Rochelle Community Hospital

NURSING DEPARTMENT STAFFING PLAN
2026

Definitions

"Acuity Model" – an assessment tool selected and implemented by the nursing department, as recommended by the Nursing Care Committee, which assesses the complexity of patient care needs requiring professional nursing care and skills and aligns patient care needs and nursing skills consistent with professional nursing standards.

"Nursing Care Committee" – a hospital-wide committee of nurses whose functions, in part or whole, contribute to the development, recommendation, and review of the hospital's nursing department staffing plan.

"Patient Acuity" – the complexity of patient care needs requiring the skill and care of a nurse, which is addressed when aligning nursing resources and professional practice standards as part of the patient's treatment plan.

"Staffing Plan" – a written plan for assignment of patient care nursing staff based on multiple nurses and patient considerations that yield minimum staffing levels and the adopted acuity model aligning patient care needs with nursing skills required for quality patient care consistent with professional nursing standards.

Professional Practice

The profession of nursing within Rochelle Community Hospital (RCH) utilizes the American Nurses Association Professional Scope and Standards of Practice as the framework for the practice. The Standards of Practice coincide with the steps of the nursing process. The Standards of Professional Nursing Practice are statements of the duties that all registered nurses, regardless of role, population, or specialty are expected to perform competently. The standards are subject to formal, periodic review and revision recommendations for change.

We support that:

- Nursing practice is individualized to meet the unique needs of patients, families, communities, and populations.
- Nurses coordinate care by establishing partnerships with patients, families, systems, and other providers to address the health needs of the patient and the public.
- Caring is central to the practice of the registered nurse and supports caregivers.
- Registered nurses use the nursing process to plan and provide individualized care to their healthcare consumers.
- A strong link exists between the professional work environment and the registered nurse's ability to provide quality health care and achieve optimal outcomes.

Written staffing Plan

The written staffing plan is developed reviewed and revised by the Nursing Care Committee. It is then presented to Administration for approval of minimum staffing needed for direct patient care.

The following will be considered:

A. The complexity of complete care, assessment on patient admission, volume of patient admissions, discharges and transfers, evaluation of the progress of a patient's problems, ongoing physical assessments, planning for a patient's discharge, assessment after a change in patient condition, and assessment of the need for patient referrals;

B. The complexity of clinical professional nursing judgment needed to design and implement a patient's nursing care plan, the need for specialized equipment and technology, the skill mix of nurses and other personnel providing or supporting direct patient care, and involvement in quality improvement activities, professional preparation, and experience;

C. Patient acuity and the number of patients for whom care is being provided;

D. The ongoing assessments of a unit's patient acuity levels and nursing staff needed shall be routinely made by the unit nurse manager and/or nursing House Supervisor;

E. The identification of additional registered nurses available for direct patient care when patients' unexpected needs exceed the planned workload for direct care staff.

The written staffing plan takes into account the time required for nursing staff documentation of patient care.

The written staffing plan will provide for staffing flexibility to meet patient needs and will utilize an acuity model for adjusting the staffing needs of each unit.

The written staffing plan, including current schedules and average daily census shall be made available upon request as required under the Hospital Report Card Act.

Nursing Care Committee

The Nursing Care Committee shall be broadly representative of the clinical service areas as practically reasonable, including Surgery, Out Patient Services (OPS), Post Anesthesia Care Unit (PACU), Intensive Care Unit (ICU), Medical-Surgical Unit (MSU), and the Emergency Department (ED). Membership of the committee is voluntary with 100% of the members being RNs, and 55% providing direct patient care.

Nursing Care Committee recommendations will be given significant regard and weight in the adoption and implementation of the written staffing plan. The written staffing plan will be reviewed semi-annually, prior to budget preparation and mid-year. Recommendations made to administration will be in written format. They must be submitted within two weeks following the scheduled meeting.

Administration will provide feedback to the Nursing Care Committee regarding unresolved or ongoing issues by way of committee meeting, and discussion will be documented in the minutes.

The Nursing Care Committee shall provide input and feedback on the following:

A. Selection, implementation, and evaluation of minimum staffing levels for inpatient care units.

B. Selection, implementation, and evaluation of an acuity model to provide staffing flexibility that aligns changing patient acuity with nursing skills required.

C. Selection, implementation, and evaluation of a written staffing plan incorporating nursing-sensitive care performance measures and the National Quality Forum's Safe Practices for Better Healthcare.

D. System-related or clinical service area nurse staffing or patient issues identified between meetings shall be shared, reviewed and addressed at the next Nursing Care Committee meeting.

Methods of Determining Staffing Levels

RCH has a substantial interest in promoting quality care and improving the delivery of health care services. Evidence-based studies have shown that the basic principles of staffing in the acute care setting should be based on the complexity of patients' care needs aligned with available nursing skills to promote quality patient care consistent with professional nursing standards.

