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DHDTC DAL#: 23-16
New York State Public Health Law Section 2805-t
Revised 2023 Clinical Staffing Plans Submissions

Please find attached Northern Dutchess Hospital's Clinical Staffing Plans.

PFI #0192

Health Commerce System Name: Northern Dutchess Hospital

Sincerely,

A handwritten signature in black ink that reads "Bridget Hewitt RN".

Bridget Hewitt, RN, BSN, MSN
Chief Nursing Officer



Northern Dutchess Hospital

Clinical Staffing Committee

October 2023

PFI # 0192

Health Commerce System Name: Northern Dutchess Hospital

NORTHERN DUTCHESS HOSPITAL

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Clinical Staffing Committee Charter

DATE: September 26, 2023

PREPARED BY: Bridget Hewitt

A. Purpose of the Steering Committee

Primary Functions

The Staffing Committee was developed for the effective scheduling and management of daily staff needs for Northern Dutchess Hospital, and to define a process that ensures the availability of qualified nursing and unit level staff to provide safe, reliable, and effective care for our patients.

Plan Principles:

- Access to high-quality nursing staff is critical to providing patients with safe, reliable, and effective care
- The optimal staffing plan represents a partnership between nursing leadership, direct nursing staff, and the entire clinical team
- Staffing is multifaceted and continually evolving. The development of the plan must consider a wide range of variables

Committee Requirements

The Staffing Committee is responsible for collaborating to review and adjust unit level staffing plans for RNs and other on-line workers.

- The committee work is guided by this charter
- The committee meets quarterly
- Committee members are required to attend 75% of the meetings to maintain their position on the committee
- The committee's work is based on individual unit needs and population served. To be considered in this process:
 - Census, including total numbers of patients on the unit on each shift and activity such as patient discharges, admissions, and transfers
 - Skill mix-level of experience or training and availability of a charge nurse on each unit.
 - Unit geography
 - Mechanisms in place for increased observation, i.e., VMS, 1:1 when needed.
 - Measures to increase worker and patient safety, which could include measures to improve patient throughput
 - Staffing guidelines adopted or published by other states or local jurisdictions, national nursing professional associations, specialty nursing associations, and other health professional organizations
 - Availability of other personnel supporting nursing services on the unit
 - Waiver of plan requirements in the case of unforeseeable emergency circumstances as defined in the public health law
 - Coverage to enable RNs, LPNs, and ancillary staff to take meal and rest breaks, planned time off, and unplanned absences that are reasonably foreseeable as required by law or the terms of an applicable CBA
 - Nursing quality indicators required by the NCQPA (section 400.25)
 - General hospital finances

- Provisions for limited short-term adjustments made by appropriate general hospital personnel overseeing patient care operations to the staffing levels required by the plan, necessary to account for unexpected changes in circumstances that are to be of limited duration

The above criteria will be considered in defining the staffing plan for each unit.

- Staff continuously monitor individual and aggregate patient care needs and make adjustments to staffing per agreed upon policy.
- If changes are made to the staffing plan throughout the calendar year, an updated staffing plan will be submitted to DOH annually.

The hospital is committed to ensuring staff are able to take meal and rest breaks as required by law. The committee will consider strategies to ensure breaks when developing the plan.

B. Staffing Committee Roles and Membership

Role of a Staffing Committee member

Staffing Committee members are not directly responsible for managing the decisions of the committee but provide solutions and support for the plan as defined above.

- Understand the strategic implications and outcomes of the staffing plan
- Be genuinely interested in the initiative and be an advocate for broad support for the outcomes being pursued in the project
- Help balance conflicting priorities and resources
- Consider ideas and issues raised
- Foster positive communication outside of the Team regarding the project's progress and outcomes

Nursing Staffing Plan Scope

- All In-Patient Units
 - Medical Surgical Units
 - OB
 - Acute Rehab
 - ICU
- All Units that Potentially Care of In-Patients
 - Emergency Department
 - PACU
- In August 2023 added
 - ASU
 - Endoscopy
 - Pain Management
 - Wound Care
 - Interventional Radiology
 - Infusion/Oncology

Regulations for ICU/Critical Care Staffing were issued by the DOH. The requirement is for 12 hours of RN care per patient day for both ICU and the OR. They will be required to participate in the committee to ensure all standards are met.

Nurse Staffing Plan Matrices

- Developed as a guide for shift-to-shift unit-based staffing
- Decisions are based on patient needs and skill mix of staff and can be adjusted up or down
- Matrices include:
 - Charge Nurse
 - RN
 - PCT
 - Unit Secretary/Monitor Tech

Other Factors and Considerations for What to Include in the Plan

- Information on nurse staffing recruitment challenges or shortages in a particular type of skill set are to be considered and its effect on the ability to meet the staffing plan
- Hospital financial challenges and the impact on the staffing committee
- Data that is not explicitly required to be included in the public report – e.g., missed breaks, gaps in staffing and specific quality data

Committee Composition

- Equal representation of management and the frontline staff
- Frontline staff include =RNs PCTs, and Unit Secretaries
- Management team includes-CNO, Nursing Management, HR, and Finance
- The CNO is the chair of the committee
- Professional Development Representative will be the official minute taker

The frontline staff and the management team get 1 on vote on the recommendations. The law preserves Managements role in creating and approving the recommendations, but management must include the reason for the veto and submit them to the DOH. Collaboration and commitment to the goal will alleviate the need for this situation.

Membership

Committee members will be determined by their peers with one alternate selected for each member.

