Wyoming County Community Hospital
PFI 001153
Nurse Staffing Plan
2022/2023
Wyoming County Community Hospital

2022/2023 Nurse Staffing Plan

1.0 POLICY

1.1 It is the policy of Wyoming County Community Health System to develop and maintain staffing plans for all inpatient units, emergency department, intensive care unit, and surgical services.

1.2 A copy of the staffing plan/policy will be provided to the collective bargaining unit and posted in each patient care unit.

1.2.1 Daily staffing for each shift will also be posted for each patient care unit.

1.3 The plan will be reviewed, at a minimum of semi-annually, against patient needs and known evidence-based staffing information, including the nursing sensitive quality indicators. The plan will be submitted to NYSDOH by July 1st of each year.

1.4 January 1st of each year, WCCHS will implement the plan adopted by July 1st of the prior calendar year.

1.5 Staffing shall be based on the needs of the patients.

2.0 PURPOSE

2.1 Healthcare professionals and support staff comprise vital components of the patient care team, bringing their particular skills and services to ensuring quality patient care.

2.2 Appropriate staffing of registered nurses available for patient care assists in reducing errors, complications and adverse patient care events, improves staff safety and satisfaction, and reduces incidences of workplace injuries.

2.3 To promote a safe and healthy work environment by ensuring an acceptable number and mix of nursing personnel to produce a desired level of care to meet the patient's needs.

3.0 SCOPE

3.1 It is well known that there are challenges in attracting and retaining nurses in rural hospitals.

3.1.1 It is also well known that there is often a nursing shortage and regional hospitals tend to compete for the same nurses.

3.2 Working in smaller healthcare facilities, rural nurses must be able to think critically and assist patients of all ages and with all types of complaints. For example, in large metropolitan hospitals, nurses are specialized in emergency medicine, pediatrics, cardiology, telemetry, and surgery. In rural hospitals such as WCCHS, nurses need to be skilled in many areas of nursing as WCCHS does not have separate care areas for each patient population. For this reason, rural nurses do have a great deal of autonomy.

3.3 There is a misconception that small rural hospitals are not fast paced and new nurses are often eager to go to larger facilities where they believe it to be busier.
4.0 SCHEDULING

4.1 A centralized scheduling approach for Maternity and Women’s Health (Obstetrics), Med/Surg, Intensive Care, and the Emergency Department is used for scheduling and monitoring staff call-ins, open unfilled shifts, and the reallocating of staff from one department to another.

4.1.1 Schedules are prepared collaboratively by the nursing scheduler and the manager of each unit.

4.1.2 As Surgical Services is somewhat unique with on call, staggering shifts, etc, scheduling is completed by the manager with input from the surgical team and maintained within the department. This is also the case with Mental Health.

4.2 When creating a schedule, the following approach is used:

4.2.1 Any employee with approved benefit time is noted in the schedule.

4.2.2 All regular full-time and part-time employees are put into the schedule rotating weekends and holidays as per job description/requirement unless otherwise worked out with the direct manager.

A. Surgical Services staff rotate on call to include weekends, holidays, and the overnight hours. At a minimum, a circulator, scrub, and PACU nurse is on call.

4.2.3 All agency employees are put into the schedule based upon the agreement with the agency individual upon acceptance of an assignment.

4.2.4 All per diem employees are offered shifts that are not filled with full- and part-time employees and are placed into the schedule where additional staffing is needed to meet or maintain appropriate staffing levels.

4.2.5 Any additional staffing needs to meet appropriate staffing levels are either posted in the form of a list on all patient care units and in the Nursing Services Office. This list provides employees with the opportunity to volunteer for any open shifts. The list is posted until positions are filled. Shifts are posted for all units with specific shift need noted OR staff members are contacted at the time of need for coverage for call-ins, increased census, etc.

4.2.6 All managers will work with their individual teams to accommodate set schedules or varying schedules based on personal home requests, school requests, etc.

4.3 It is the responsibility of the unit manager and/or nursing supervisor to ensure an adequate number of nursing personnel for each shift and assign staff as indicated based on activity, patient acuity, and individual nurse skill sets. The nursing scheduler can assist in staffing at the direction of the manager, nursing supervisor, and the Chief Nursing Officer.

