



# **JOINT NURSE STAFFING COMMITTEE**

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**Proposal**

Western State Hospital  
Joint Nurse Staffing Committee  
January 29, 2015

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**STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
WESTERN STATE HOSPITAL**

*9601 Steilacoom Blvd. SW • Tacoma,, WA 98498-7213 • (253) 582-8900*

January 29, 2015

To: Ronald Adler, WSH CEO

From: Julia Cook, ARNP, Psychiatric Nurse Executive, Co-Chair  
Barbara Shelman, RN 1199NW Co-Chair  
Joint Nurse Staffing Committee

Re: Joint Nurse Staffing Committee Proposal for 2015 and Forward

**Background**

In the interest of brevity, we are attaching the background and history information. See previous proposals dated 12/30/2010, 02/06/2014 committee charter and the RCW for committee background information.

**Development of the WSH Joint Nurse Staffing Committee (JNSC) Plan**

The WSH Joint Nurse Staffing Committee reviewed many staffing models to include the Model used at a State Hospital in Staunton, Virginia approved by the Department of Justice. Members of the Committee went to Harborview Medical Center Psychiatric Units to review the staffing plan used. Oregon State Hospital, Multicare and Franciscan Health Care Systems were also consulted. The Committee reviewed the data gathered from the clinical indicators compiled during the last year.

The Committee reviewed the March 2009 DSHS report to Legislature “State Hospital Ward Sizes, Discharge Practices, and Community Placement Issues”. The report contained recommendations from Dr. Jeffery Geller, a consultant heading a workgroup in 2008. The recommendations addressed caseloads, discharge practices and bed capacity.

The Committee also reviewed the “Workplace Violence Prevention Programs Review” by A.J. Rosen and Associates September 13, 2013. The consultants were contracted by DSHS to identify ways to improve the workplace violence prevention program at both Eastern State Hospital and Western State Hospital.

The Joint Nurse Staffing Committee elected to focus on safe and consistent staffing. JNSC recommendations incorporate best practices from all reviewed models. The staffing plan is based on the identification of acute vs. extended wards as listed below:

CFS	East	Central	South
E1 Extended	E2 Acute	C2 Extended	S3 Extended
F1 Acute	E3 Extended	C3 Acute	S7 Extended
F2 Acute	E5 Acute	C4 Acute	S8 Extended
F3 Extended	E6 Acute	C5 Acute	S9 Extended
F4 Extended	E7 Extended	C6 Acute	S10 Extended
F5 Acute	E8 Extended	C7 Extended	W1S Extended
F6 Acute		C8 Acute	W1N Extended
F7 Extended			
F8 Extended			

Definitions:

Extended: Provide treatment to patients unable to be stabilized on acute care wards

Acute: Have volatile patients, unfamiliar with processes, creating an increased risk and harm to self, others, and increased risk of escape. These wards have increased level of activities such as admissions, transfers, discharges, and assigned tasks.

**Committee Recommendations for 2015**

**1. *Increase Registered Nurse Availability***

- Increase the RN2s to three assigned per ward (days and evenings) to promote the availability of two RN2 direct care staff seven days a week.
  - Three RN2s will provide a continuity of care for patients. Wards will not be left without RN2 coverage even during emergent times or lunch breaks.
  - RN2s will be able to thoroughly assess patients and develop comprehensive, individualized care plans to meet the needs of patients.
  - The additional RN2 will afford educational opportunities for patients and staff improving patient care and contributing to successful community placement.
  - Additional RN2 will maximize coverage while minimizing overtime.
- Permanent RN2 Float Pool for each Center and Shift
  - Three full time, permanent center-based float RN2s available on each shift.
  - The float pool will assist with continuity of care with familiarization with the processes of the center.
  - Float pool will provide coverage for schedule leave, unscheduled leave and training reducing RN overtime.

- Assign one RN3 Nurse Supervisor to every dayshift ward (except W1S/W1N which share one) and acute care evening ward. Assign an RN3 to a maximum of two night shift wards and two evening extended care wards.
  - The recommended staffing level of the RN3 allows the supervisor to perform supervisory functions such education, discipline and referrals.
  - The RN3 will be able to monitor, audit and evaluate the competency of all staff and ensure all education requirements are completed.
  - The RN3 will be able to establish clear, consistent expectations for all staff and ensure consistency in the expectations and requirements for direct care staff

## 2. *Maintain LPN/PSN Availability*

- Three LPN/PSNs assigned per ward to promote the availability of two LPN/PSNs seven days a week on day and evening shift.
  - LPN/PSNs are needed for medication administration, treatments, collection of data to assist with nursing diagnosis and identify nursing needs of patients.
  - Certain psychiatric disorders are independent risk factors for diabetes creating a greater need for nursing care.
  - Many other physical illnesses are associated with psychiatric disorders due to life styles such as nutritional disorder, receiving physicals and screenings, exercise and smoking.

## 3. *Adjust MHT/PSA staffing in Accordance with Intensity of Ward*

- Minimum five MHT/PSAs assigned to work wards designated as acute care wards on day and evening shift.
  - Patients on acute wards are usually psychiatrically unstable and unpredictable.
  - Acute wards have volatile patients unfamiliar with processes creating an increase risk in harm to self, others and an increased risk of escape.
  - Acute care wards have an increase in ward activities and assigned tasks.
  - Promotes continuity of care through therapeutic engagement.
- Minimum four MHT/PSAs assigned to wards designated as extended care wards seven days a week on day and evening shift.
  - Extended care wards provide treatment for patients unable to be stabilized on an acute care ward.
  - Patients have chronic history of mental illness and require intensive engagement by direct care nursing staff to motivate participation in the patient recovery mall and to mollify volatile patients.
  - Promotes continuity of care through therapeutic engagement.