Name	Role	Responsibility

C. Steering Committee Meetings

Meeting Schedule and Process

- The Team will meet quarterly for 1 hour
- Staff members will be paid for their meeting attendance
- Staff members will be relieved of duties to attend this committee meeting.
- If changes are made to the staffing plan throughout the calendar year, an updated staffing plan will be submitted to DOH annually.
- The meeting agenda and minutes from the last meeting will be distributed prior to next meeting to ensure proper preparation by all speakers and shared understanding of decisions, action items, and next steps

Meeting Agenda

At each meeting, project status will be reported to the Team with the following agenda items:

Introductory items such as:

- Introductions
- Review Agenda
- Minutes from last meeting
- Review of actions arising from previous Steering Committee meetings

Review Project Status

- Overall Status
- Milestone review
- Formal acceptance of deliverables
- Accomplishments against last meeting’s plans
- Issues/resolutions
- Plans for the next reporting period
- Specific requests for assistance of the Steering Committee

Review and summarize new actions from this meeting

Plans, date, and location for next meeting



NORTHERN DUTCHESS HOSPITAL PLAN FOR THE PROVISION OF PATIENT CARE

I. INTRODUCTION

Northern Dutchess Hospital is an 84-bed acute care hospital serving Rhinebeck and the surrounding communities of northeastern Dutchess County, southern Columbia County and northern Ulster County. NDH is a major contributor to the wellness of the community as well as contributing to the economic and social vitality of the area. Northern Dutchess Hospital is an affiliate of Nuvance Health, that also includes Vassar Brothers Medical Center, Putnam Hospital Center, Sharon Hospital, Danbury Hospital, New Milford Hospital, Norwalk Hospital, and other affiliates. This affiliation offers patients immediate access to a higher level of care not available at Northern Dutchess Hospital, including advanced cardiac care, cardiac surgery, psychiatric services, intensive neonatal services, maternal fetal medicine, and advanced oncologic surgery. It also affords patients access to acute rehab.

II. MISSION, VALUES

Patient Care Services at Northern Dutchess Hospital are driven by Nuvance Health's mission and values, and the needs of the community. The Mission Statement is the driving force of the organization:

Our Reason for Being

We exist to...Pursue Impossible. So we can improve the lives of every person in our community.

Personal

Being top caliber starts with how we treat and respect people. So we see each patient, listen, then speak and act with purpose and compassion.

Imaginative

Discovering what's possible for our patients and our communities means challenging the expected. So we seek better, never settle and inspire curiosity.

Agile

Progress is only achieved through change. So we better serve our patients by overcoming barriers, pivoting with efficiency and staying open-minded.

Connected

Achievements don't happen in silos. So we share ideas, communicate clearly, act with consistency and work together as a unified team to care for those who need us.

Because we strive to...Redefine Expected. Changing assumptions by challenging traditional healthcare experiences.



Based upon the mission, values and strategic goals of NDH and Nuvance Health, the Plan for Provision of Patient Care:

- Defines clinical and support services that are required to meet Northern Dutchess Hospital's mission and strategic goals.
- Ensures that Northern Dutchess Hospital has an organized and systematic approach to the provision of care/services, with an emphasis on patient safety, quality communication, and compassionate person-centered care.
- Ensures that Northern Dutchess Hospital has an effective process for identifying, planning and implementing new/enhanced services to meet patient and community needs.

The provision of patient care is planned, organized and delivered through the collaborative efforts of the Board of Directors, Medical Executive Committee and Administration.

III. DEFINITION OF PATIENT CARE SERVICES

Patient Care Services at Northern Dutchess Hospital occur through an organized process designed to ensure the delivery of safe, effective and timely care/treatment. The provision of care requires specialized knowledge, skill and judgment. As such, Patient Care Services are planned, provided, delegated and supervised by professional healthcare providers. These providers will seek out and incorporate the unique needs and desires of each individual patient whenever possible. Patient care encompasses the recognition and treatment of disease, wellness promotion, patient/family teaching and patient advocacy. Physicians, registered nurses and other healthcare professionals function collaboratively as part of a multidisciplinary team to achieve positive patient outcomes and a patient experience that focuses on quality, patient-centered goals.

Patient Care Services are limited to those departments that have direct contact with patients. Patient Care Services are provided primarily by licensed staff and are supported by a variety of individuals and departments which may or may not have direct contact with the patients, but who support the care provided by professional staff providers.

IV. ORGANIZATION

All major hospital functions and services are planned, implemented and evaluated annually with appropriate scope, budgets, staffing and performance assessment. The management team plans and evaluates hospital performance in conjunction with the Board of Trustees and the Medical Staff. Plans are developed to provide direction for the year, in support of the Northern Dutchess Hospital and Nuvance Health strategic and operating goals.

Staffing plans for patient care departments have been developed based on the *NYS DOH Safe Staffing Guidelines* implemented in January 2023. The regulations requires that a staffing committee consisting of front line licensed and unlicensed care providers with hospital management and administrators, develop a staffing plan for all patient care units. This plan is to ensure safe patient care is prioritized with healthcare worker safety and satisfaction as the foundation for effective patient care. The staffing plans are developed based upon the level, scope, acuity and frequency of care to be provided; the qualifications required; and the



competency of staff needed to provide the care. Guidelines are established for review of the plan every 3 months as well as processes for staff to file grievances if the staffing grids are not met.

The staffing plan is supported by a review based upon: changes in patient need/expectation, utilization rates and trends; employee turnover; budget; performance improvement and staffing effectiveness results; benchmark standards; changes in services/technology; and regulatory and safety requirements. Staffing effectiveness is evaluated on an ongoing basis, utilizing both human resources and patient outcome indicators as defined by the Performance Improvement program.

A key focus for 2023 is the management of volume surges encountered by all service lines. The impact of both inpatient and outpatient surges has become increasingly apparent in resource management and the ability to provide excellent, timely care. The growth in the Emergency Department, Surgical Services volume, and Acute care admissions require a plan for management, escalation, and agility in our response to these demanding events. The Surge Plan is a comprehensive document that defines levels of escalation, communication, and steps to mobilize the resources needed to facilitate care and support for patients and staff in the affected area.

V. STANDARDS OF CARE

Patient Care Services are integrated throughout the hospital organization. Patients with similar health needs can expect to receive the same level of care throughout the hospital.

