LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

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Nursing Staffing Guidelines during Contingency and Crisis Conditions	12/30/20	560
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Departments Consulted:	Reviewed & Approved by:	Approved by:
Nursing Department	Professional Practice Committee Nurse Executive Committee Attending Staff Association Executive Committee	(signature on file) Annie Marquez Chief Nursing Officer

PURPOSE

Guidelines for the staffing of nursing units during contingency and crisis conditions. During times of public health emergencies and crisis, the standards for staffing may need to change. While the primary goal in any disaster is to maintain usual staffing standards of care as much and for as long as possible, crisis standards of care may need to be implemented on a regional or statewide basis, mandated by resource scarcity. Prior to the implementation of crisis measures, many intermediate changes in practice patterns are appropriate in order to conserve resources and minimize risk to staff without diverging from usual staffing standards.

LAC+USC Medical Center is utilizing the units that have negative pressure and private rooms to care for patients that have COVID or Persons Under Investigation (PUI) and cohorting patients when results come back where possible. Normal staffing patterns will be maintained based on patient acuity and the California set staffing ratios until such time that the demand exceeds the supply.

All non-essential staff including clerical will report to and be assigned by Labor Pool.

Definition:

Pandemic: The Centers for Disease Control (CDC) defines a pandemic as an epidemic that has spread over several countries or continents, usually affecting a large number of people.

Contingency Planning and Implementation: The process by which systems through planning aims to protect a basic standard of care for as long as possible. Contingent changes in practice patterns and resource allocation must be undertaken prior to invoking crisis standards of care.

Crisis Standards of Care: Is invoked at a regional or state-wide level and are defined as a substantial change in usual health care operations. These changes are made necessary by a pervasive (e.g. pandemic respiratory infection) or catastrophic disaster. It is recognized that this level of care may fall below the usual standard of care in the community.

Critical Care Nurse: A registered nurse (RN) who has completed an orientation and demonstrated competencies in critical care nursing

Acute Care Nurse: A RN who has completed an orientation and demonstrated competencies in acute care (med-surg/telemetry) nursing.

Non-Acute Care Nurse: A RN who has completed an orientation and demonstrated competencies in nursing. This may include the RN from clinical or procedural areas.

POLICY

The staffing of nursing units may change during times of crisis. Over the course of the crisis elective surgeries will be canceled and normal referral patient populations will be severely limited. Staff members who normally care for these types of patients will be available to care for other patient populations. Given that the surge of cases presenting during a pandemic will likely mirror the reduction in available staff, changes will need to be made to existing staffing ratios and models of care delivery. Effective management of critically ill patients infected with the Covid-19 virus is dependent upon the efficient provisions of evidence-based care models. Ensuring the safety and resilience of nursing staff during pandemic-related surge capacity is an essential component of disaster preparedness.

The Society of Critical Care Medicine (SCCM) endorses using a team based models of care of utilizing, non-critical care trained physicians, certified registered nurse anesthetists, operating room nurses, general ward nurses, non-critical care advance practice providers and others to greatly augment the trained and experienced critical care staff. The SCCM offers free online training resources to help these non-typical critical care staff as they prepare to care for critically ill patients during the crisis. While the level of care may not be the same as in the typical critical care in non-crisis times, having the care directed by trained and experienced members of the critical care team is an effective way to maximize care for large numbers of critically ill patients.

The American Association of Critical Care Nurses also supports team-based strategies to expand the staffing pool to manage the surge of critical patients during the COVID-19 pandemic. The AACN suggests pulling those closest fit to an ICU RN who have had previous ICU experience and who may have some of the ICU skills. It also recognizes the medical surgical RN who has the basic foundational nursing to help support the staff in the ICU.

LAC+USC care team models are based upon the Tiered Staffing Strategy for Pandemic. The model doesn't include additional support staff who may or may not be available in all areas. The model also assumes a partnership with the multidisciplinary care team including ICU Physicians, Hospitalists and Respiratory Care Practitioners

PROCEDURE- ICU

Contingency Standard of Staffing:

- Capacity: ICU at or near capacity

- Trigger: All possible means of recruiting staff (i.e. ICU RNs still less than 80% based on acuity and census)
- Staffing Ratio: In normal staffing ratio, 1-2 patients per RN
- Maximize all beds, compress specialty units together

As per usual, attempts to get the ICU RN's who are relief and can pick up additional shifts and agency ICU trained RN's will be used in critical care first.