## 4. *Institutional Counselor Availability*

- Three IC2s assigned to all wards on day and evening shifts to ensure two IC2s are available seven days a week to provide active treatment and nursing care.

- Patients who refuse or unable to participate in Recovery Mall settings or patients who are escape risks will receive active treatment seven days a week.
- Increased activities will decrease violence on wards
- Work collaboratively with direct care staff to provide patient care

#### 5. *Procedural Change*

- Abolish the absorption of the first 1:1 ward assignment.
- Nursing IC2s remain on assigned ward to provide treatment to patients and not provide treatment in the Recovery Malls.
- Increase additional nursing personnel to accommodate the addition of every 15 minute checks on all three shifts on all wards.

#### 6. *The Joint Nurse Staffing Committee looks forward to your response.*

#### **Members of the Western State Hospital Joint Nurse Staffing Committee**

##### *1199 SEIU NW Members*

- **Barbara Shelman 1199NW Co-Chair**
- Mikel Sparling, RN2, CFS
- Mattie Brickle, RN3, Nsg Admin
- Linda Holbrook, RN2, PTRC-C
- Kim D'Silva, RN2 PTRC-S
- Tal Kim, RN3 CFS
- Willie Saw, RN3
- Paul Vilja, RN3

##### *WSH Hospital Administration Members*

- **Julia Cook, Nurse Executive, Co-Chair**
- Kathleen Jamison, APNE
- Kimmi Munson Walsh, NAD
- Michael Dyer, RN4
- James Sprague, IC3, Safety Office
- Craig Gibelyou, LPN4, East Campus Clinic
- Kristi Enge, MHT, PTRC-C
- Kelly Rupert, LRS

##### *Administrative support*

- Wendi Pumphrey-Rios, AA3

# Appendix A



**STATE OF WASHINGTON**  
**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**  
**WESTERN STATE HOSPITAL**  
9601 Steilacoom Blvd. SW, Tacoma, WA 98498-7213

February 6, 2014

To: Ronald Adler, WSH CEO

From: Julia Cook, WSH PNE Co-Chair  
Paul Vilja, RN, 1199NW WSH Co-Chair  
Joint Nurse Staffing Committee

Re: Special Report: Staff Balancing Plan

### **Background of Joint Nurse Staffing Committee**

In response to The Joint Commission Accreditation (TJC) standards for hospitals Western State Hospital (WSH) established the Staffing Effectiveness Committee in 2004 in a collaborative labor management model with management, and union representatives from each of the unions that represent nursing employees (WFSE & 1199NW).

In November 2006 a consultation requested by DSHS with Dr. Gellar occurred. As a result of that consultation a statewide hospital staffing work group was formulated January, 2007 by HRSA/MHD. That Task Group produced the "State Hospitals Direct Care Staffing Review and Recommendations" August 17, 2007.

Nurse Staffing legislation was passed in the regular 2008 state legislative session in the form of HB 3123. That legislation included state psychiatric hospitals in the expectation that staffing committees would be established at hospitals. Primary responsibilities of the nurse staffing committee shall include: Development and oversight of an annual patient care unit and shift-based nurse staffing plan, based on the needs of patients, to be used as the primary component of the staffing budget.

This bill was prescriptive in what was to be considered in developing the plan: Census, 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; Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations.

In July, 2008 it was determined that the Nurse Staffing Effectiveness committee would add the directions of this bill for developing a staffing plan to its objectives.

July 2009 the contents of the bill had been adopted by labor and management and implemented as agreed in the 09-011 collective bargaining agreement with SEIU 1199NW, Article 38.

#### Staffing Effectiveness Committee Functions (Article 38)

1. TJC Staffing effectiveness requirement: Help to meet the requirements of the Joint Commission to measure and evaluate staffing with patient outcomes.
2. Nursing Recruitment/Retention monitoring to assure adequate levels of licensed nurses and development of plans to retain current nurses.
3. Nurse Scheduling Standards (Nursing Standard 216) develop, review, and revise the consistent plan for how staffing is done in the hospital.
4. Staffing Database and reports to be developed to measure successes and use in budget planning, staffing plan changes.
5. Develop Nurse Staffing Plan, (Meet HB 3123). This includes tasks of the staffing plan development, review of staffing complaints/nurse sensitive indicators/posting of plans and items in the house bill that the hospital is responsible to DSHS to implement.

#### Developing the WSH Nurse Staffing Plan

The WSH Staffing Effectiveness committee determined that building on the 2007 MHD/HRSA staffing model was the preferred method to determine a WSH staffing plan including the purpose, objectives, definitions of wards and staffing formulas.

1. WSH adopted the purpose of the MHD model that includes, assure and enhance patient and Staff Safety, management tool for strategic planning and a framework to articulate and support budget requests.
2. The objective adopted was to identify minimum staffing requirements for patient/staff safety to maintain hospital accreditation (TJC) and Medicare (CMS) certification.
3. Ward Types identified are consistent with the MHD model of Acute/Admissions and Extended wards.
  - Acute/Admission wards primarily receive patients from evaluation and treatment centers, other hospitals, jails, ERs, or transfers from other admit wards. Patient characteristics most likely assessed are medication/treatment regiment not stable, on admit less than 1 week, in the state hospital less



than 1 month, or require 1:1 staff, medical supervision for acute medical or increased staffing for physical care/safety needs.