Major policies, standards and processes guiding clinical practice include, but are not limited to:

- Admission of Patients
- Assessment/Reassessment
- Care of Patients
- Physicians' Orders
- Care Coordination
- Infection Control
- Patient Rights/Responsibilities
- Patient Safety, including restraints, medication administration and reconciliation, and safety goals
- Pain Management
- Documentation in the Electronic Medical Record (EMR)
- Advanced Directives, Ethical Issues
- Informed Consent
- Patient Confidentiality and Compliance Concerns
- Organ/Tissue Donation
- Job Descriptions
- Performance Improvement and Patient Experience
- Medical Staff Rules and Regulations



- Performance measures related to Core Measures, HCAHPS and Value-Based Purchasing
- EMTALA

VI. DEPARTMENTAL COLLABORATION AND COMMUNICATION

Care is delivered utilizing an interdisciplinary approach. This interdisciplinary commitment of all patient care departments is demonstrated through collaborative planning of care, policy and procedure development, patient rounds, open communication, Plan-Do-Check-Act (PDCA) teams, and participation in performance improvement activities. Interdepartmental communication is facilitated by the following formal venues:

- Routine Patient Rounding
- Leader Rounding to assess Patient Experience
- Daily Safety Huddles (management, departmental)
- Monthly department manager meetings
- Bi-weekly senior management meetings
- Medical staff departmental meetings
- Patient rounds for Case Management/Length of Stay
- Senior Leader rounding to focus on Staff Engagement
- Monthly department staff meetings
- Nursing Council meetings
- Unit Based and Coordinating Nursing Committees (promoting self-governance)
- Patient Experience Council NDH/System
- Bi-monthly Safety/Emergency Management meetings
- Patient Family Advisory Council (PFAC)

Patient care departments collaborate with the medical staff to provide effective patient care. The medical staff is responsible for the medical care provided to all patients and has the responsibility to participate in the process to evaluate and improve the patient care at Northern Dutchess Hospital.

VII. CONSULTATIONS AND REFERRALS FOR PATIENT CARE SERVICES – CONTINUUM OF CARE

To ensure that Patient Care Services are available in a timely manner to meet the needs of the patient, all essential services are provided either directly by Northern Dutchess Hospital or through referral, consultation and/or contract with providers who provide quality service.

Essential patient services provided on an ongoing basis by an outside contract provider are approved by the medical staff and the Board. Written agreements are maintained that require the contractor to meet applicable quality and performance standards. Consultations are given and requested according to the Rules and Regulations of the Medical Staff Bylaws. Formal written transfer agreements and policies exist to ensure timely and appropriate services to patients whose needs cannot be met within the facility.

VIII. SCOPE OF SERVICES

Northern Dutchess Hospital provides a range of comprehensive inpatient and outpatient services to the community in accordance with state and federal regulations, standards of care, and professional practice and codes. Our patients range in age from newborns to the geriatric population.

Each department has a defined scope of service and plan of care which supports the operation of Northern Dutchess Hospital. Each patient care department plan delineates the scope of service, population served, staffing plan, competency, orientation and training, budget and allocation of resources, and performance improvement/safety. The plan outlines the processes used in each department to provide care based on patient needs. Support departments also have a written plan for the department which delineates their role in providing support for patient care activities. Plans are updated on an annual basis in the departmental annual reports.

IX. SUPPORT SERVICES/FUNCTIONS

Support services and functions are designed to ensure that Patient Care Services are maintained in a timely and continuous manner. They support the comfort, safety and efficiency of services and are fully integrated with Patient Care Services. These services/functions include, but are not limited to:

- Leadership/Management
- Quality and Risk Management
- Patient Safety
- Patient Experience
- Corporate Compliance
- Infection Control
- Antibiotic Stewardship
- Human Resources
- Information Technology
- Facilities Management (including Environmental Services (EVS), Food Service, Security, Plant Services)

X. APPROVALS

Chairman, Board of Directors

President and CEO

Medical Director

Chief Nursing Officer

Northern Dutchess Hospital Medical Surgical

SCOPE OF SERVICE

The Medical Surgical Units at Northern Dutchess Hospital provide care to patients ages 18 – 100+ with varying diagnosis. The Medical Surgical department includes two units: Med Surg Sosnoff with 40 beds and Med Surg South with 17 beds. All patients have private rooms and, combined, the units can provide telemetry monitoring for up to 24 patients. Additionally, two rooms on the Med Surg South unit are equipped to provide continuous video EEG monitoring and serve as an Epilepsy Monitoring Unit (EMU).

The patient population admitted to the Medical Surgical Units include:

- Cardiac patients in nature that do not require any hemodynamic drips or monitoring.
- Pulmonary patients that do not require mechanical ventilation.
- Neurological patients/CVA that are stable and/or post TPA.
- Surgical patients ranging from GYN/GU, General, ENT, Thoracic, Bariatric, Plastic and a large volume of Orthopedics specializing in total joint replacements and spinal surgeries.
- General Medical
- COVID-19
- Hospice and palliative care
- Epilepsy
- DHE infusions for migraine therapy
- In addition to our inpatient population, the Medical Surgical units provide care for 23-hour surgical holds and patients assigned to observation status.

EMPLOYEE OVERVIEW

The Director of Patient Care Services and two Assistant Nurse Managers make up the Medical Surgical and Acute Rehab Leadership team. The Director is responsible for the overall operations of the units. The Assistant Nurse Managers provide oversight of staff and serve as the team leader in handling issues and concerns as they arise for their assigned units. One Assistant Nurse Manager also serves as the Bone and Joint Coordinator and leads the service line for Orthopedics in the hospital. This role is patient focused. Key components of the role include staff and patient education, data collection and analysis, and coordination of care. This role is the face of the program for NDH.

Designated Charge RNs are on every shift on both medical-surgical units; they assist the leadership team in managing patient flow and providing support for staff. This model ensures that both staff and patient needs and concerns can be addressed in a timely manner. These units are supported by Patient Care Technicians and Unit Secretary/Telemetry Technician.

Ancillary staff working on the Medical Surgical units also receive ongoing education. This year there has been a focus on cross-training PCT and Unit Secretary/Telemetry Technician roles as well as continued COVID response training. This provides our staff with opportunities to grow and learn in their current positions. Additionally, support for ancillary staff returning to school to become RNs is also provided.

The hospital employs transportation aides who assist in moving patients throughout the hospital.

We utilize Video Monitoring System (VMS) equipment for additional monitoring of high-risk fall and confused patients. These VMSs are monitored by offsite staff.