Surge Standard of Staffing

The staffing patterns will continue per mandated ratios. At this point in time there will be a team nursing approach where an ICU will be partnered with a med/surg RN). Recruiting staff from adequately staffed units must be considered. Med/surg RN's may be recruited to care for ICU patients as conditions worsen. Orientees to areas work within their current capabilities. Consideration for patient care assignments should be lower acuity patients. Med/surg RN's will consult with ICU RN's.

- Capacity: ICU capacity/care needs exceeded, but not at crisis mode
- Trigger: All possible means of recruiting staff (i.e. ICU RNs still less than 80% based on acuity and census)
- Staffing Ratio: In ratio with use of non-ICU RN's (Team nursing)
- Add additional inpatient beds where possible

Example: Maintain current ICU nurse to patient care model (1 RN to 2 patients at a minimum). A med/surg RN will take ICU patient assignment as described above (essentially, pulling a med/surg RN into the ICU to care for lower acuity ICU patients)

RN's who would not normally be assigned to these levels of care would be med/surg RN's who are competent in these areas to be assigned a team of patients. The med/surg RN's who would be assisting the ICU RNs would be given additional "just in time" training to the areas and would be able to do patient care with assistance.

Crisis Standard of Staffing

- Capacity: ICU exceeds normal capacity/critical care needs, ventilated/critical care patients in non-ICU settings (e.g. PACU, OR, etc.)
- Trigger: < 80% staff needs met and non-ICU areas are being utilized.
- Staffing ratio: Out of ratio, Use of Team-Nursing

It is assumed in this model that all ICU RN's have been mobilized and the demand exceeds the resources. To meet the patient care needs, multiple RN's from med/surg units will be partnered to care for a team of patients and in this model, a team based on guidelines from the SCCM and the Task Force for Mass Critical Care.

Med/Surg RN's may be assigned to the ICU to care for lower ICU acuity care patients. The med/surg RN's may care for patients on stable vasoactive medications drips and stable ventilator patients. Med/Surg RN's will work in collaboration with and supervision of the ICU RN.

The SCCM tiered Pandemic strategy has been adapted

Critical Care Nursing Team Roles (see 560-A Addendum)

Shift Activities

- Every 12 hours (Every 8, if shorter shifts used)
- Unit huddle for oncoming shift with provider/nurse updating on any new information (i.e. disease course, new CDC info, new cases in the facility, etc.)
- Address any staff concerns, staff health and well-being
- Address any changes to patient care activities as workflow adjusts to meet surge needs

Care Team huddle (shift start)

- Team members briefly review individual skill sets/roles and tasks assigned for shift (as in ACLS but pertinent skills such as ICU-level medications, general med administration, ETT suctioning, intubation, IV starts, vital signs monitoring, etc.)
- Team Rounding after shift change report received
- Red flags for each patient (e.g. vital signs/labs) reviewed and placed on the in-room white board (in place of a white-board, a piece of paper with the red flags could be hung in the patient room)

Every 4 hours

- Care team huddle (5 min or less) to discuss any concerns or significant changes in patient status/management

Every 2 hours

- Ensure hydration/restroom breaks for all team members
- Any health concerns addressed
- Fatigue from time in PPE
- Skin breakdown/rash from time in mask/PPE
- Any additional concerns
- Assessing Supplies/ Equipment

PROCEDURE- PCU

The staffing patterns will continue from mandated ratios to Team-Nursing as indicated. Med-surg RN's, and clinic LVNs and support staff may be recruited to care for PCU patients. Orientees to areas work within their current capabilities. Recruiting staff from adequately staffed units must also be considered. Consideration for patient care assignments should be lower acuity patients.

Med/surg RN's, and clinic LVN's and support staff will consult with PCU RN's. At this point in time there will be a team-nursing approach where a med/surg RN will be partnered with a PCU RN.

Contingency Standard of Staffing:

- Capacity: PCU beds at or near capacity
- Staffing Ratio: In normal staffing ratio, 2-3 patients per RN
- Maximize all beds, compress specialty units together

Surge Standard of Staffing

- Capacity: Med/surg beds capacity exceeded, but not at crisis mode
- Staffing Ratio: Goal is to maintain normal staffing ratio with use of med/surg RNs
- Add additional inpatient beds in D+T building, Inpatient building

Crisis Standard of Staffing

- Capacity: PCU exceeds normal capacity
- Staffing ratio: Out of ratio, use of Team-Nursing

It is assumed in this model that all PCU nurses have been mobilized and the demand exceeds the resources. To meet the patient care needs, nurses from med/surg units will be partnered to care for a team of patients and in this model, we have identified a team based on guidelines from the SCCM and the Task Force for Mass Critical Care and modified for PCU areas. A med/surg nurse will work in collaboration with and under supervision of a PCU RN. Clinical LVN's and support staff may be utilized to support unit.