- Extended Wards primarily receive patients from other wards. Patient characteristics on these wards are most likely assessed as having stable medication/treatment regiment treatment refractory and require longer stay, close to discharge or identifies as needing Long Term Care (LTC) require little or no acute psychiatric interventions, medically stable , gain levels of responsibility quickly allowing independence.
4. HPPD ( Hours of patient care per day or nursing care hours (NCH)
- HPPD: The direct nursing care hours per patient day (All nursing classifications in the nursing department who provide direct care on wards) required to provide minimum care ours per patient. Calculated using these factors: number of direct care nursing staff required on a ward or unit in a 24/7 setting, 8 hours per day worked by each nursing staff and ward census
  - Coverage factor: the mathematical factor used to calculate the number of direct care nursing FTEs needed to cover a position on the floor of the hospital 24/7. Baseline adopted was 1.8 in order to provide for the consistent minimum of nursing care. The formula is a tool to define the basic minimum care and does not reflect when a 1:1 care is needed for treatment and safety or if the census exceeds capacity.
  - Required Nursing Care Hours Formula:  $1.8 \text{ coverage} \times \text{census (average) per ward type} \times \text{HPPD} / 8 \text{ hours}$
  - Required Nursing Care Hours standards with Percent(%)of RN coverage.
    - The percent of RN reflects the need to assure the appropriate level of nursing care is performed and care is supervised according to federal, state and community standards of care. These are established using available Department of Justice standards, nursing care data for WSH, TJC and CMS requirements.
    - **Acute Care Ward standard recommended: 6.0NCH/35% RN**
    - **Extended Care Ward standard recommended : 5.5NCH/30%RN**

#### **2009 -2010 Committee Accomplishments.**

Using these recommendations, and building on the 2007 work, the Committee enhanced the earlier staffing model by including factors not considered in that earlier effort. For the six-month period January 1, 2009 through June 30, 2009, the committee examined not only scheduled staff (the “Master Schedule”), but also included unscheduled leave use for that period, on-call use, redeployment (pulls), vacancies, and overtime use, and included a factor to account for other kinds of leave as well as the 24/7 staffing needs required by a hospital setting. For each ward and shift for that six month period, the following were computed:

- Total Planned Available Nursing Care Hours
- Total Actual Nursing Care Hours Available
- Planned Available Hours Per Patient Day

- Actual Available Hours Per Patient Day
- Planned Available RN %
- Actual Available RN %

We also obtained the average cost for a nursing FTE, including benefits, by adding up the annual cost of all nursing FTE's (regardless of job class) and dividing by the total number of FTE's. This resulted in an average of \$65,907 per year.

From these figures, calculations were made to determine the total number of FTE's needed and the associated cost. We found that at our current capacity, WSH would need 116 additional nursing FTE's to meet the recommended model. At an average of \$65,907 per year, we would need an additional \$7,645,212 per year. In the current budget climate, that is clearly not going to happen. Exploring alternatives, we determined that at ward capacities of 24, only 7 additional RN nursing FTE's would be needed to meet the model, for an additional cost of \$461,349 per year.

#### **2010 Model at 30 bed average capacities:**

Acute (F1, F2, F5, F6, E1,E2, C3, C5, C6, C7, C8) December 2010 current ward capacities and budgeted nursing FTE for Acute care wards (11 wards/327 beds) are 362 nursing FTE or (30-37 FTES/29-30 beds). Using the model each acute care ward for a 29-30 census requires 49.5 nursing FTES per ward.

Based on the formula for nursing care hours ( $1.8 \times 327 \times 6.0$  NCH/by 8 hours= 441) nursing FTE are needed or *an additional 80 nursing FTE are needed*. To meet the 35% RN skill mix per the model of those 80 nursing FTE , 51 RN FTEs are needed to provide the 35% mix.

Extended Care (F3, F4, F7, F8, E3, E5, E7, S3, S7,S8,S9,S10) Extended Care wards (12 wards/364 beds) have a current nursing FTE of 357.8 or 25-32FTES/ 28-32 bed ward. Using the model each 30-32 bed ward requires 43 to 47 FTE.

Based on the formula for nursing care hours ( $1.8 \times 364 \times 5.5$  NCH/8 hours=450.45 FTE) an additional 92.26 FTE are needed. To meet the 30% RN skill mix 135 RNs are needed. Current RN FTE is 90. Of the needed 92.26 nursing FTE, 45 RN FTE are needed.

On-call FTEs: Factoring in funded on-call nursing FTE of 35 (15 RN) from the total of 170 total FTE/96 RN projected to be needed to meet the model provides a WSH total additional nursing FTE need of 135 total FTE /81 RN.

#### **2011 RECOMMENDED PLAN**

1. Reduce ward capacities to 25

- ACUTE: An acute care ward of 25 beds requires 36 FTEs to provide the 6.0 nursing care hours. Reducing current acute care wards to 25 bed capacity per ward would reduce acute beds to 272. The formula is  $1.8 \times 272 \times 6.0/8=367$  nursing FTE needed or an addition of 5.2 FTE to the current 362.

The RN skill mix of 35 % requires 128 RNs. There are now 103 RN FTE for the acute care area so while 5.2 RN FTE is needed another 20 positions would need conversion in current positions to become RN positions

- EXTENDED CARE: An extended care ward of 25 patients requires 34 FTEs to provide 5.5 nursing care hours. Reducing current extended care wards to 25 per ward reduces bed capacity to 303 beds. The formula is  $1.8 \times 303 \times 5.5 \text{ NCH} /8=375$  nursing FTE needed or an addition of 17 nursing FTE.