4.4 All attempts will be made to meet the staffing ratios as outlined in the following pages. In the event the established nurse:patient and aide:patient ratio cannot be met, staffing will be as close as possible to the established ratio.

4.4.1 Collaborative discussions will occur with the nursing supervisor, managers, and Chief Nursing Officer in the event there is a need to “board” patients in the ED due to staffing issues and/or any safe staffing concerns.

4.4.2 Managers may be asked to assist in their respective departments either during the normal work week or off shifts and weekends if staffing, acuity, and volume are of concern.
5.0 PATIENT ASSIGNMENT

5.1 The manager, nursing supervisor or charge nurse/team leader is responsible for completion of patient assignments for all nursing units.

5.1.1 All patients are assigned to a responsible professional staff member.

6.0 MEALS / BREAKS / TIME OFF

6.1 Meals, breaks, and time off will be provided as per the CSEA agreement.

6.2 Coverage of a nurse for assigned patients will be provided or assigned either by the charge nurse, nursing supervisor, nurse manager, to another staff nurse to allow for meals and breaks.

6.2.1 Coverage for ancillary staff, ie, hospital aides, PCTs, medical receptionists, etc, will be as above in 6.2.

6.3 Planned time off (ie, vacation, holiday) is as per the CSEA agreement by submitting requests and/or discussions with the managers and schedulers.

7.0 DAILY STAFFING ADJUSTMENT

7.1 Nursing leadership will adjust staff on a continuous basis throughout the shift and adjustments are based upon individual unit census, acuity, and nurse skill mix.

7.2 It is the responsibility of the nursing supervisor or manager to assure that the appropriate staffing for the current oncoming shift occurs. This includes adjusting staff as necessary by calling staff in when needed, putting staff on-call as needed, and/or calling staff off.

7.2.1 Nurses who are scheduled, but are not needed due to low patient census, etc., will be contacted to offer “on-call”. “On-call” is voluntary. If the nurse takes on-call, he or she must be available to come in to work during the scheduled shift if a situation arises that necessitates the need for more staff. The nurse must be able to be at work within 30 minutes of being contacted to come in for Surgical Services and no longer than 60 minutes for Med/Surg, ICU, ED, and Maternity & Women’s Health.

A. Being on-call means the employee does not report to work unless contacted by the nursing services staff or nursing leadership to come to work. At no time should anyone other than nursing leadership or nursing services staff contact an employee to come to work.

B. Compensation for on-call is per CSEA contract.

7.2.2 If the census is such on any patient care unit that there are too many members, the nursing supervisor or manager will adjust staffing to an appropriate level per staffing guidelines outlined in this policy. Potential solutions to staffing overages include, but are not limited to:

A. Call employees off. This means they are not obligated to report to work for their scheduled shift. This is at the agreement of the staff member and nursing supervisor.

B. Any employees with scheduled overtime will be contacted first.

C. Per diems are called off next.

D. Any requests for “first call off” will then be called.
E. Agency/travelers are always an option to be called off, but the individual must be agreeable to taking the shift off with no pay. If the individual is not agreeable, they should report to work and the above other options will be used.

7.3 Floating to other nursing units to work will be used cautiously. A patient care assignment will only occur if the staff member being floated is qualified to work in that area. Otherwise, the individual floating will assist within their scope of practice. Nursing services will not call employees off on one unit and float from another unit to cover unless an emergency, call-in, etc.

7.4 Any scheduling needs as a result of call-ins are filled using the Seniority Call List located in the scheduling book in the Nursing Services Office. Nursing supervisors and managers along with the nursing scheduler are responsible for filling the schedule to meet the needs of the patient care unit.

7.5 Occasionally employees agree to flex their normal work schedule to meet the individual needs of the patient care unit. This is often done in the Surgical Services units, as well as all other areas. This is an agreement between the employees and the employer. Hours normally worked will not be altered to avoid the payment of overtime unless mutually agreed upon between the employer and employee.

8.0 ADDITIONAL STAFFING RESOURCES

8.1 Respiratory therapy provides coverage 24/7 to manage ventilators and BiPAPs, draw ABGs, and administer nebulizer treatments, as well as other respiratory related treatments and procedures.