RCH promotes an organizational climate that values registered nurses' input in meeting the health care needs of hospital patients. In addition to a minimal staffing level, an "Acuity Model" is used to guide the assignment of direct care nursing staff. Adjustments to meet acute needs (i.e. high census etc.) will be continually reviewed to assure appropriate staffing.

I. PREANESTHESIA PHASE

Preadmission

Perianesthesia nursing roles during this phase focus on assessing the patient and developing a plan of care designed to meet the pre-anesthesia physical, psychological, educational, sociocultural, and spiritual needs of the patient/family/significant other. The nursing role also focuses on preparing the patient, family, and significant other for his or her experience throughout the perianesthesia continuum. Interviewing and assessment techniques are used to identify potential or actual problems that may occur.

Staffing for the preadmission unit is one RN. If available, a CNA may also be present. Length of time spent per patient is dependent on patient health status, planning for special supplies and equipment to meet patient needs and required support for pre-anesthesia interventions.

Day of Surgery/Procedure

Perianesthesia nursing roles during this phase focus on validation of existing information and completion of preparation of the patient. The perianesthesia registered nurse continues to assess the patient and develops a plan of care designed to meet the physical, psychological, education, sociocultural, and spiritual needs of the patient/family/significant other.

Pre-Operative Phase

Due to the varied complexities of the unit, recommended staffing ratios must be determined based on, but not limited to the following criteria:

- Patient safety
- Number and acuity (patient characteristics and requirements of care) of patients
- Complexity (management of patient acuity) and intensity of care
    - Examples include: average time in patient preparation (e.g., education, testing, history, completion, patient education, preoperative testing, intravenous access, completion of required paperwork / electronic charting, blood product administration, interpreter services, etc.).
- Medication reconciliation/administration (antibiotics, sedation, anxiolytics, etc.)
- Procedures (e.g., insertion of invasive lines, regional blocks)

- Need for additional monitoring
- Additional processes of the specific unit (e.g., blending of levels of care, etc.)

II. INTRA-OPERATIVE PHASE

Surgery

One RN per patient per Operating Room (OR) in the role of circulating nurse. One scrub person per patient per room; may be an RN or Surgical Technologist. In some circumstances, a scrub person may not be required.

Additional staff members, with appropriate competencies, may be used as appropriate for the following:

- Moderate sedation – one RN dedicated to monitoring the patient and separate from the dedicated RN circulator.
- Local anesthesia – depending on patient needs, nursing assessment, type of procedure, and RN may be needed to monitor the patient in addition to the RN circulator.
- Complex surgical procedures and patients with compound needs may require an additional RN circulator and scrub person.
- Technological demands (e.g., lasers).
- First assist requirements.

III. POSTANESTHESIA PHASE

PACU

The perianesthesia registered nursing roles during this phase focus on providing post anesthesia nursing care to the patient in the immediate post anesthesia period, and transitioning them to Phase II level of care, the inpatient setting, or to an intensive care setting for continued care (see Blended Levels of Care).

Two registered RNs, one whom is competent in post anesthesia phase I nursing will remain in the same unit where the patient is receiving Phase I.

- Staffing should reflect patient acuity. In general, a 1:1 nurse-patient ratio in PACU allows for appropriate assessment planning, implementing and evaluation for discharge as well as increased efficiency and flow of patients through the PACU area.
- New admissions should be assigned so that the nurse can devote his/her attention to the care of that admission until *critical elements are met.
- Staffing patterns should be adjusted as needed based on changing acuity and nursing requirements, and as discharge criteria are met.

CLASS 1:2 ONE NURSE TO TWO PATIENTS

- Two conscious patients, stable and free of complications but not yet meeting discharge criteria.
- Two conscious patients, stable and 8 years of age or under, with family or competent support staff present, but not yet meeting discharge criteria.
- One unconscious patient hemodynamically stable, with a stable airway, an older than the age of 8 years; one conscious patient, stable and free of complications.

CLASS 1:1 ONE NURSE TO ONE PATIENT

- At time of admission, until the *critical elements are met
- Critical elements can be defined as:
- Transfer of care has occurred from the anesthesia provider with an opportunity for question and answer.
- Initial assessment is complete.
- Patient has a stable/secure airway.
- Patient is free from agitation, restlessness, and or combative behaviors.
- Airway and or hemodynamic instability.
- Examples of an unstable airway include but are not limited to:
- Requiring active interventions to maintain airway patency such as manual jaw or chin lift and or an oral airway.
- Evidence of obstruction, active or probable, such as gasping, choking, crowing, wheezing.
- Symptoms of respiratory distress including dyspnea, tachypnea, panic, agitation, cyanosis.
- Unconscious patient 8 years of age or younger.
- A second nurse must be available to assist as needed.
- Patients with contact precautions until there is sufficient time for donning and removing personal protective equipment and washing hands between patients.