In the model a 30% RN skill mix requires a total of 112.5 RN FTE. There are now 90 RN FTE. An additional 22.5 RN FTE would be required, the 17 nursing FTE plus the converting of 5.5 other nursing FTES.

Funded nursing on call RN positions total 15. Total number of new FTE needed to fund the model is 22.5 (all RN). Using the 15 on call RN positions funded as full time FTE then only 7.5 RN new positions are needed. A plan to convert other nursing positions to the needed RN positions for the model needs to be developed.

Note: wards E6, E8, S4, C1 and C4 are not included in either model at this time as the programs on those wards require further consideration and do not fit the acute or extended models.

## 2. Acuity System Revisions

Each shift, the RN assesses the acuity of the patients on their wards and enter the information into the Johnson's Acuity system in Cache. The total acuity is multiplied by a "factor" to generate an estimate of the number of nursing staff needed. It had been many years since those factors had been examined. So, in 2009 and early 2010, the Committee revised these factors to base them on the recommended staffing model (nursing care hours) and on nursing judgment of the time required to care for patients with different acuity levels. It is in this system where variability of patient need is reflected as it is based on the patients' needs and the interventions of nursing. The new factors were implemented into the Johnson's Acuity system as of February 1, 2010. The Staffing Effectiveness Committee is currently assessing the difference the revised factors have made in the estimates of nursing staff needed.

## **2014 RECOMMENDED PLAN**

Over the past year Western State Hospital (WSH) changed administrations and Chief Executive Officer (CEO) resulting in change to the focus of the Joint Nurse Staffing Committee. The New administration governing WSH is the Behavioral Health and Service Integration Administration (BHSIA).

The BHSIA Strategic Plan for 2013-2015 established Strategic Objectives to support the Department of Social and Health Services (DSHS) Business Plan Goals of Health, Safety, Protection, Quality of Life and Public Trust for vulnerable persons. BHSIA's core services focus on Individual Support, Health Care Quality and Costs and Administration. The DSHS and BHSIA goals and objectives are supported by the WSH Strategic Goals of service, safety, staff, stewardship and culture of safety.

These goals and objective are incorporated in the fundamentals of patient care at WSH. The role of staffing is crucial in providing optimal patient care aligned with the goals and objectives of the hospital, administration and DSHS. The Joint Nurse Staffing Committee (JNSC) works diligently to establish a method of ensuring adequate staffing while remaining within budgetary constraints.

The recommendations from the Joint Nurse Staffing Committee do not include the previous recommendation of HPPD to establish base staffing levels. The American Psychiatric Nurses Association (APNA) indicated in a position paper titled "Staffing Inpatient Psychiatric Units" dated 02/17/2012, hours per patient day (HPPD) was not a reliable system for determining staffing needs in a psychiatric hospital. The HPPD method looks at hours required over the past 24 hour period. Psychiatric patient care needs cannot be determined by triage therefore the care hours in an in-patient psychiatric setting is fluid requiring frequent adjustment. The HPPD results in over-estimation of care hours needed and fails to address issues such transfers, admission and the unpredictability of psychiatric patients.

The Committee reviewed issues contributing to the exorbitant use of overtime. The committee determined there were five major issues impacting the use of overtime: unscheduled absences, days off, rotating weekends, RN ratio (supervisor vs charge), and the use of one to one (1:1) staffing.

#### Unscheduled Absences:

WSH adopted a system for scheduling on March 18, 2013, the system is transparent and enables staff to see ward based staff schedules on a shift by shift basis. The scheduling program allows supervisors to track scheduled and unscheduled absences used by their assigned employees. The supervisor is then able to indicate if the absence is authorized or unauthorized permitting the supervisors to initiate the just cause process if needed. The Psychiatric Nurse Executive (PNE) educated the nurse supervisors on the process of when and how to indicate unauthorized absence to improve accountability of staff.

#### Days off:

The Committee reviewed every schedule for every ward on every shift of the hospital. The committee found the days off were not leveled resulting in overstaffing during the middle of the week and understaffing on the weekends requiring overtime to compensate for the staffing deficit. The committee revised the shift schedules to balance the staff availability to ultimately ensure staff from every skill mix is scheduled on every shift.

#### Rotating Weekends:

Charge nurses are afforded the opportunity to have fixed or rotating days off for weekend coverage compensation. Review of the scheduler system revealed registered nurses with rotating weekends used more unscheduled leave and used unscheduled leave in conjunction with their days off. The committee recommends all charge nurses have fixed days off to enable their schedules to be predictable and potentially decrease the use of unscheduled absences.

#### RN Ratio

WSH found filling the charge nurse positions are more challenging than the nurse supervisor positions. The Nurse Supervisor works in the charge nurse capacity when the charge nurse is not available therefore preventing the charge nurse from performing supervisory functions. The Nurse supervisor can supervise more than one ward effectively, however; the charge nurse can only effectively charge one ward. The committee proposes placing a freeze on hiring new Nurse Supervisors and reallocating the Nurse Supervisor position to a charge nurse enabling wards to have consistent charge nurse coverage.

#### One to One Staff (1:1)

The committee acknowledged the increased use of 1:1 staff contributing to the increase in overtime use. The committee recommends all 1:1 assignments are reviewed every twenty-four hour period by the treatment team to ensure the patient requires the 1:1 and is receiving benefit from having a 1:1 assigned.