There is a charge nurse without an assignment, but he/she can take patients if the acuity/volume requires it.

**Northern Dutchess Hospital
Medical Surgical Sosnoff
Staffing Guidelines**

ADC	RN 7a-11p	PCT 7a-11p	USY/TeleTech	RN 11p-7a	PCT 11p-7a	USY/TeleTech
40	7	4	1	7	4	1
39	7	4	1	7	4	1
38	7	4	1	7	4	1
37	7	4	1	7	4	1
36	7	4	1	7	4	1
35	7	4	1	7	4	1
34	7	4	1	6	4	1
33	7	3	1	6	3	1
32	6	3	1	6	3	1
31	6	3	1	6	3	1
30	6	3	1	6	3	1
29	6	3	1	6	3	1
28	6	3	1	5	3	1
27	6	3	1	5	3	1
26	5	3	1	5	3	1
25	5	3	1	5	3	1
24	5	3	1	5	3	1
23	5	3	1	5	2	1
22	5	2	1	5	2	1
21	5	2	1	4	2	1
20	5	2	1	4	2	1

*Charge Nurse not included in the RN total.

**Northern Dutchess Hospital
Medical Surgical South
Staffing Guidelines**

ADC	RN Day	PCT Day	USY/TeleTech/EMUs	RN Night	PCT Night	USY/TeleTech/EMUs
16	3	2	1	3	2	1
15	3	2	1	3	2	1
14	3	2	1	3	1	1
13	3	2	1	3	1	1
12	2	2	1	2	1	1
11	2	2	1	2	1	1
10	2	1	1	2	1	1
9	2	1	1	2	1	1
8	2	1	1	2	1	1
7	2	1	1	2	1	1
6	1	1	1	1	1	1
5	1	1	1	1	1	1
4	1	1	1	1	1	1
3	1	1	1	1	1	1
2	1	1	1	1	1	1
1	1	1	1	1	1	1

*USY to be determined based on acuity and census.

*For EMU patients, a USY/TeleTech is required.



Northern Dutchess Hospital LDRP/Mother/Baby Unit

SCOPE OF SERVICE

The Birth Center at Northern Dutchess Hospital is a Level 1 LDRP model maternity unit. The unit includes nine (9) LDRPs, three semiprivate rooms, two antepartum rooms, and a two-bed triage unit. The nursery has 15 bassinets. The Birth Center provides 24-hour inpatient care, utilizing 12-hour shift nursing coverage in accordance with AWHONN staffing guidelines.

The Mother/Baby care model is a nursing delivery system which enables the registered nurse to plan, organize, direct patient-centered comprehensive nursing care, and evaluate its effectiveness. The framework for this care model parallels the philosophy, objectives, and policies of the hospital, nursing service, and Obstetrical Department and strategically aligns with the Nuvance mission, vision, and values.

The goal of the Birth Center is to provide our patients with a safe, family-centered birthing experience while empowering them with the education and skills they need to safely care for themselves and their infant. Education and support are provided throughout the antepartum, intrapartum, and postpartum periods.

EMPLOYEE OVERVIEW

- The Unit is staffed according to AWHONN (Association of Women's Health, Obstetric, and Neonatal Nurses) staffing guidelines.
- There is 24-hour neonatal coverage available in house.
- Unit Management continues to engage in leader rounding in order to identify issues and provide resolution for patient concerns.
- Continued bedside handoff for shift-to-shift report in order to increase hand-off safety and encourage patient participation in their care.
- All RNs are required to have S.T.A.B.L.E. training, NRP certification, and EFM (Intermediate) training, within one year of hire.
- There is a Unit Secretary who provides clerical support during the day on this unit.
- There is a Patient Care Technician who provides support for patients with activities of daily living, takes vital signs, provides bedside patient care, and stocks rooms.
- Lactation consultants are available and provide breastfeeding support to breastfeeding moms.



Northern Dutchess Hospital - Birth Center Staffing Guidelines

Nurse-to-Woman or Nurse-to-Baby Ratio	Care Provided
Antepartum *	Proposed Free Float Charge Nurse who will assume responsibility
1 to 2-3 *	Women during nonstress testing
1 to 1 *	Woman presenting for initial obstetric triage, first 15-20 minutes
1 to 2-3 *	Women in obstetric triage after initial assessment and in stable condition
1 to 3	Women with antepartum complications in stable condition
1 to 1	Woman with antepartum complications who is unstable
1 to 1	Continuous bedside attendance for woman receiving IV magnesium sulfate for the first hour of administration for preterm labor prophylaxis and no more than 1 additional couplet or woman for a nurse caring for a woman receiving IV magnesium sulfate in a maintenance dose
1 to 2 (usually 1:1)	Women receiving pharmacologic agents for cervical ripening, possible 1 PP couplet
Intrapartum	
1 to 1	Woman with medical (such as diabetes, pulmonary or cardiac disease, or morbid obesity) or obstetric complications during labor (such as preeclampsia, multiple gestation, fetal demise, indeterminate or abnormal FHR pattern, women having a trial of labor attempting vaginal birth after caesarean birth)
1 to 1	Woman receiving oxytocin during labor
1 to 1	Woman laboring with minimal-to-no pain relief or medical interventions
1 to 1	Woman whose fetus is being monitored via intermittent auscultation
1 to 1	Continuous bedside nursing attendance to woman receiving IV magnesium sulfate for the first hour of administration; 1 nurse to 1 woman ratio during labor and until at least 2 hours postpartum and no more than 1 additional couplet or woman in the patient assignment for a nurse caring for a woman receiving IV magnesium sulfate during postpartum
1 to 1	Continuous bedside nursing attendance during initiation of regional anesthesia until condition is stable (at least for the first 30 minutes after initial dose)
1 to 1	Continuous bedside nursing attendance to woman during the active pushing phase of second-stage labor
1 to 2	Women in labor without complications
2 to 1 *	Birth: 1 nurse responsible for the mother and 1 nurse whose sole responsibility is the baby

