Demonstrate mechanisms by which direct care nurses are educated about matching staff assignments to patient needs and staff member skill sets and experience.

As described in the MGH Department of Nursing Direct Care Staffing Guidelines (attachment 4.15.a), patient care assignments are made at the unit level by the Nursing Director or Staff Nurse delegate. A multitude of factors are considered when creating the assignment and include patient needs, patient acuteness, nursing care requirements, continuity of care and “knowing the patient,” current census, projected discharges and admissions, staff requirements, and staff skill and experience levels. This requires the input of the Staff Nurses and Resource Nurses who have knowledge of both the needs of the patient and the skills of the staff. The needs of the patient may be determined through the experience of the previous shift’s nurses in providing care to that particular patient, or through the knowledge and experience of the staff in estimating the needs of a specific patient population.

Using the Direct Care Staffing Guidelines as a foundation, all RN staff receive information regarding staffing and daily assignments during nursing orientation. On the patient care units, nurses learn about the intricacies of creating an assignment through experiential learning while being precepted in the Resource Nurse role. For example, on White 9, a General Medical Unit, the staff have developed “Resource Nurse Guidelines” (attachment 4.15.b) which describes the roles and responsibilities of the resource nurse with regard to making a daily assignment.

“The role and responsibility of the Resource Nurse is to…coordinate collaborative staff nurse decisions to address staffing and nursing assignments.”

The document describes key points to consider when making out the daily assignment including:

- Patient acuity level.
- Experiential level of the staff and appropriateness of assignments. (Include this as a point of discussion during resource nurse report.)
- Staffing levels
- Primary nurse assignments
- Location/geographical assignments
- Previous assignments
- Anticipated discharges and not assigning multiple discharges to one RN
- Patients scheduled for multiple diagnostic tests.
- Student nurse assignments
- Patients on precautions
- Patients who are restrained
- Patients at risk for falls
- Admissions
- Information from Resource Nurse report sheet.
In addition, the staff work with preceptors and Clinical Nurse Specialists to craft an assignment that meets patient care needs as well as the educational needs of staff. A Neonatal Intensive Care Unit (NICU) Staff Nurse describes the process used by the Resource Nurse and the Staff Nurses to determine the assignment of a patient requiring extracorporeal membrane oxygenation:

“It was late morning on a particularly busy day in the NICU. I had a two-patient assignment as did most of my co-workers. The Resource Nurse had received several “heads-up” phone calls from another hospital about a baby who might need to come to MGH for ECMO treatment (extracorporeal membrane oxygenation). When it was definite that the transfer was going to happen, we adjusted patient assignments to be able to accommodate a “one-to-one” admission.”

While each patient care unit develops its own mechanisms for educating staff on the standards that guide creating a daily assignment, the standards remain consistent throughout the organization. This flexibility allows each patient care unit to tailor the process to meet the unique needs of their patient population and nursing staff.
TITLE: DIRECT CARE STAFFING GUIDELINES

Identification of required direct care staffing occurs at three levels: long-term projections for the fiscal year, near-term scheduling for successive four-week cycles and daily staffing for shift-to-shift requirements. Staffing levels are based on volume and acuity of patients (nursing workload) and factored for distribution of workload over various time periods, experience and mix of staff, and logistical and support issues.

Staffing budget

Staffing projections and total budgeted full-time equivalent (FTE) requirements are developed in conjunction with the overall organizational budgeting process. Workload is based on anticipated volume (admissions, length of stay and procedure volume as projected by physicians chiefs and senior management) and, for the relevant inpatient units, current acuity (as measured through the QuadraMed patient classification system). Staffing budgets are developed at the unit level using average daily workload and staffing to project annual FTE requirements. Key target ratios such as hours per unit of work, staff mix and nonproductive factors are identified using current and historical data and are negotiated within the leadership staff – nurse managers, associate chief nurses and the chief nurse. Operational support staff within Patient Care Services provide support in the analysis and interpretation of data and in the development of the detailed budget.

Periodic Scheduling

Throughout the year, schedules are developed and produced in four-week cycles using the on-line OneStaff scheduling system. Among the patient care units, there is a variety of scheduling models tailored to the needs of the individual unit’s patients and staff. Within the parameters of relevant regulatory requirements and organizational personnel policies, individual units set their own criteria for scheduling – shift designations and lengths, schedule and shift rotation patterns and priorities for paid and unpaid time off. Staff participate in the scheduling process, identifying their preferences and requests and, on many units, preparing the schedule according to established guidelines and under the overall direction of the Nurse Manager. The core schedule is based on overall budget projections adjusted for predictable variations in workload, for example, weekday to weekend differences or seasonal fluctuations, as identified through analysis of trended unit-specific data. The exempt status of the professional staff provides a level of flexibility that allows for maximum consideration of staff needs and preferences in providing for appropriate resources to meet patients’ needs for nursing care. Scheduling for nonexempt staff, while more restricted in terms of flexibility, also considers staff needs and preferences in determining appropriate schedules to meet patient and unit need.
Attachment 4.15.a continued

Daily Staffing

Day-to-day and shift-to-shift staffing decisions are made by the Nurse Manager or staff nurse delegate. Staffing decisions and patient care assignments are based on patient needs – current volume, turnover and projected admissions, patient acuity and nursing care requirements – and staff requirements – skill and experience levels, work schedules and availability, minimum staffing requirements and reasonableness. In the event that additional staff are needed for a particular shift, there are multiple options available to the manager or, in the absences of the manager, to the staff nurse delegate.