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#### **Members of the Western State Hospital Nurse Staffing Committee :**

1199 SEIU NW Members

- Paul Vilja 1199NW Co-Chair
- Tal Kim, RN3, Forensics
- Mattie Brickle, RN3, PTRC-C
- Willie Saw, RN3, PTRC-S
- Heather Rayman, RN3 Nursing Admin

WFSE: Members

- James Sprague, IC3
- Craig Gibelyou, LPN4
- Daniel Dawson, MHT1

WSH Nurse Management members:

- Julia Cook, Psychiatric Nurse Executive, Co-Chair
- Michael Dyer, RN4
- Jay Sandhu, RN4
- Christy Forsythe, RN4, CFS

Administrative support:

- Wendi Pumphrey-Rios, Administrative Assistant

## Appendix B



**STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
WESTERN STATE HOSPITAL**

*MS: W27-19 • 9601 Steilacoom Blvd. SW • Tacoma,, WA 98498-7213 • (253) 582-8900  
(253) 756-2824*

December 30, 2010

To: Jess Jamieson, WSH CEO

From: Jo Ann Blacksmith, ARNP, Psychiatric Nurse Executive  
Katharine Dexter, RN, 1199NW WSH Chair  
Nurse Staffing Effectiveness Committee

Re: Report from the Nurse Staffing Effectiveness Committee for 2011 and Forward

### **Background**

In response to The Joint Commission (TJC) accreditation standards for hospitals, Western State Hospital (WSH) established the Staffing Effectiveness Committee in 2004 in a collaborative model between management and representatives from each of the unions that represent nursing employees (WFSE & 1199NW).

In November 2006 a consultation requested by DSHS with Dr. Gellar occurred. As a result of that consultation, a statewide hospital staffing work group was formed in January, 2007 by HRSA/MHD. That Task Group produced “State Hospitals Direct Care Staffing Review and Recommendations,” August 17, 2007.

Nurse staffing legislation was passed in the regular 2008 state legislative session in the form of HB 3123. That legislation included state psychiatric hospitals in the expectation that staffing committees would be established at hospitals. Primary responsibilities of the nurse staffing committee were to include,

*”Development and oversight of an annual patient care unit and shift-based nurse staffing plan, based on the needs of patients, to be used as the primary component of the staffing budget. . .”*

This bill was prescriptive in what was to be considered in developing the plan: Census; 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 the nursing personnel providing care; the need for specialized or intensive equipment; the architecture and geography of the patient care unit; and staffing guidelines

adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations.

In July, 2008 it was determined that the Staffing Effectiveness Committee would add to its objectives the direction of this bill for developing a staffing plan. By July 2009 the contents of the bill had been adopted by labor and management and implemented as agreed in the 2009-2011 collective bargaining agreement with SEIU 1199NW, Article 38. Therefore, the objectives and functions of the Committee became:

1. The TJC staffing effectiveness requirement: Help to meet the requirements of the Joint Commission to measure and evaluate staffing with patient outcomes.
2. Nursing recruitment and retention monitoring to assure adequate levels of licensed nurses and to develop plans to retain current nurses.
3. Nurse scheduling standards (Nursing Standard 216): Develop, review, and revise the plan for how staffing is done in the hospital.
4. Staffing database and reports development to measure successes and use in budget planning and staffing plan changes.
5. Meet HB 3123 through staffing plan development, review of staffing complaints, examination of nurse sensitive indicators, posting of plans, and other items in the house bill that the hospital is responsible to DSHS to implement.

### **Development of the WSH Nurse Staffing Plan**

The WSH Staffing Effectiveness Committee determined that building on the 2007 HRSA/MHD staffing model was the preferred method to determine a WSH staffing plan:

1. WSH adopted the purpose of the MHD model that included assuring and enhancing patient and staff safety, developing a management tool for strategic planning, and designing a framework to articulate and support budget requests.
2. The objective adopted was to identify minimum staffing requirements for patient and staff safety to maintain hospital accreditation (TJC) and Medicare (CMS) certification.
3. The ward types identified were consistent with the MHD model of Acute/Admissions and Extended wards:
  - **Acute/Admission** wards primarily receive patients from evaluation and treatment centers, other hospitals, jails, ERs, or as transfers from other admission wards. Patients are likely to have unstable medication and treatment regimens, be recently admitted, require 1:1 staffing, need medical supervision for acute medical conditions, or need increased staffing for safety needs.
  - **Extended Wards** primarily receive patients from other wards. Patients are likely to have stable medication and treatment regimens but be treatment refractory, require a longer stay, be close to discharge, be identified as needing long term care and requiring little or no acute psychiatric interventions, be medically stable, or gain levels of responsibility quickly allowing independence.
8. The model was based on HPPD (hours of patient care per day) and NCH (nursing care hours):



- **HPPD.** The direct nursing care hours per patient day required to provide minimum care for patients. It is calculated using the number of direct care nursing staff required on a ward or unit in a 24/7 setting, assuming 8 hours per day worked by each nursing staff, and ward census.
- **The Coverage Factor.** The mathematical factor used to calculate the number of direct care nursing FTEs needed to cover a position on the floor of the hospital 24/7. The baseline adopted was 1.8 in order to provide for a consistent minimum of nursing care. The formula is a tool to define the basic minimum care and does not reflect when 1:1 care is needed for treatment and safety or if the census exceeds capacity.
- **Required Nursing Care Hours Standards with Percent of RN Coverage.** The percent of total nursing care hours provided by an RN reflects the need to assure the appropriate level of nursing care is performed and that care is supervised according to federal, state, and community standards of care. These are established using available Department of Justice standards, nursing care data for WSH, and TJC and CMS requirements. The acute care ward standard recommended is 6.0 nursing care hours per patient per day with 35% of those hours provided by an RN. The extended care ward standard recommended is 5.5 nursing care hours per patient per day with 30% of those hours provided by an RN.