8.2 Discharge planning/case management personnel assist in the care of patients from 7 a.m. to 5 p.m.

8.3 Occupational, Speech, and Physical Therapy are available for patient care as needed.

8.4 Pharmacy personnel are available in house from 7:00 a.m. to 6:30 p.m. Monday-Friday and 8 a.m. to 4 p.m. on weekends. An outsourced agency is contracted with to provide services and support during the hours that Pharmacy personnel are not in-house.

8.5 Lab techs are available in-house 24/7 for lab draws.

8.6 Mental Health personnel are available to assist with de-escalation, consults, etc.

8.7 A nursing supervisor OR manager is available Monday to Friday from 7 a.m. to 3 p.m. and a nursing supervisor is available 3 p.m. to 7 a.m. and 24 hours/day on the weekends to assist in high acuity areas.

8.8 Nurse managers are available in-house Monday to Friday 8 a.m. to 4 p.m. and available via phone for outside of working hours to assist with unique situations and/or staffing situations.

8.9 Hospitalist is on duty 24/7.

8.10 An individual from Administration is on call 24/7 to assist with unique situations and provide appropriate direction to the nursing supervisor.

8.11 Additional resources to secure safe staffing is offering of overtime and bonus/stipend to pick up additional time.
9.0 MANDATORY OVERTIME / UNFORESEEABLE EMERGENCY

9.1 NYS Labor Law Section 167, 12CRR-NY 177.1.

9.2 Definitions:

9.2.1 **Regularly scheduled work hours:** The predetermined number of hours a nurse has agreed to work and is normally scheduled to work pursuant to the budgeted hours allocated to the nurse’s position by the employer. This may include pre-scheduled on-call time and the time necessary to communicate shift report regarding patient status necessary to ensure patient safety.

For part-time nurses, regularly scheduled work hours mean those hours a part-time nurse is regularly scheduled to work pursuant to the budgeted hours.

For per diem nurses or employment agency nurses, the employment contract and the hours provided therein shall serve as the basis for determining the nurse’s regularly scheduled work hours.

9.2.2 **Overtime:** Shall mean work hours over 40 hours in 1 week and above the nurse’s regularly scheduled work hours (ie, over 8 hours for 8 hour/day employees).

9.2.3 **Nurse** – Shall mean a registered professional nurse (RN) or licensed practical nurse (LPN) as defined by Article 139 of the Education Law who provides direct patient care.

9.3 Wyoming County Community Health System will NOT require a nurse to work more than the nurse’s regularly scheduled work hours, except as per the restrictions to mandatory overtime law and scheduling of on-call in addition to regular work hours outlined below.

9.3.1 Health care disaster, such as a natural or other type of disaster that increases the need for health care personnel, unexpectedly affecting the county in which the nurse is employed or in a contiguous county.

9.3.2 Federal, state or county declaration of emergency in effect in the county in which the nurse is employed or in a contiguous county.

9.3.3 Where a health care employer determined there is an emergency, necessary to provide safe patient care, in which case the health care provider shall, before requiring an on-duty employee to remain, make a good faith effort to have overtime covered on a voluntary basis, including, but not limited to, calling per diems, agency nurses, assigning floats or requesting an additional day of work from off-duty employees, to extent such staffing option exist.

A. Emergency, including an unanticipated staffing emergency, is defined as an unforeseen event that could not be prudently planned for by an employer and does not regularly occur (ie, 50% or more of RNs calling in is unforeseen and considered an emergency).

B. An unforeseen event could be multiple serious injuries (fires, auto accidents, building collapse), chemical spills or releases, a widespread outbreak of an illness requiring hospitalization for many individuals in the community served by the health care employer, or the occurrence of a riot, disturbance, or other serious event within an institution that increase the level of nursing care needed.
C. Patient care emergency shall mean a situation that is unforeseen and could not be prudently planned for, and, as determined by the health care employer, requires the continued presence of the nurse to provide safe patient care. (Vacations are NOT unforeseen).

D. An ongoing medical or surgical procedure in which the nurse is actively engaged and whose continued presence through the completion of the procedure is needed to ensure the health and safety of the patient.

9.3.4 Nurses may be scheduled to work on-call hours in addition to their regularly scheduled work hours to meet staffing minimums for a given unit. This may result in additional work hours over the staff’s FTE. On-call requirements are at the discretion of the unit manager.