Northern Dutchess Hospital - Birth Center Staffing Guidelines

Nurse-to-Woman or Nurse-to-Baby Ratio	Care Provided
Postpartum and Newborn Care *	Proposed Free Float Charge Nurse who will assume responsibility
1 to 1	Continuous bedside nursing attendance to couplet in the immediate postoperative recovery period (for at least 2 hours)/well baby
1 to 3	Mother-baby couplets after the 2-hour recovery period (with consideration for assignments with mixed acuity rather than all recent post-caesarean cases)
1 to 2	Women on the immediate postoperative day who are recovering from caesarean birth as part of the nurse-to-patient ratio of 1 nurse to 3 mother-baby couplets
1 to 5-6	Women postpartum without complications (no more than 2-3 women on the immediate postoperative day who are recovering from caesarean birth as part of the nurse-to-patient ratio of 1 nurse to 5-6 women without complications)
1 to 3	Women postpartum with complications who are stable
1 to 5-6	Healthy newborns in the nursery requiring only routine care whose mothers cannot or do not desire to keep their baby in the postpartum room
1	* At least 1 nurse physically present at all times in each occupied basic care nursery when babies are physically present in the nursery
1 to 1	Newborn boy undergoing circumcision or other surgical procedures during the immediate preoperative, intraoperative, and immediate postoperative periods
1 to 3-4	* Newborns requiring continuing care
1 to 2-3	* Newborns requiring intermediate care
1 to 1	* Newborn requiring multisystem support – until transfer to higher level of care
1 to 1 or greater	* Unstable newborn requiring complex critical care – until transfer to higher level of care
1	At least 1 nurse available at all times with skills to care for newborns who may develop complications and/or need resuscitation



Northern Dutchess Hospital - Birth Center Staffing Guidelines

Nurse-to-Woman or Nurse-to-Baby Ratio	Care Provided
Minimum Staffing	
3	A minimum of 3 nurses as minimum staffing even when there are no perinatal patients, in order to be able to safely care for a woman who presents with an obstetric emergency that may require caesarean birth (1 nurse circulator; 1 baby nurse, one or both of whom should have obstetric triage, labor, and fetal assessment skills). A scrub nurse or surgical tech should be available in-house or on-call such that an emergent birth can be accomplished within 30 minutes of the decision to proceed. Another labor nurse should be called in to be available to care for any other pregnant woman who may present for care while the first 3 nurses are caring for the woman undergoing caesarean birth and during post-anesthesia recovery.

It should be recognized that these staffing ratios represent minimal staffing, require further consideration based on acuity and needs of the service, and assume that there will be ancillary personnel to support the nurse.

Northern Dutchess Hospital ICU

SCOPE OF SERVICES

The Critical Care Unit of Northern Dutchess Hospital provides a setting where high-risk, acute patients can receive specialized care by a skilled interdisciplinary team. This team conducts patient care rounds twice a week to discuss and plan for the care of our ICU patients. The unit strives to preserve the dignity and privacy of patients and their support system, respect social and economic status, personal traits, and the nature of individual health problems.

The Critical Care Unit is a seven-bed unit that provides services for medical, surgical, pediatric, and geriatric inpatients from surrounding counties. Among the services provided are: continuous cardiac monitoring, hemodynamic monitoring, ventilator management, noninvasive advanced airway management, frequent vital signs and pulse oximetry monitoring. Education and ICU standards are maintained to ensure adequate planning, intervention, and follow-up. All patients and families are supported and educated on individualized plans of care, advanced directives, infection control, and ethical issues.

We continue to partner with HiCuity Health (previously branded AICU) to provide this additional service for our patients. With the addition of high-tech cameras and monitors, Tele-ICU gives our patients access to intensivists 24/7. These specialists in critical care collaborate with our providers and nurses to provide our patients with high quality evidence-based care. Additionally, HiCuity collects and presents outcome data on a monthly basis.

After-hour PACU coverage is an additional responsibility of this unit when the volume and acuity allow. If the volume requires, the PACU staff will take call to ensure the safe care of all patients. The ICU functions as the PACU for Phase I Recovery for all post-surgical interventions (Labor and Delivery omitted).

EMPLOYEE OVERVIEW

The ICU leadership team is comprised of the Director of Patient Care Services (DPCS) of the ED and ICU; The ICU Medical Director, who is a pulmonologist and intensivist; and the Assistant Nurse Manager of Patient Care Services (ED ICU). The Directors maintain 24/7 responsibility for the overall operations of the department including but not limited to the implementation and evaluation of strategic and unit-specific goals and objectives that meet and promote the standards of quality and contribute to the organization's success. The DPCS and Medical Director maintain direct oversight of the Professional and non-professional Nursing Staff and Medical staff respectively. The Assistant Nurse Manager of Patient Care Services creates the unit schedule in collaboration with director; ensures staff utilize best practices and adhere to policy and procedure; performs staff rounding; performs patient rounds; performs quality audits; implements process improvement actions; provides individual and team education; supports the maintenance of a fair and just culture; supports and encourages professional growth and development; and provides direct clinical support during surge and high acuity events.

While daily operations are overseen by the director, one RN is designated as the unit charge nurse. This RN assists leadership in managing the daily assignment, ensuring the safe and equitable distribution of patients, managing patient flow, performing service recovery, reviewing all transfers, and providing support to staff as needed. This model helps to ensure timely recognition and management of issues or concerns reported or identified by staff, patients, or their family members.

Staff: The department is staffed with ICU trained nurses and Patient Care Technicians (PCTs). Registered Nurses are required to maintain current certification in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). In addition, they are encouraged and financially supported to receive additional Certifications through the AACN including but not limited to CCRN, PCRN, MSRN, and Crisis Prevention Intervention (CPI). The PCTs maintain current certification in Basic Life Support (BLS) and demonstrate competency in performing bedside patient care, including but not limited to vital signs, point-of-care diagnostics testing, EKGs, and safe-patient handling. Serving a dual role as the unit secretary, the PCTs demonstrate knowledge of current patient care practices, facilitate communication by making and answering calls, facilitate efficient throughput of transfers to alternate units and diagnostic testing through the capacity management system, and maintain the safety of patients' protected health information (PHI) when faxing or copying records, and help leadership order supplies. All staff demonstrate competency in HIPPA practices and performing concurrent and accurate documentation in the electronic medical record, Cerner Power Chart.