Using these recommendations and building on the 2007 work, the Committee enhanced the earlier staffing model by including factors not considered in that earlier effort. For the six-month period January 1, 2009 through June 30, 2009, the committee examined not only scheduled staff (the “Master Schedule”), but also included unscheduled leave use for that period, on-call use, redeployment (pulls), vacancies, and overtime use, and included a factor to account for other kinds of leave as well as the 24/7 staffing needs required by a hospital setting (the coverage factor). For each ward and shift for that six month period, the following were computed:

- Total Planned Available Nursing Care Hours
- Total Actual Nursing Care Hours Available
- Planned Available Hours Per Patient Day
- Actual Available Hours Per Patient Day
- Planned Available RN %
- Actual Available RN %

We also obtained the average cost for a nursing FTE, including benefits, by adding up the annual cost of all nursing FTEs (regardless of job class) and dividing by the total number of FTEs. This resulted in an average of \$65,907 per year.

From these figures, calculations were made to determine the total number of FTEs needed and the associated cost. We found that at our current capacity, WSH would need 116 additional nursing FTEs to meet the recommended model. At an average of \$65,907 per year, we would need an additional \$7,645,212 per year. In the current budget climate, that is clearly not going to happen. Exploring alternatives, **we determined that at ward capacities of 24, only 7 additional RN nursing FTEs would be needed to meet the model, for an additional cost of \$461,349 per year.**

Our current model at an average capacity of 30 beds per ward compared with the desired model is as follows:

- **Acute wards (F1, F2, F5, F6, E1,E2, C3, C5, C6, C7, C8).**
  - In December 2010, these 11 wards had a total capacity of 327 beds and a total of 362 budgeted nursing FTEs, resulting in 33 FTEs for every 30 beds.
  - Using the model, each acute care ward requires 49 nursing FTEs per 30-bed ward.

Based on the formula for nursing care hours (1.8 x 327 x 6.0 NCH/ 8 hours):

  - These wards together need 441 FTEs for ***an additional 80 nursing FTEs needed.***
  - To meet the 35% RN skill mix per the model, of the 80 nursing FTEs needed, ***51 FTEs need to be RN FTEs.***
  
- **Extended wards (F3, F4, F7, F8, E3, E5, E7, S3, S7,S8,S9,S10).**
  - In December 2010, these 12 wards had a total capacity of 364 beds and a total of 357.8 budgeted nursing FTEs, resulting in 29 FTEs for every 30 beds.
  - Using the model, each extended ward requires 43 nursing FTEs per 30-bed ward.

Based on the formula for nursing care hours (1.8 x 364 x 5.5 NCH/8 hours):

  - These wards together need 450 FTE's for ***an additional 92 nursing FTEs needed.***
  - To meet the 30% RN skill mix per the model, of the 92 nursing FTEs needed, ***45 FTEs need to be RN FTEs.***
  
- **On Call Nursing FTEs.**
  - Factoring in the 35 funded on-call nursing FTEs (15 of which are RNs), ***WSH needs 135 additional nursing FTEs, of which 81 need to be RN FTEs.***

## **Committee Recommendations for 2011**

### ***7. Reduce ward capacities to 25.<sup>1</sup>***

- An acute care ward of 25 beds requires 36 FTEs to provide the 6.0 nursing care hours. Reducing current acute care wards to 25 beds per ward would reduce total bed capacity to 272. The formula is  $1.8 \times 272 \times 6.0/8=367$  nursing FTEs needed or ***an addition of 5 FTEs*** to the current 362.
  - The RN skill mix of 35% requires 128 RN FTEs. There are now 103 RN FTEs for the acute care areas, so while 5 FTEs are needed, another 20 RN positions are needed.
  
- An extended care ward of 25 beds requires 34 FTEs to provide the 5.5 nursing care hours. Reducing current extended care wards to 25 beds per ward would reduce total bed capacity to 300 beds. The formula is  $1.8 \times 300 \times 5.5/8=371$  nursing FTEs needed ***or an addition of 13 nursing FTEs*** to the current 358.
  - The RN skill mix of 30% requires 113 RN FTEs. There are now 90 RN FTEs for the extended care areas, so while 13 FTEs are needed, another 22.5 RN FTEs are needed.
  
- Funded nursing on-call RN positions total 15. The total number of new FTEs needed to fund the model is 22.5 (all RN). Using the 15 on call RN positions funded as full time FTEs then ***only 7.5 RN new positions are needed.***

<sup>1</sup> Wards E6, E8, S4, C1, and C4 are not included in the model at this time as the programs on those wards require further consideration and do not fit either the acute or extended models.

8. **Acuity System Revisions.** Each shift, RNs assesses the acuity of the patients on their wards and enter the information into the Johnson's Acuity system in Cache. The total acuity is multiplied by a "factor" to generate an estimate of the number of nursing staff needed. It had been many years since those factors had been examined. So, in 2009 and early 2010, the Committee revised these factors to base them on the recommended staffing model (nursing care hours) and on nursing judgment of the time required to care for patients with different acuity levels. It is in this system where variability of patient need is reflected as it is based on the patients' needs and the interventions of nursing. The new factors were implemented into the Johnson's Acuity system as of February 1, 2010. The Staffing Effectiveness Committee is currently assessing the difference the revised factors have made in the estimates of nursing staff needed. In addition, planning is underway to add additional fields to the acuity system to capture the status of all staff for each ward and shift.