9.4 A patient care emergency cannot be established in a particular circumstance if that circumstance is the result of routine nurse staffing needs due to typical staffing patterns, levels of absenteeism, and time off typically approved by the employer for vacation, holidays, sick leave, and personal leave, unless a Nurse Coverage Plan is in place, has been fully implemented, and failed to produce staffing to meet the particular patient care emergency.

9.5 A patient care emergency will not qualify as an exception to the prohibition against mandatory overtime if it was caused by the health care employer’s failure to develop or properly and fully implement a Nurse Coverage Plan.

9.6 PROCEDURE

9.6.1 Before requiring an on-duty nurse to work beyond his or her regularly scheduled work hours to address a patient care emergency, WCCHS nursing leadership shall make a good faith effort to have overtime covered on a voluntary basis or to otherwise secure nurse coverage by utilizing all methods set forth in this plan. The nursing supervisor shall document attempts to secure nurse coverage through the use of phone logs or other records.

9.6.2 Alternative staffing methods shall include:

A. Voluntary overtime which is posted.

B. Per diem staff.

C. Requesting an additional day of work from off-duty employees.

D. Arrangements for assignment for nurse floats.

E. Contracts with agencies.

9.6.3 Only after WCCHS has taken all the above efforts, will mandatory overtime be imposed in order to maintain quality patient care.

9.6.4 If the staffing deficit cannot be filled, WCCHS will notify the appropriate person at least two (2) hours prior to the end of his/her shift that involuntary overtime may be required, or if the call came less than two (2) hours prior to the end of the shift, as soon as possible.

9.6.5 Staff are prohibited from working greater than sixteen (16) continuous hours or greater than sixty (60) hours per week at the bedside. An employee who has worked sixteen (16) hours will not be required to return to work in less than eight (8) hours.
9.6.6 WCCHS will maintain a written record of its efforts to fill the staffing deficits. RN staff have the right to request to look at call list containing the information on call made in an effort to fill the deficit.

9.6.7 Involuntary overtime for employees will be rotated equitably by turn.

9.6.8 This policy does not prohibit a nurse from voluntarily working overtime.

9.7 CLINICAL STAFFING COMMITTEE

9.7.1 The Committee shall be responsible to develop and oversee the implementation of an annual clinical staffing plan and submit annually to the NYSDOH.

A. The plan will be adopted by consensus of the committee as outlined in Section 2805-t of the public health law.

9.7.2 The Committee shall consist of appropriate members as outlined in the public health law.

9.7.3 Employees participating in the staffing committee shall be on scheduled work time and compensated at the appropriate rate of pay. The members shall be fully relieved of all other work duties during meetings of the committee and shall not have work duties added or displaced to other times as a result of their committee responsibilities.

9.7.4 The Committee will review, assess, and respond to complaints regarding potential violations of the approved plan, staffing variations, or other concerns regarding the implementation of the plan.

A. At no time shall there be any retaliation or intimidation of an employee for notifying the committee or hospital administration of staffing concerns.

9.8 CENSUS/ACUITY

9.8.1 WCCHS utilizes professional judgement and benchmarking approaches in determining the nurse-to-patient ratio methodology. All staffing ratios/numbers listed in the following grids are recommended staffing. They are at the discretion of the nurse supervisor, manager, and the chief nursing officer based on patient needs/acuity and volume.

9.8.2 Modifications to the staffing grids will be based on the following, but not limited to:

A. Patient acuity and needs.
B. Patient volume.
C. Pending admissions, discharges, and transfers.
D. Level of experience of nursing personnel providing care.
E. The need for specialized or intensive equipment and/or medications.
F. Special characteristics of the patient population.
G. Availability of other personnel supporting nursing services on the unit.
H. Patient need for 1:1 observation.
I. Frontline nursing staff concerns.
J. Finances and available resources.
K. Short-term adjustments made by the Chief Nursing Officer due to unexpected changes in circumstances that are to be limited in duration.