CLASS 2:1 TWO NURSES TO ONE PATIENT

a) One critically ill, unstable patient.

Phase II Level of Care

Perianesthesia nursing roles during this phase focus on preparing the patient/family/significant other for care in the home or Extended Care level of care.

Two competent personnel, one of whom is an RN competent in phase II postanesthesia nursing, are in the same unit where the patient is receiving phase II level of care. An RN must be in phase II at all times while a patient is present.

- Staffing should reflect patient acuity and complexity of care. In general, a 1:3 nurse patient ratio allows for appropriate assessment, planning, implementing care and evaluation for discharge as well as increasing efficiency and flow of patients through the Phase II area. This also allows flexibility in assignments as patient acuity is subject to change.
- New admissions should be assigned so that the nurse can devote his/her attention as needed to appropriate discharge assessment and teaching
- Staffing patterns can be adjusted as needed as acuity/nursing interventions and discharge criteria are met.

CLASS 1:3 ONE NURSE TO THREE PATIENTS

a) Over 8 years of age.

b) 8 years of age and under with family present.

CLASS 1:2 ONE NURSE TO TWO PATIENTS

a) 8 years of age and under without family or support staff present.

b) Initial admission of patient post procedure.

CLASS 1:1 ONE NURSE TO ONE PATIENT

a) Unstable patient of any age requiring transfer to a higher level of care.

Extended Care Level of Care

The nursing roles in this phase focus on providing the ongoing care for those patients requiring extended observation/intervention after transfer/discharge from Intra op or PACU levels of care.

Two competent personnel, one of whom is an RN possessing competence appropriate to the patient population, are in the same unit where the patient is receiving extended care level of care. The need for additional RNs and support staff is dependent on the patient acuity, complexity of patient care, patient census and the physical facility.

CLASS 1:3/5 ONE NURSE TO THREE-FIVE PATIENTS

Examples of patients that may be cared for in this phase include but are not limited to:

1. Patients awaiting transportation home.
2. Patients with no caregiver.
3. Patients who have had procedures requiring extended observation/interventions (e.g., potential risk for bleeding, pain management, PONV, etc.).
4. Patients being held for an inpatient bed.

Blended Levels of Care

Perianesthesia units may provide Phase I, Phase II, and/or Extended Care levels of care within the same environment. This may require the blending of patients and staffing patterns. The perianesthesia registered nurse uses prudent judgment based on patient acuity, nursing observations and required interventions to determine staffing needs.

IV. MEDICAL/SURGICAL/TELEMETY UNIT

STAFFING PLAN

A systematic assessment of patient acuity is used as a guideline to plan staffing for the Medical/Surgical Unit. This process is individualized to each patient. This system, along with standards of care, minimal staffing requirements, staff competence and distribution, help determine staffing requirements for the unit.

Use of objective data has been used to assure appropriate staffing levels and skill mix of staff. Outcomes of patient care are the primary means of assuring that staffing levels are appropriate.

Thus core staffing to provide safe and competent care to a census of up to 6 patients with a percentage of 2.2% Low/Green acuity (0-80), 66% Medium/Yellow acuity (81-170), High/Red acuity (171 and above).

2 RNs
1 C.N.A.
1 H.U.C.

The core staffing can be flexed up or flexed down as deemed appropriate by the House Supervisor. However, the in-house staff should never be below 3 staff members with patient census of 1 or more. Census, acuity levels, and staff competence in the Emergency Department will be considered when flexing up or flexing down of Medical/Surgical staffing. Medical/Surgical staff can be sent to the Emergency Department to work within their scope of practice.

PATIENT ACUITY MODEL

	Medical/Surgical Staffing Matrix		
Census	Low (0-80) Acuity	Medium (81-170) Acuity	High (171 & above) Acuity
13	3 RN 2 C.N.A. 1 HUC	4 RN 2 C.N.A. 1 HUC	6 RN 3 C.N.A. 1 HUC
12	3 RN 2 C.N.A. 1 HUC	3 RN 2 C.N.A. 1 HUC	6 RN 3 C.N.A. 1 HUC
11	3 RN 2 C.N.A. 1 HUC	3 RN 2 C.N.A. 1 HUC	6 RN 3 C.N.A. 1 HUC
10	2 RN 2 C.N.A. 1 HUC	3 RN 2 C.N.A. 1 HUC	5 RN 2 C.N.A. 1 HUC
9	2 RN 1 C.N.A. 1 HUC	3 RN 2 C.N.A. 1 HUC	5 RN 2 C.N.A. 1 HUC
8	2 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC	4 RN 2 C.N.A. 1 HUC
7	2 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC	4 RN 2 C.N.A. 1 HUC
6	2 RN 1 C.N.A. 1 HUC	2 RN 2 C.N.A. 1 HUC	3 RN 2 C.N.A. 1 HUC
5	2 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC	3 RN 1 C.N.A. 1 HUC
4	1 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC
3	1 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC	2 RN 1 C.N.A. 1 HUC
2	1 RN 1 HUC	1 RN 1 HUC	2 RN 1 HUC
1	1 RN 1 HUC	1 RN 1 HUC	2 RN 1 HUC
0	1 RN 1 HUC/CNA	1 RN 1 HUC/CNA	1 RN 1 HUC/CNA