### **Members of the Western State Hospital Nurse Staffing Committee**

#### ***1199 SEIU NW Members***

- **Katharine Dexter 1199NW Co-Chair (Dan Conroy through June 2010)**
- Dan Conroy, RN3, Staff Development (now retired)
- Janet Wright, RN2, Forensics
- Virginia Field (Sue), RN3, Central/South Hall
- Christy Forsythe, RN3, Forensics
- Yusun Miller, RN3, Central Hall
- Willie Saw, RN3, South Hall
- Anne Taggart, RN3, Staff Development
- Linda Skaggs, RN3, East Campus (member since 2004)
- Paul Vilja, RN3, East Campus

#### ***WFSE Members***

- James Sprague, IC3
- Craig Gibelyou, LPN4

#### ***WSH Nurse Management members***

- **Jo Ann Blacksmith, Nurse Executive, Co-Chair**
- Kelly Saatchi, RN4
- Michael Dyer, RN4

#### ***Committee Resources***

- Barbara Hawkins, Research Investigator
- Georgette Nunez, IT Specialist

#### ***Administrative support***

- Daniel Gapsch, MHT5

## Appendix C



WSH Joint Nurse Staffing  
Committee Charter  
December 4, 2014

Committee Name:	Western State Hospital (WSH) Joint Nurse Staffing Committee
Committee Membership and Leadership	<p>Designated Co-Chair: Barbara Shelman, RN2 SEIU Co-Chair: Julia Cook, Psychiatric Nurse Executive</p> <p>Committee Membership:</p> <p>The Joint Nurse Staffing Committee will consist of direct client care Registered Nurses appointed by the SEIU Local Chair and an equal number (or less) appointees by the PNE or designee.</p> <p>Each area where nursing care is provided will have the opportunity to provide advice to the Joint Nurse Staffing Committee. These areas will be called to meetings when their attendance is required. Committee meetings are open and any interested Registered Nurse employed by WSH may attend, but only committee members will have a vote.</p> <p>The Joint Nurse Staffing Committee will be co-chaired by the SEIU Local Chair and PNE (or designee).</p>
Purpose:	<p>Develop and oversee implementation of an annual nurse staffing plan which will serve as the primary component of the staffing budget after approval and/or recommendations has been submitted by the Chief Executive Officer (CEO).</p> <p>Semi-annually review the current nurse staffing plan.</p> <p>Respond to staffing concerns presented to the committee.</p> <p>Assure unit staffing plans, shift-based staffing and relevant clinical staffing for each shift are publically available.</p>
Required by:	<p>RCW 70.41.420 (Nurse Staffing Committee) Article 38 (Joint Nurse Staffing Committee) CBA between DSHS &amp; SEIU 1199NW</p>
Reports to:	<p>State Legislature Governing Body CEO</p>

<p>Duties:</p>	<p>A. Development and oversight of an annual patient care unit and shift-based nurse staffing plan, based on the needs of patients, to be used as the primary component of the staffing budget. Factors to be considered in the development of the plan should include, but are not limited to:</p> <ol style="list-style-type: none"> <li>1. Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;</li> <li>2. Level of intensity/acuity of all patients and nature of the care to be delivered on each shift;</li> <li>3. Skill mix;</li> <li>4. Level of experience and specialty certification or training of nursing personnel providing care;</li> <li>5. The need for specialized or intensive equipment;</li> <li>6. 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;</li> <li>7. Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations; and</li> <li>8. Hospital finances and resources.</li> </ol> <p>B. Semiannual review of the staffing plan against patient need and known evidence-based staffing information, including the nursing sensitive quality indicators collected by the hospital; and</p> <p>C. Review, assess, and respond to staffing concerns presented to the committee.</p> <p>D. Creation of an Annual Report</p> <p>E. Produce the hospital's annual nurse staffing plan. If this staffing plan is not adopted by the hospital, the CEO shall provide a written explanation of the reasons why to the committee. The CEO reporting back to the committee within 90 days from the date the CEO receives the committee recommendations.</p> <p>F. Posting of Staffing Plan and Staffing Levels</p> <p>Each hospital shall post, in a public area on each ward, the nurse staffing plan and the nurse staffing schedule for that shift on that ward, as well as the relevant clinical staffing for that shift. The staffing plan and current staffing levels must also be made available to patients and visitors upon request.</p> <p>Co-chair duties: facilitates meetings, sets agenda, primary contact for committee members, presents to other committees, presents the annual report updates, and oversees member participation. Gives Recruitment and Retention Report to UMCC – by both sides.</p> <p>Joint Nurse Staffing Committee Co-chairs (or designees), shall attend a Recruitment and Retention Statewide Union Management Communication Committee meeting annually. Additional meetings may be scheduled if required.</p>
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	SEIU Local Chair to participate and report JNSC data and vacancy levels to the Recruitment and Retention Communication Committee annually as outlined in SEIU CBA Article 23.2C.
Timeline for Outcome Completion	<p>The Joint Nurse Staffing Committee is to complete and submit an annual nurse staffing plan for CEO review no later than February 1 of each year.</p> <p>The Joint Nurse Staffing Committee is to complete and submit a semiannual review of the currently implemented staffing plan for CEO review no later than August 1 of each year. This semiannual review shall utilize designated nurse sensitive quality indicators to complete its assessment.</p> <p>The Joint Nurse Staffing Committee may be tasked with special assignments by the CEO; timeframes for special assignments shall be subject to CEO determination.</p>
Meeting Frequency:	Minimum of ten (10) times annually.
Meeting Management:	<p>Participation by a hospital employee shall be on scheduled work time and compensated at the appropriate rate of pay. Members shall be relieved of all other work duties during meetings. Staff Registered Nurse members of the Joint Nurse Staffing Committee will be paid, and preferably will be scheduled to attend meetings as part of their normal full time equivalent hours for the majority of the meetings. It is understood that meeting schedules may require that a Registered Nurse member attend on his/her scheduled day off. In this case, the Registered Nurse may be given equivalent hours off during another scheduled shift.</p> <p><b>Record-keeping/minutes:</b></p> <ul style="list-style-type: none"> <li>• Meeting agendas will be submitted 2 days in advance.</li> <li>• The minutes of each meeting will be distributed to all committee members, with approval of the minutes as a standing agenda item for each meeting. The Co-chairs will sign after approval.</li> <li>• A master copy of all approved meeting minutes from the Joint Nurse Staffing Committee will be maintained and available for review on the Western State Hospital Intranet website.</li> <li>• The website will be kept up to date.</li> </ul> <p><b>Attendance requirements and participation expectations:</b></p> <ul style="list-style-type: none"> <li>• All members are expected to attend at least 80 percent of the meetings held each year. Failure to meet attendance expectations may result in removal from the committee by the PNE or SEIU co-chair.</li> <li>• If a member needs to be excused, requests for an excused absence are communicated to PNE or SEIU co-chair or the co-chairs. Failure to request an excused absence will result in attendance recorded as “absent” in the meeting minutes.</li> <li>• Replacement will be in accordance with aforementioned selection</li> </ul>