9.9 SPECIAL NURSE QUALIFICATIONS

9.9.1 Abbreviations:

A. NRP: Neonatal Resuscitation Program
B. ACLS: Advanced Cardiac Life Support
C. BLS: Basic Life Support
D. PALS: Pediatric Life Support
E. PMCS: Preventing and Managing Crisis Situations

9.9.2 Obstetrics – NRP, ACLS, BLS
9.9.3 Medical/Surgical – BLS, ACLS highly recommended
9.9.4 Intensive Care – ACLS, BLS, PALS and PMCS highly recommended
9.9.5 Emergency Department – ACLS, BLS, PALS, PMCS
9.9.6 Mental Health – BLS, PMCS
9.9.7 Surgical Services – BLS, ACLS, PALS

10.0 DISCLOSURE OF NURSING QUALITY INDICATORS

10.1 Wyoming County Community Health System shall make available to the public, to any state agency responsible for licensing or accrediting the facility, and/or to any employee, or employee’s collective bargaining agent information regarding nurse staffing and patient outcomes.

10.2 Quality indicators monitored, but not limited to, include health-care associated infections, pressure ulcers, medications errors, and falls with moderate or greater injury.

10.3 The following will be made available:

10.3.1 Number of RNs and unlicensed personnel providing direct care.

10.3.2 Ratio of patients per RN:

A. Expressed in actual numbers and total care per patient including the adjustment for case mix and acuity.

B. Expressed as a percentage of patient care staff broken down in terms of the total patient care staff for each unit and for each shift.
Maternity and Women's Health / Obstetrics (5 inpatient beds, 3 labor rooms, 6 bassinets, 1 C-section suite)

0700 to 1900  2 RNs  1900 to 0700  2 RNs

WCCHS utilizes Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) staffing guidelines when determining staff needs on a shift-by-shift basis. WCCHS supports AWHONN concept in that hospitalization for labor, birth, and postpartum is the most concentrated activity-intense part of the childbirth continuum, with significant implications for immediate and future health. Childbirth and newborn care in the hospital setting deserve careful attention to appropriate nurse staffing based on individual patient characteristics and clinical situations to promote safe, high-quality nursing care and optimal patient outcomes.

All aspects of patient care are on the 4th floor to include intrapartum, antepartum, postpartum, and newborn care. The operating suite for C-sections is also on the 4th floor.

Intrapartum: 1:1 is utilized for the following:

- Patient in labor with minimal or no pharmacologic pain relief
- Utilization of intermittent auscultation during active phase of first stage of labor
- Patient in second stage of labor
- Patients with medical or obstetrical complications
- Oxytocin induction or augmentation of labor
- Patients receiving epidural anesthesia

Antepartum/Postpartum:

- Patients who are stable 1:3 ratio is utilized
- Patients who are unstable are 1:1 and reviewed for the potential of being transferred to higher level of care
- During the immediate post-partum period, the nursing ratio should include one nurse for the mother and a second nurse for the baby. Once the critical elements of care are reached, the mother’s nurse may accept care of the newborn.
  - Critical elements of the mother include: initial assessment, repair of the perineum if needed, and the mother is hemodynamically stable.
  - Critical elements of the newborn include: initial assessment and care to include medication, several sets of vital signs, identification bracelets are applied, newborn is stable, and report has been given to the mother’s nurse.
  - The second RN should assist the first RN in transferring the mother from the labor bed to the postpartum bed.

Newborns and Couplelet Care:

- Recently born newborns and those requiring close observation 1:4 ratio
- Unstable newborns and newborns being transferred 1:1
  - WCCHS is a Level 1 Nursery
- Normal mother-newborn couplet care is 1:3 couplets

Outpatient Care:

- RNs prescreen mothers for scheduled C-sections
- RNs assess and care for labor checks and stress tests

There is one Team Leader for the unit who reports directly to the Chief Nursing Officer. Additional resources are included previously in the plan.
**Medical/Surgical Unit** (37 inpatient, observation, and swing beds)

<table>
<thead>
<tr>
<th>0700 to 1900</th>
<th>1900 to 0700</th>
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<tbody>
<tr>
<td>1 Charge RN</td>
<td>1 Charge RN whenever possible</td>
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<tr>
<td>1 RN: 6 patients</td>
<td>1 RN: 7 patients</td>
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</tbody>
</table>

> 20 Patients

<table>
<thead>
<tr>
<th>0700 to 1900</th>
<th>1900 to 0700</th>
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<tbody>
<tr>
<td>3 Hospital Aides</td>
<td>2 Hospital Aides</td>
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<tr>
<td>1 Medical Receptionist</td>
<td>1 Medical Receptionist</td>
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< 20 Patients