Northern Dutchess Hospital ICU Staffing Guidelines

Patients	Total RNs *	PCT/Tele Tech
1	2	0
2	2	0
3	2	0
4	2	1
5	2	1
6	3	1
7	3	1

Staffing requirements, alternative plans to augment optimal staffing, floating, and assisting during downtime:

- Charge Nurse included in total RN numbers.
- ICU serves as the PACU from 11pm-7am, seven days a week.
- ICU RN must transport all ICU patients to and from testing.
- When possible, the ICU will be staffed with a minimum of 2 trained or critical care nurses.
- Once there are 5-6 patients, the ICU should be staffed with 3 RNs (2 ICU or CC nurses minimum).
- Once there are 6 patients, staff with 3 RNs and 1 PCT.
 - The 3rd RN may be an MS or Float RN.
 - * If the patients all have ICU status, the MS RN can assist with nursing and tech duties, but not take an assignment that includes managing the care of an ICU patient. |
- ICU does not have a USY position.
- The ICU provides direct and indirect patient care, monitors consult calls and facilitates transports, manages all internal and external incoming calls, serves as a transporter, orders and stocks supplies, cleans and manages equipment, serves as a sitter when required.
- We utilize Video Monitoring System (VMS) equipment for additional monitoring of high-risk fall/confused patients. These VMS cameras are monitored by offsite staff.



Northern Dutchess Hospital Inpatient Acute Rehabilitation Unit

SCOPE OF SERVICE

The Paul Rosenthal Rehabilitation Center provides comprehensive inpatient rehabilitation services to adults (18 years old or older) with neurological and other medical conditions of recent onset or regression that have experienced a loss of function in activities of daily living, mobility, cognition, or communication. Diagnoses of patients admitted to the Rehabilitation Unit include cerebrovascular accident, spinal cord injury or dysfunction, brain injury, amputation, multiple traumas, hip fracture, debility due to prolonged hospitalization such as COVID 19 or other progressive neurological syndrome such as Guillain-Barre, Parkinson's disease, or Multiple Sclerosis.

The 10-bed unit is located in the Paul Rosenthal Pavilion at Northern Dutchess Hospital. It consists of seven private rooms and two semi-private rooms. The patient rooms and rehabilitation gym are equipped with state-of-art equipment. Services provided include rehabilitation medicine, rehabilitation nursing, physical and occupational therapy, speech-language pathology, social work, and case management. In addition, prosthetics and orthotics, vocational rehabilitation, and audiology are provided when necessary through affiliate agreements with external organizations.

The Paul Rosenthal Rehabilitation Center is CARF accredited. CARF (Commission for Accreditation of Rehabilitation Facilities) accreditation represents the highest level of accreditation awarded to rehabilitation facilities.

EMPLOYEE OVERVIEW

- Director of Therapy Services, Director of Patient Care Services, Associate Nurse Manger, Therapy Supervisor and Clinical Admission Liaison make up the Acute Rehab leadership team. Therapies are provided by licensed physical, occupational and speech therapy clinicians. Nursing care is provided by trained Registered nurses and patient care technicians. There is an assigned charge nurse each shift to facilitate patient care and support staff.
- The hospital employs transportation aides who assist in moving patients throughout the hospital.
- We utilize Video Monitoring System (VMS) equipment for additional monitoring of high-risk fall and confused patients. These VMSs are monitored by offsite staff.

Rehabilitation Staffing Guidelines

CENSUS	7AM – 7 PM		7 PM – 7 AM	
	RN	PCT	RN	PCT
1	1	1	1	1
2	1	1	1	1
3	1	1	1	1
4	1	1	1	1
5	1	1	1	1
6	2	1	2	1
7	2	1	2	1
8	2	1	2	1
9	2	1	2	1
10	2	1	2	1
11	2	1	2	1

*No USY on this unit

Northern Dutchess Hospital Emergency Department

SCOPE OF SERVICE

The Emergency Department (ED) at Northern Dutchess Hospital is a 16-bed, hospital-based suite, open 24 hours/day with at least one physician experienced in emergency care on duty, and specialty consultation is available within approximately sixty minutes. The ED is responsible for the provision of various emergency medical services to unscheduled patients across the age spectrum who present with a broad spectrum of illnesses and injuries, some of which may be life-threatening. In addition to delivering care within the ED suite, emergency department personnel respond to all code blue call and stroke calls.

The scope of service includes but is not limited to the initial triage assessment [Emergency Severity Index (ESI)], medical screening exam diagnostic testing (lab, radiology), simple and complex procedures, ongoing assessment and evaluation of treatments, consultation with specialty providers, follow-up referrals, and final disposition (discharge, transfer, or admission to the hospital).

Additionally, the Emergency Department serves as medical control for Emergency Medical Services. The ED physicians provide offer medical advice and guidance for patients being transported to the hospital, who refuse medical attention, and who die in the field.

SPECIALTY CARE SERVICES

- **Designated Stroke Center:** At NDH we deliver the highest standard of quality care to patients suffering from acute stroke symptoms by employing the most up-to-date technology and medications. This includes immediate access to brain scan with concurrent I-Stat Creatinine point-of-care testing along with Head and neck CT angiogram. The RN and medical staff are well-trained in the administration of life-saving intravenous t-PA to eligible patients who have suffered an acute stroke. In addition, the ED staff work in collaboration with Nuvance's Division of Neuro-Intervention to ensure eligible patients receive timely treatment with intra-arterial t-PA or mechanical embolectomy.
- **Cardiac Care:** The emergency staff is highly skilled in the rapid recognition and treatment of patients with acute cardiac conditions. We work in collaboration with Nuvance Health's Division of Cardiology and Interventional Cardiology to provide timely delivery of the most current medications and technology – including angioplasty and open-heart surgery. Patients with acute cardiac emergencies either receive a "clot busting agent" TNK within 30 minutes (when the CCL is unavailable) or transfer to VBMC or other tertiary cardiac center of choice for emergent angioplasty and/or other lifesaving cardiac surgery. Patients who meet criteria for Percutaneous Cardiac Intervention (PCI) receive medications as requested by the cardiac interventionist, including but not limited to aspirin, Ticagrelor, beta-blockers, heparin, etc., and transfer as soon as possible (< 60 minutes) to achieve a Door to Balloon time of ≤ 90 minutes.