ICU Staffing Plan Level 1 – One nurse to one patient
Such patients are highly complex, vulnerable, and unpredictable and hemodynamically unstable requiring multiple pressors being titrated or interventions q 15 minutes; they require many resources and cannot participate in their care.

Level 2 – One nurse to two patients
These patients are also highly complex and unpredictable but require fewer resources and can minimally participate in their care. They may be awaiting transfer to the Med/Surg unit or home. This is the typical ICU patient assignment.

Level 3 – One nurse to three patients
Such patients may need hourly assessments and/or interventions; they are moderately complex, moderately stable, and more predictable. They can participate in their care.

A CNA or Unit Clerk will be assigned as a resource for ordering and obtaining supplies and to facilitate communication between departments.

Specific ICU Staffing Guidelines:
1. An RN in the Critical Care role will be scheduled for provision of low frequency, high risk situations, when needed. This nurse may work in the ICU, the ED or on Med Surg.
2. In the absence of high acuity in the ED or Med Surg, the Critical Care capable RN will supplement staffing in the Med/Surg area, evaluate patients for risks for core measure compliance. (See also Critical Care RN guidelines).

Specific Emergency Department Staffing Guidelines:
1. Minimum Emergency Department RN staffing will consist of two nurses at all times. Whenever possible, one of the nurses should be an ED Core RN. The skill mix of the scheduled nurses will be taken into consideration, with efforts made to schedule RNs with ACLS, PALS, TNCC, etc.
2. Additional nurses may be scheduled during busier times of the day and on busier days of the week.
3. An ED Tech may be scheduled around the clock. In the absence of an ED Tech, nursing staff will perform Tech duties such as doing EKGs, taking specimens to Lab, applying post molds and splints, etc. during their shifts.
4. RN patient assignments may be determined by, and adjusted according to, patient acuity.
5. The House Supervisor and the Emergency Services Manager may provide assistance during times of high census or high acuity.
6. Additional staff may be reassigned from other hospital areas and/or called in from home as needed during extreme high census/acuity situations.

Supervision:

Nursing personnel are supervised by the unit manager, House Supervisor, and the Chief Nursing Officer. When the patient census is such that additional personnel are needed, in-hospital staff will be utilized whenever possible. Additional staff may be called in by the unit manager or House Supervisor, as needed.

General Nursing Services Staffing Guidelines

1) Schedules will be created to provide care in the Med/Surg, ICU, ED, and House Supervisor areas for patient coverage daily. Current staffing needs will be determined by the department manager and/or House Supervisor before the start of each shift.
2) Low Census decision-making for Hospital Resources and Patient Needs:
    - Staffing for up to 0-1 patients, commonly called minimum staffing, is designed to meet the goal of having enough resources in-house for potential situations that may arise. Minimum staffing is initiated with the M/S census but must take into account the ED flow, ICU census needs, and OR schedule, as well as the skills and experience levels of the nursing and support staff.
3) RNs needed to care for OPS patients should be scheduled for the OPS area but may work with those patients in a variety of areas. Patients scheduled for OPS, OP transfusions, or IV meds will be included in the calculations for staffing if additional staff is needed to care for them. In the absence of scheduled staff in OPS or an influx of patients scheduled in that area, staffing may be adjusted to accommodate the needs of the patients.
4) All staff are expected to meet the needs of our patient population and on low census, days may be asked to float to other nursing departments as determined by competency.
5) A log will be kept of low census days and will be rotated amongst staff on duty.
6) The House Supervisor may be expected to take patients in any department as necessary.

References

American Nurses Association (ANA). (2015). *Nursing: Scope and standards of practice.* (3rd ed.). Silversprings, MD.

Emergency Nurses Association. (2018). *Position statement: Staffing and productivity in the emergency department*. Enaorg. Retrieved November 1, 2021, from https://www.ena.org/

Safe practices for better healthcare. (2010). National Quality Forum. https://www.qualityforum.org/News_And_Resources/Press_Kits/Safe_Practices_for_Better_Healthcare.aspx

Schick, L., & Windle, P. E. (Eds.). (2021). *Perianesthesia nursing core curriculum: Procedure, phase I and phase II PACU nursing* (4th Ed.). Saunders.