PCU Nursing Team Roles (see 560-B Addendum)

<u>Shift Activities</u>

- Every 12 hours (Every 8, if shorter shifts used)
- Unit huddle for oncoming shift with provider/nurse updating on any new information (i.e. disease course, new CDC info, new cases in the facility, etc.)
- Address any staff concerns, staff health and well-being
- Address any changes to patient care activities as workflow adjusts to meet surge needs

<u>Care Team huddle (shift start)</u>

- Team members briefly review individual skill sets/roles and tasks assigned for shift (pertinent skills such as high flow nasal canula, intubation, general med administration, suctioning, IV starts, vital signs monitoring, etc.)
- Team Rounding after shift change report received

- Red flags for each patient (e.g. vital signs/labs) reviewed and placed on the in-room white board (in place of a white-board, a piece of paper with the red flags could be hung in the patient room)

Every 4 hours

- Care team huddle (5 min or less) to discuss any concerns or significant changes in patient status/management

Every 2 hours

- Ensure hydration/restroom breaks for all team members
- Any health concerns addressed
- Fatigue from time in PPE
- Skin breakdown/rash from time in mask/PPE
- Any additional concerns
- Assessing Supplies/ Equipment

PROCEDURE- Med/Surg/Telemetry

The staffing patterns will continue per mandated staffing ratios. Clinic and procedure nurses may be recruited to care for med/surg or telemetry patients. Orientees to areas work within their current capabilities. Recruiting staff from adequately staffed units must also be considered. Consideration for patient care assignments should be lower acuity patients. Clinic and procedure RN's will consult with med/surg/telemetry RN's. At this point in time there will be a team-nursing approach where a med/surg/telemetry RN will be partnered with a clinic or procedure RN

Contingency Standard of Staffing:

- Capacity: Med/surg/telemetry beds at or near capacity
- Staffing Ratio: In normal staffing ratio, 4-5 patients per RN
- Maximize all beds, compress specialty units together

Surge Standard of Staffing

- Capacity: Med/surg/telemetry beds capacity exceeded, but not at crisis mode
- Staffing Ratio: Goal is to maintain ratio with use of clinical and procedural RNs, may use Team- Nursing
- Add additional inpatient beds in D+T building

Crisis Standard of Staffing

- Capacity: Med/Surg/telemetry exceeds normal capacity
- Staffing ratio: Out of ratio, use of Team-Nursing

It is assumed in this model that all med/surg/telemetry nurses have been mobilized and the demand exceeds the resources. To meet the patient care needs, nurses from procedural and clinical areas will be partnered to care for a team of patients and in this model, we have identified a team based on guidelines from the SCCM and the Task Force for Mass Critical Care and modified for med/surg areas. A procedural or clinic RN will work in collaboration with and under supervision of a med/surg/telemetry RN.

The SCCM tiered Pandemic strategy has been adapted

Acute Care Nursing Team Roles (see 560-C Addendum)

Shift Activities

- Every 12 hours (Every 8, if shorter shifts used)
- Unit huddle for oncoming shift with provider/nurse updating on any new information (i.e. disease course, new CDC info, new cases in the facility, etc.)
- Address any staff concerns, staff health and well-being
- Address any changes to patient care activities as workflow adjusts to meet surge needs

Care Team huddle (shift start)

- Team members briefly review individual skill sets/roles and tasks assigned for shift (pertinent skills such as general med administration, suctioning, IV starts, vital signs monitoring, etc.)
- Team Rounding after shift change report received
- Red flags for each patient (e.g. vital signs/labs) reviewed and placed on the in-room white board (in place of a white-board, a piece of paper with the red flags could be hung in the patient room)

Every 4 hours

- Care team huddle (5 min or less) to discuss any concerns or significant changes in patient status/management

Every 2 hours

- Ensure hydration/restroom breaks for all team members
- Any health concerns addressed
- Fatigue from time in PPE
- Skin breakdown/rash from time in mask/PPE
- Any additional concerns
- Assessing Supplies/ Equipment

Surge Documentation Guidelines

See 560-D Addendum “Surge Documentation (Program Flex) Guidelines”

REVISION DATES