- **Sepsis Care:** The Registered Nurses and Medical providers are skilled in the rapid recognition of early sepsis, severe sepsis, and septic shock. We continue to use sepsis tools to improve communication regarding and documentation for Sepsis and Septic Shock. The sepsis quality coordinator in collaboration with nursing and medical leadership reviews all severe sepsis cases for compliance with the three and six - hour bundles

EMPLOYEE OVERVIEW

Dyad Leadership: The ED leadership team is comprised of the Director of Patient Care Services (DPCS), Team Health ED Medical Director (THMD), and the Assistant Nurse Manager of Patient Care Services (APCM). The Director's maintains 24/7 responsibility for the overall operations of the department including but not limited to the implementation and evaluation of strategic and unit specific goals and objectives that meet and promote the standards of quality and contribute to the organization's success. The DPCS and THMD maintain direct oversight of the Professional and non-professional Nursing Staff and Medical staff respectively. The Assistant Nurse Manager of Patient Care Services create the unit schedule in collaboration with director oversight, ensures staff utilize best practices and adhere to policy and procedure, performs staff rounds, performs patient rounds, performs quality audits, implements process improvement actions, provides individual and team education, supports the maintenance of a just culture, supports and encourages professional development, and provides direct clinical support during surge and high acuity events.

While the Director maintains 100% oversight and responsibility of daily operations, a clinical charge nurse leads the team each shift. This RN assists leadership in managing the daily assignment, ensuring the safe and equitable distribution of patients by number and acuity, managing patient flow, de-escalation and service recovery, making LWT calls, reviewing all transfers, and providing support to staff as needed. This model helps to ensure timely recognition and management of issues or concerns reported or identified by staff, patients, or their family members.

Staff: The department is staffed with emergency trained registered nurses, specialty technicians, and unit clerks. Registered Nurses are required to maintain current certification in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS). In addition, they are encouraged and financially supported to receive additional Emergency Nursing Certification in Trauma (TNCC) and Pediatrics (ENPC), Crisis Prevention Intervention (CPI), and Board Certification by the BCEN. The specialty care technicians maintain current certification in Basic Life Support (BLS) and demonstrate competency in performing bedside patient care, including but not limited to vital signs, point-of-care diagnostics testing, EKG's, phlebotomy, safe patient handling, and the application of orthopedic splints. The unit secretaries demonstrate knowledge of current patient care practices, facilitate communication by making and answering calls, facilitate efficient throughput of admissions through the capacity management system, maintain logs and call lists, and maintain the safety of patients' protected health information (PHI) when faxing or copying records. All staff demonstrate competency in HIPPA practices and performing concurrent and accurate documentation in the electronic medical record, Cerner First Net.

Emergency Department Staffing Guidelines

The goal of this staffing plan is to create staffing ratios that provide efficiency in care and department flexibility while holding the ideals of patient safety and satisfaction at its core.

Time	Number of RNs	Number of Techs	Unit Secretary	Dedicated Charge	Dedicated Triage	Department Flow
7:00	3	1				One nurse each in zone 1 and 2. The third nurse is charge, acting as charge and triage with taking responsibility for minor acuity patients (hallways). ED tech acting as tech for all patients and performing unit secretary duties.
9:00	5	1				Two nurses in zones 1 and 2. Charge nurse remains as acting charge and triage. ED tech remains acting as unit secretary and tech.
10:00	5	1	1			No change to nurse assignments. Addition of unit secretary at this time. Tech now responsible for "tech duties" only.
12:00	7	2	1	x	x	Two nurses remain in zones 1 and 2. One nurse takes over as dedicated triage. Another nurse now moves into zone 3 (hallways). Charge nurse now gives up their low acuity/hallway patients and acts as dedicated charge. Two techs split the department responsibility in half. Unit secretary remains unchanged.
19:00	7	2	1	x	x	Change of shift occurs, no change to roles or ratios.
21:00	5	2	1			Two nurses leave. Charge takes role of triage nurse. Two nurses remain in zones 1 and 2. Zone 3 nurse leaves, those patients are to be split by charge and the nurses of zones 1 and 2.
22:00	5	2				No change to nursing roles. Unit secretary leaves, the remaining 2 techs split the duties secretary and techs.
24:00	3	1				Two nurses leave, 1 nurse remains in both zones 1 and 2. Charge remains triage and responsible for low acuity patients. One tech leaves, the remaining tech takes over all secretary and tech duties.
1:00-	2*	1				*Only on lower census days (Wednesday, Thursday, Saturday) the third nurse that came in at 1900 will leave at 0100. In this case the two remaining nurses will split the department nursing duties.

Emergency Department Staffing Guidelines

RNs	Techs	USY
0700-1900 (x3)	7A-7P	10A-10P
0900-2100 (x2)	12P-12	
1200-2400 (x2)	7P-7A	
1900-0700 (x3) **		
1900-0100 **		

** There will be 3 nurses 1900-0700 on Sundays, Mondays, Tuesdays, and Fridays as demanded by department/census needs. On lower censes days (Wednesday, Thursday, and Saturday) there will be 2 nurses 1900-0700 and 1 nurse 1900-0100.

ZONE	Number of Beds	Number of Nurses	Number of Techs	Acuity Level
ZONE 1	8*	2	1	ESI 1, 2, 3
ZONE 2	9*	2	1	ESI 1, 2, 3
ZONE 3	5	1	Split by techs on shift	ESI v3, 4, 5

*During hours where zone 3 does not have a dedicated nurse, hallways/low acuity patients to be split by charge nurse and the nurses of zones 1 and 2.