♦ negotiating changes in scheduled time among the unit staff
♦ utilizing staff from the Central Resource Team (CRT) or cross-trained staff from other units
♦ accessing per diem shifts, straight time hours beyond standard hours or overtime hours by unit staff
♦ calling in staff scheduled on stand-by.

In some circumstances it is also possible to coordinate with the Admitting Department regarding the placement of patients so that a unit that is staffed adequately for existing patient workload will not be overburdened with the admission of additional patients for whom appropriate staffing is not available.

Decisions about downsizing assure that the remaining staff can meet current and anticipated patient care needs, that the appropriate mix of staff is available, and that minimum staffing requirements (that is, at least two registered nurses, regardless of the patient census) are met. If workload is less than anticipated and downsizing becomes an option, the manager or responsible staff nurse can cancel any scheduled overtime hours, per diem shifts or straight time hours beyond standard hours, or release any allocated CRT staff or staff from other units. For exempt staff, flexible scheduling also provides for negotiated schedule changes. For all staff, there is also the option of cross covering on another unit if the individual is competent in that area or of taking paid time off.

Staff who are responsible for making staffing decisions have the support of on-site Clinical Supervisors, Nurse Managers who have 24-hour accountability and, if necessary, the Associate Chief Nurses and the Chief Nurse who are available to the staff at all times.

Reference: Statement of Accountability, Nursing Practice Manual, 1.41.01

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Reviewed and approved: Nursing Executive Operations 08/03
Massachusetts General Hospital  
Patient Care Services  
Nursing Service  
White 9 General Medicine  
Resource Nurse Guidelines

**Introduction:**

The primary goal of the resource nurse is to facilitate the provision and coordination of patient care on any given shift and to assist staff in addressing patient care issues and staff needs. The resource nurse plays a vital role in supporting daily operations on the unit in collaboration with the nurse manager and clinical nurse specialist. Some of these activities include interdisciplinary patient care rounds, coordination of patient admissions, transfers, and discharges, troubleshooting supply and equipment issues, monitoring infection control and the patient classification system (WinPFS or Medicus). Nurses who function in the resource role demonstrate clinical competency as well as an ability to prioritize, and think critically. The resource nurse is an advocate for patients, families, and staff, and integrates conflict resolution and negotiation into daily practice. The resource nurse leads by example and utilizes unit leadership to assist in problem solving, assessment and management of patient, family, and visitor needs, administrative aspects of the role (e.g. staffing requirements, scheduling) and exploring personal professional development goals and learning needs.

**Guidelines:**

1. RN orientees will receive information related to the resource role and have scheduled observation time with an experienced resource nurse as part of their unit based orientation. Formal orientation to the role will be contingent upon successful completion of departmental and unit-base orientation as well as input from experienced resource nurses and nurse preceptors in collaboration with the nurse manager and clinical nurse specialist. Target timeline for completion of resource nurse orientation is six months following departmental and unit orientation.

2. Orientation to the resource role will be completed in one week with Day 1 being an observation day followed by three days in the role under the direction of an experienced resource nurse preceptor. The need for additional experience will be determined by the preceptor in collaboration with the CNS and nurse manager. Once oriented, each RN will be expected to function in the role of resource nurse.

3. The resource nurse will designate resource nurse assignments on the daily assignment sheet. The assignment will be reviewed by the oncoming resource nurse at change of shift and revised accordingly based upon patient acuity and staffing.

4. RNs who function in the resource role and precept RN orientees should not be assigned as resource nurse when orienting new nurse hires whenever possible.
5. Resource nurses will be assigned on the 7:00am to 3:00pm, 3:00pm to 11pm, and 11pm to 7am shifts to facilitate continuity of care and coordination/coverage for unit activities such as new admissions and discharges.

6. Staff RNs functioning as the resource nurse will complete the daily assignment for the oncoming shift. Staff RNs functioning as the resource nurse for the night shift will review the assignment from the day and evening shifts and complete the assignment for the following day shift based upon staffing and patient care needs.