processes.

- It is the expectation of the Joint Nurse Staffing Committee that all members will participate actively, including reading required materials in advance of the meeting as assigned, coming prepared to meetings, and engaging in respectful dialogue as professional committee members.

**Decision-making process:**

- Consensus will normally be used as the decision-making model.
- Should a particular issue need to be voted upon by the committee, the action must be approved by a majority vote of the full committee.
- Quorum: 6 voting members of the committee present would constitute a quorum, 3 from 1199 nurses and 3 from the employer. If one of the members present is the co-chair, they would be the 3rd member.

**Visitors and Guest Participation:**

- Guests and visitors may observe Joint Nurse Staffing Committee Proceedings.
- Guests and visitors may participate in the committee meeting while it is in progress.

## Appendix D

### RCW 70.41.420

#### **Nurse staffing committee.**

(1) By September 1, 2008, each hospital shall establish a nurse staffing committee, either by creating a new committee or assigning the functions of a nurse staffing committee to an existing committee. At least one-half of the members of the nurse staffing committee shall be registered nurses currently providing direct patient care and up to one-half of the members shall be determined by the hospital administration. The selection of the registered nurses providing direct patient care shall be according to the collective bargaining agreement if there is one in effect at the hospital. If there is no applicable collective bargaining agreement, the members of the nurse staffing committee who are registered nurses providing direct patient care shall be selected by their peers.

(2) Participation in the nurse staffing committee by a hospital employee shall be on scheduled work time and compensated at the appropriate rate of pay. Nurse staffing committee members shall be relieved of all other work duties during meetings of the committee.

(3) Primary responsibilities of the nurse staffing committee shall include:

(a) Development and oversight of an annual patient care unit and shift-based nurse staffing plan, based on the needs of patients, to be used as the primary component of the staffing budget. Factors to be considered in the development of the plan should include, but are not limited to:

(i) Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers;

(ii) Level of intensity of all patients and nature of the care to be delivered on each shift;

(iii) Skill mix;

(iv) Level of experience and specialty certification or training of nursing personnel providing care;

(v) The need for specialized or intensive equipment;

(vi) 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; and

(vii) Staffing guidelines adopted or published by national nursing professional associations, specialty nursing organizations, and other health professional organizations;

(b) Semiannual review of the staffing plan against patient need and known evidence-based staffing information, including the nursing sensitive quality indicators collected by the hospital;

(c) Review, assessment, and response to staffing concerns presented to the committee.



(4) In addition to the factors listed in subsection (3)(a) of this section, hospital finances and resources may be taken into account in the development of the nurse staffing plan.

(5) The staffing plan must not diminish other standards contained in state or federal law and rules, or the terms of an applicable collective bargaining agreement, if any, between the hospital and a representative of the nursing staff.

(6) The committee will produce the hospital's annual nurse staffing plan. If this staffing plan is not adopted by the hospital, the chief executive officer shall provide a written explanation of the reasons why to the committee.

(7) Each hospital shall post, in a public area on each patient care unit, the nurse staffing plan and the nurse staffing schedule for that shift on that unit, as well as the relevant clinical staffing for that shift. The staffing plan and current staffing levels must also be made available to patients and visitors upon request.

(8) A hospital may not retaliate against or engage in any form of intimidation of:

(a) An employee for performing any duties or responsibilities in connection with the nurse staffing committee; or

(b) An employee, patient, or other individual who notifies the nurse staffing committee or the hospital administration of his or her concerns on nurse staffing.

(9) This section is not intended to create unreasonable burdens on critical access hospitals under 42 U.S.C. Sec. 1395i-4. Critical access hospitals may develop flexible approaches to accomplish the requirements of this section that may include but are not limited to having nurse staffing committees work by telephone or electronic mail.

[2008 c 47 § 3.]

### Notes:

**Findings -- Intent -- 2008 c 47:** See note following RCW [70.41.410](#).