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<th>0700 to 1900</th>
<th>1900 to 0700</th>
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<tbody>
<tr>
<td>2 Hospital Aides</td>
<td>2 Hospital Aides</td>
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<tr>
<td>1 Medical Receptionist</td>
<td>1 Medical Receptionist</td>
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WCCHS has one M/S unit located on the 3rd floor. Patient population consists of inpatients, observations, and swing bed patients. Common diagnosis are COPD, pneumonia, COVID, CHF, sepsis, postop patients to include total joint replacements, colon resections, hip fracture repairs, GYN, and occasional cholecystectomies.

Industry standard nurse to patient ratio varies from 1:4 to 1:5. WCCHS takes into account that there are not separate units for observation and swing bed patients which are generally lower in acuity.

At times, the Charge RN may be asked to take a small patient assignment. There is one Director for both M/S and ICU who reports directly to the Chief Nursing Officer. Additional resources are included previously in the plan.

**Also reference 9.8.1**
**Intensive Care Unit** (5 inpatient ICU beds, 4 correctional services beds)

<table>
<thead>
<tr>
<th>Time</th>
<th>Staffing Details</th>
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</table>
| 0700 to 1900 | 1 RN: 2 ICU patients  
1 RN: 5 M/S/CSU patients |
| 1900 to 0700 | 1 RN: 2 ICU patients  
1 RN: 5 M/S/CSU patients |

WCCHS stands by the American Association of Critical-Care Nurses (AACC) principles:
- Nurses are essential to the successful delivery of healthcare.
- Appropriate nurse staffing is crucial for optimal patient care.
- Appropriate staffing is inextricably linked to healthy work environments.
- Higher nurse job satisfaction, which leads to lower staff turnover, is closely tied to appropriate staffing.
- The creation of appropriate staffing plans requires a nimble, comprehensive approach.

Patients placed in the ICU either meet criteria as an ICU patient or are a Med/Surg patient requiring closer observation.

WCCHS contracts with Department of Corrections and had a 4-bed inpatient locked unit, Correctional Services Unit (CSU). This unit is located directly outside of the ICU. ICU staff care for these patients who are designated as Med/Surg patients.

ICU patients are defined as, but not limited to:
- Ventilators
- Critical drips to include insulin
- Respiratory failure, DKA, postop patients, sepsis
- Drug overdoses

Med/Surg patients in the ICU may be, but not limited to:
- Behavioral health with suicidal ideation and a medical condition
- Any medical diagnosis in which the provider is concerned of deterioration

There is one Director for both M/S and ICU who reports directly to the Chief Nursing Officer. Additional resources are included previously in the plan. Hospital aides or additional nurse support is provided whenever possible during times of high census and acuity of patients.

- When the ICU does not have any patients, the nursing staff will be floated to assist in other patient care areas.
**Emergency Department** (12 beds with additional areas available, can accommodate up to 18 pts.)

<table>
<thead>
<tr>
<th>Time</th>
<th>0700-1000</th>
<th>1000-2200</th>
<th>2200-0700</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Triage</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>RN</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>ED Clerk</td>
<td>1</td>
<td>1 RN or 1 LPN</td>
<td>1 ED Clerk</td>
</tr>
<tr>
<td>PCT</td>
<td>1</td>
<td>1 ED Clerk</td>
<td>1 PCT</td>
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</tbody>
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The Emergency Department shall consist of professional nursing staff to provide safe patient care and nonprofessional staff to support/assist nurses in caring for emergency patients. The staffing plan is determined through registration times and patient acuity studies along with recommendations from the Emergency Nurses Association (ENA). ED staff schedules stagger to provide the most coverage during established peak census and acuity levels. There must be one RN assigned to triage at all times.

During periods of high census and/or boarding of patients, the Director will collaborate with the supervisor to determine staff resources available from other departments to be deployed to the ED, or to assist in patient throughput. ED will first use and/or assess its ability to staff with ED employees. Every effort will be made to obtain additional resources for patients requiring behavioral observation every 15-minute checks or 1:1 monitoring.

