN RN		1		
	2nd Scrub Tech(if >2 C Sections/BTL scheduled and/or anticipate 5+ discharges OR scheduled NST, 4+labors, VBAC, SCN assist (may be on call for partial shifts				
1:1	Active labor patients with Pitocin/>3cm/Epidural				
	Patients on Magnesium (except stable PP mom or non contracting antepartum)				
	Unstable antepartum patients(preterm labor progressing, PIH with frequent assessments, unstable blood sugars, active vaginal bleeding, non-reassuring FHR, patients receiving >4 medications/shift				
	VBAC/TOLAC				
	C section admission (2 hours prior to surgery to 2 hours post surgery or until stable)				
	Recovery x2 hours ALL PATIENTS				
	Fetal demise up until 3 hours post partum				
1:2-3	Stable antepartum patients				
	Stable postpartum mom on magnesium				
	Induction with prostaglandins: Cytotec, Cervadil				
	Normal PP moms and babies (each couplet counts as 2 patients, so 3 couplets = 6 patients)				
Recovery Room Care-RN will be in constant attendance until criteria met. One RN for mom and one staff member to monitor infant recovery for each infant. Minimum 2 RNs will attend every birth (vaginal or c section). One for mom, one for each baby. Also, a person able to intubate must be present (RT or CRNA)					
CORE STAFFING: Charge, Resource, Scrub, Circulator, Recovery, SCN=Total 6 RN/LPN staff members					

Special Care Nursery

*Score each baby's acuity according to the highest level of care given for time period.
**For shift of admission, discharge, or CPS meeting day, increase to next level for that shift ONLY. (i.e. F1 to F2, and at least an F2)

Code for Admission	Status	Example of Level
N	Wellborn Infant 0.25 FTE	Needs to stay in nursery due to maternal absence or illness. Ex: awaiting adoption or CPS placement. Baby catching for high risk deliveries (0.25 each shift)
F	Newborn Level I Focused #0171 1:3-4 Nursing Care AWHONN F1 0.25 FTE < 5 items F2 0.33 FTE ≥ 5 items	Low Complexity Care needs are stable but require frequent evaluation and observation during the immediate PP period: • Routing bilirubin and blood glucose monitoring (or single therapy) • Observation post resuscitation care • Initiation of phototherapy and no IV needed • NAS management (un-medicated) new or score 1-5 • Isolette or warmer for thermoregulation and stable • Septic workup no treatment • Growing premature infant with no oxygen or IV needed
M	Newborn Level II Intermediate Care #0172 1:2-3 Nursing Care AWHONN M1 0.33 FTE ≤ 4 (0.33) items M2 0.5 FTE ›4 (0.33) items; or any 0.5 item	Moderate Complexity Needs: • IV meds, IV fluids-hydration only (0.33) • Stable, or wearing O2 nasal cannula or CPAP (0.33) • Feeding intolerance and/or fed by NG or OG for lack of nippling (0.33) • Intensive Phototherapy-multiple phototherapy lights (0.33) • Temperature instability requiring adjustments to isolette temp. (0.33) • Sepsis evaluation and sepsis treatment (0.33) • Apnea/bradycardia within 72 hours, or that requires tactile stimulation or periodic oxygen < 6x./shift (0.33) • Drug withdrawal therapy (receiving medications) and/or NAS score ›5 (0.5) • Occasional de-saturates with feedings (0.5) • Infant in isolation (0.5)
L	Newborn Level III Intensive Care #0173 1:1-2 Nursing Care AWHONN L1 0.5 FTE ≤ 3 (0.5) items L2 0.75 ›3 (0.5) items OR one 0.75 FTE items If total of all items for baby is ›2.0 move to C	Hemodynamically unstable or infants with complex medical conditions that require invasive therapy: • Unstable-titrating O2% or pressure via nasal cannula or CPAP; extended PPV (0.5) • Desaturations with most feedings (0.5) • Blood Transfusion (0.5 • Peripheral titration or bolus of Glucose (Hypoglycemia Tx), or TPN and/or Lipids infusion, not to including weaning (0.5) • Apnea/bradycardia that requires tactile stimulation or periodic oxygen ≥ 6x/shift (0.5) • Pharmacologic treatment of apnea or bradycardia episodes (0.5) • Early stages of NEC (presenting with green bile, ↑abdominal girth, distension, need for suctioning (0.75) • NIV or intubation with mechanical ventilation-stable (0.75) • Central line UAC and/or UVC (0.75)
C	Newborn level IV Critical Infants to be transferred #0174 1:1.0 FTE	Infant requiring transfer to a Level III hospital. Requires advanced intervention or technical care. • Severe congenital malformations or acquired conditions, active/passive cooling, heart defects, surgical intervention, late stage NEC, gastroschesis, mechanical ventilation unstable, IV bolus or continuous drip therapy for severe physiologic metabolic instability (dopamine, insulin, Prostin)