7. The resource nurse preferably should not have a patient assignment. Should taking a patient care assignment become necessary, every attempt should be made to allow the resource nurse to have no more than two patients. During the evening or night shifts where generally fewer RNs are assigned, the resource nurse needs to carefully consider the acuity level of his/her patient assignment in order to meet role expectations. The resource nurse will consult with the nurse manager, clinical nurse specialist, and/or nursing supervisor whenever necessary.

8. The following information must be included on the daily assignment sheet:
   - Full name and licensure of each RN for each shift unless listed on the back of the assignment sheet.
   - Name of each patient the RN is assigned to care for and full name and assignment of each PCA for per shift.
   - Co-assignment of non-professional staff with a professional staff member.
   - Start and stop time for each staff member.
   - Resource nurses are included on assignment sheet and must be included in the actual staffing numbers.
   - Orientees should be identified on the assignment sheet as being in orientation. They are not included in the actual staffing numbers until the sixth week of orientation (see back of Patient Classification Staffing Data sheets for guidelines of when to count employees).
   - Off-unit, non-direct care activities, e.g. council/committee meetings, educational activities, administrative projects should be identified on assignment sheet and hours should be deducted.
   - Designation of staff coverage for patient(s) when assigned RN is off the patient care unit.

9. Key points to consider when making out the daily assignment include:
   - Patient acuity level.
   - Experiential level of staff and appropriateness of assignments. (Include this as a point of discussion during resource nurse report. Recommend assigning at least one experienced RN on each POD when newer, less experienced staff are scheduled.)
   - Staffing levels.
   - Primary nurse assignments.
• Location/geographical assignments.
• Previous assignments.
• Anticipated discharges and not assigning multiple discharges to one RN.
• Patients scheduled for multiple diagnostic tests.
• Student nurse assignments.
• Patients on precautions.
• Patients who are restrained.
• Patients at risk for falls.
• Admissions.
• Information from resource nurse report sheet.

10. The role and responsibility of the resource nurse is to:
• Meet with staff at the beginning of each shift to collect pertinent information related to patient acuity, discharges, and other clinical issues or problems. Staff RNs will report changes in patient condition, impending discharges, and other clinical information to the resource nurse as required throughout each shift.
• Coordinate collaborative staff nurse decisions to address staffing and nursing assignments.
• Triage communication from the clinical supervisor and other intradepartmental staff as appropriate to facilitate unit operations and patient care.
• Work with Admitting and peers to coordinate admissions, patient placement, and nursing assignments.
• Ensure that all patients are classified each shift.
• Complete and fax Medicus staffing data form and file in the Classification Staffing Data Notebook.
• Complete and fax IV charge list.
• Assist with patient care as needed which may include but is not limited to:
  - ADLs
  - Phlebotomy
  - IV insertion
  - Patient positioning/transfers
  - Contacting physician teams to address patient problems
• Monitor patient problems and clinical issues on an ongoing basis and consult the appropriate resources in collaboration with the CNS.
• Discuss discharge-planning needs with the junior resident, RN case manager, social worker, and CNS during interdisciplinary rounds.
• Facilitate discussion and resolution of staff conflicts and when a breakdown in communication occurs.
• Consult with the CNS and/or nurse manager related to clinical and administrative issues.
• Serve as a back-up in emergency/critical situations to support staffing and patient care activities.
• Collaborate with the CNS and/or nurse manager to coordinate staff attendance at unit-based inservices or other internal educational programs as staffing permits.
Attachment 4.15.b continued

- Collaborate with staff RNs and PCA’s to plan for breaks and meal times. Staff are allowed one unpaid 30 minute meal period and one paid 15 minute break period in each work period greater than 6 hours.
- Make patient care assignments that respect primary nurse relationships, equitably distribute the workload (refer to Medicus data), and consider the competencies and skill level of staff.
- Check emergency equipment according to hospital policy.
  (Code cart EKG machine, and monitor/defibrillator unit need to be checked daily. In addition, EKG machine and monitor/defibrillator should be checked after each use.)
- Perform end of shift verification count with another staff RN at 7am each morning.
- Perform a discrepancy check for narcotics and controlled substances and Omnicell temperature check at 3pm and 11pm.

11. In the event of a disaster, the Resource Nurse will:
- Assure PATCOM is updated to determine bed availability. If disaster occurs during the night shift with no scheduled OA, PATCOM should have been updated at the end of the evening shift.
- Account for all staff on duty.
- Assess and identify patients for discharge home and/or skilled nursing facility in collaboration with RN case manager, CNS, Medical Team, and nursing staff.
- Complete and fax the Disaster Status Form (fax 4-3486) and the Equipment Availability Form (fax 6-6973).
- If an internal disaster, follow the safety manual guidelines.
- Maintain communication with nursing supervisor.
- If directed to activate the emergency call list, call the closest staff members first. Unit staff are to remain on duty until directed otherwise (i.e. staff relieved or event is over).
- Prepare to expedite acceptance of patients from the ED. Complete evaluation may be pending. ED will need space to accommodate disaster victims.

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