Trauma patients are cared for with a 1:1 ratio
Critical patients are cared for a 1:2 or 1:1 ratio
Non trauma and non-critical patients are 1:6 ratio

ED has an Emergency Physician on 24/7 along with midlevel provider on from 1000-2200 daily. If census is low, the ED physician may release the midlevel provider.

There is one Nurse Director who reports directly to the Chief Nursing Officer. Additional resources are as noted previously in the plan.
**Mental Health** (12 inpatient beds)

<table>
<thead>
<tr>
<th>Time</th>
<th>Staffing</th>
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<tbody>
<tr>
<td>800-2000</td>
<td>2000-0800</td>
</tr>
<tr>
<td>1 RN</td>
<td>1-2 RNs and/or</td>
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<tr>
<td>2 MHTA</td>
<td>1-2 MHTA</td>
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</tbody>
</table>

1 Social Worker (8am-4pm) and/or 1 Crisis Worker (8am-4pm)
1 PAO (4pm-12am)
1 Unit Assistant M-F 7am-3pm

The inpatient Mental Health unit is a locked unit located on the first floor. The Social Worker and PAO assist with consults in other areas such as the Med/Surg, ICU, and in the ED.

Mental Health staff provide forensic mental health services in the Wyoming County jail.

Psychiatric coverage is provided by a psychiatrist and/or psychiatric NP 24/7.

Mental Health has a Director who reports to the CEO. Additional resources are as noted previously in the plan.
Surgical Services

Surgical services staffing is based on AORN guidelines. At a minimum per area/OR:

1 RN Circulator / case
1 RN/LPN/Tech Scrub / case
1 RNFA Based on procedure
2 RN 1 direct caregiver/1 within hearing range for assistance in post anesthesia recovery unit (PACU), as necessary
1 RN and another staff member up to 2 patients in the ambulatory care unit based on procedure

Ancillary staff include:

1 Director of Surgical Services
1 Surgical Services Scheduler
1 Product/Materials Specialist
1 Central Sterile Tech
1 Central Sterile Aide

Surgical Services Staffing is based on the AORN Position Statement on Perioperative Safe Staffing, On-Call Practices and New York Codes, Rules and Regulations Title: Section 405.12 – Surgical Services, and ASPANs “Patient Classification/recommended staffing guidelines”

- Clinical staffing procedures are based on:
  - Unique needs of the patient (e.g. acuity, monitoring needs, etc.)
  - Procedural complexity and technological demands
  - Professional competency (minimum qualification to function in specified role)
  - Professional proficiency (advanced knowledge/skill in particular areas of clinical practice)
  - Skill mix of personnel
  - Professional practice standards
  - Health care regulations, accreditation requirements, and state staffing laws

- Minimum staffing per AORN, ASPAN, and NYS include the following:
  - Preoperative
    - Minimum of 1 RN with additional RNs based on number of patients, type of procedures, and acuity of patients
  - Intraoperative
    - Minimum 1 RN per patient per OR in the role of RN circulator
    - Minimum 1 scrub person per patient per OR: Certified Scrub Tech, LPN, or RN.
    - Additional staff, with appropriate competencies may include:
      - Moderate sedation – 1 RN to monitor patient/ 1 dedicated RN circulator
      - Local anesthesia – 1 RN to monitor patient/ 1 dedicated circulator
      - Complex surgical procedures/high patient acuity/technical demands (lasers) – may require additional RN circulator (s) and scrub person (s)
  - Postoperative - Reflects ASPAN’s “Patient Classification/recommended staffing guidelines”
    - Phase I – maintained during on-call situations
      - Two registered nurses competent in Phase I care
        - 1 at the bedside providing direct patient care
        - 1 should be immediately available to assist – able to directly hear a call for assistance
        - Additional staff members, as necessary
    - Phase 2
      - Two competent personnel
        - 1 RN competent in Phase II post anesthesia nursing
        - Both in same room/unit where patient is receiving care
- Extended Observation
  - Two competent personnel
    - 1 RN with competence appropriate to patient population
    - Both in same room/unit where patient is receiving care
- Discharge from Service
  - 1 RN assesses readiness of patient providing comprehensive handoff to receiving health care professional and organizes safe transfer
- Postoperative Follow-Up
  - 1 RN completes discharge follow-up