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SURGICAL SERVICES

- Ambulatory Surgery
- Infusion
- Operating Room
- PACU
- Endoscopy
- Pain Management
- Interventional Radiology



Northern Dutchess Hospital Ambulatory Surgery

SCOPE OF SERVICE

The Ambulatory Surgery Unit (ASU) is located in two sections on the third floor, the Rosenthal Pavilion and Sosnoff Tower which is adjacent to PACU and easy access to the Surgical Suite. In the Rosenthal Pavilion or Outpatient Unit (OPU), there are a total of (14) bays, 3 of which include cardiac monitoring with a centralized nurses' station.

Rosenthal Pavilion supports the intake and Phase II recovery for Endoscopy, Pain Management, IR, Cardiac Catheterization and Electrophysiology Services. Sosnoff Tower (ASU) supports all outpatient surgical procedural preparedness and stations. The hours of operation are 6:30 a.m. to 7:00 p.m. weekdays.

In addition to the surgical entity, the nurses are cross-trained to provide staffing for the Endoscopy Unit, Pain Management, Cardiac Cath, and EP recovery. The unit is under the direct supervision of an RN Team Lead and staffed by Registered Nurses, Patient Care Technicians, Unit Clerks, and a Scheduler.

Ambulatory Surgery Staffing Guidelines

ADC - 16	RN	PCT	USY
7a – 3p	5	1	1
3p – 11p	3	0	0

- Open 6:30a-7:00p
- Supported during day by a Unit Secretary and a Patient Care Technician
- Lead RN included in daily staffing to aid with patient flow
- Staffing is in accordance with ASPAN guidelines and is adjusted according to shifts in OR volume.





Northern Dutchess Hospital Infusion

SCOPE OF SERVICE

Infusion Center for Oncology and non-Oncology infusions, located in the Rosenthal Pavilion. Chemotherapy orders are provided by Oncologists (2), Oncology NP's (3) with a provider on site during working hours. The department includes Pharmacists (2), Coordinator (1), FT RN's (4), and PT RN's (3), PCT (1), Scheduler/USY (1).

All RN's have completed ONS Fundamentals of Chemotherapy, the Coordinator and 2 RN's have OCN Certification. Equipped with 14 chairs, including the swing room (4) and negative pressure/isolation room (1) and room with a stretcher (1) to accommodate a bed-ridden patient.

Non-oncology infusions (hydration, antibiotic therapy, blood transfusions, immunotherapies, and other treatment modalities) support hospital privileged Primary Care Physicians, Neurologists, Gastroenterologists, Cardiologists and Obstetricians treatment needs in the community. The Infusion Center is open from 7:30a-6:00p Monday through Friday and patient accommodations are made regularly to provide excellence in patient satisfaction. Coverage for non-oncology infusions is also provided on weekends as needed using on-call RN (ASU) or Med Surg Floor RNs as census dictates. The Oncology coordinator manages both cost centers and reports to Director of Surgical Services.

Infusion Staffing Guidelines

ADC - 40	RN	PCT	USY
7a – 3p	5	1	1
3p – 11p	5	1	1

- Department is open 7:30am-6:00pm, Monday-Friday.
- This department is supported by two pharmacists, a chaplain, a social worker and one RN unit manager.
- This department supports both chemo and non-chemo infusion.
- There is on-call RN coverage over weekends to accommodate non-chemo infusions.
- Staffing model is in accordance with ONS guidelines.
- Nurse-to-patient assignment is 1:3.





Northern Dutchess Hospital Operating Room

SCOPE OF SERVICE

Surgical Services is comprised of Operating Rooms, Post Anesthesia Care Unit, Central Sterile, Endoscopy, Infusion, Ambulatory Surgery, Pain Management, Pre-Surgical Testing and Anesthesia. These departments provide quality care using a multidisciplinary approach that reflects the mission of our hospital. Invasive, non-invasive, curative, diagnostic and palliative interventions are performed, utilizing evidenced based standards of practice. Coordination of services is provided through multi-tiered communication processes, both internal and external.

Comprehensive, individualized care is provided to our patients, age 6 months to geriatric, with consideration for the physiologic, psychological, and social needs of each individual patient and service population.

- Surgical Services is supported by: IR, Radiology, Pathology, Laboratory, Materials Management, Environmental Services, Facilities, BioMed, IT and other departments as required to care for patients. The Director of Surgical Services has responsibility to all areas in Surgical Services and reports directly to CNO.

STAFFING

At Northern Dutchess Hospital, we follow the AORN Staffing Guidelines:

- At a minimum, one perioperative RN circulator should be dedicated to each patient undergoing an operative or other invasive procedure and should be present during that patient's entire intraoperative experience.
- Having a practice environment with a minimum of one perioperative RN circulator dedicated to each patient undergoing an operative or other invasive procedure, for the duration of the procedure, will provide for safe, quality patient care in the surgical arena.
- Intraoperative: One RN per patient per OR in the role of the RN circulator. One scrub person per patient per room; may be RN or surgical technologist.
Additional staff members, with appropriate competencies, may be used as appropriate for the following:
 - complex surgical procedures and patients with compound needs may require additional RN circulator(s) and scrub person(s)
 - technological demands (e.g., lasers, robotics, audiovisual equipment, auto transfusion device)

- The OR is located on the third floor of Sosnoff Tower adjacent to Ambulatory Surgery and PACU. There are six operating rooms on the third floor and an obstetrical operating room located within the Neugarten Birthing Center on the second floor which OR staff support 24/7/365.
- The OR scheduler (2) office is located in Rosenthal wing.
- Family waiting area is located adjacent to ASU/PACU
- Staff consists of FT RN (7), Per Diem RN (5), Robotics RN Clinical Coordinator (1), Surgical Technician (9), OR Aides (2) Anesthesia Technician (2). An OR Manager and RN Charge (2) oversee the day-to-day operation and report to Director of Surgical Services. Manager and Director work closely with oversight of all aspects of daily operations and budget. Elective and urgent cases are scheduled using block time Monday through Friday from 7:30 am until 5:00 pm. Two Baylor teams (1) RN and (1) Surgical Tech rotate weekends from Saturday 7:00 am to Monday 7:00 am for any weekend cases added on. One on-call team is available for emergent cases until 7:00 pm and weekend coverage from 7:00pm Friday until 7:00 am Monday to back up Baylor team when needed.



Northern Dutchess Hospital PACU

Staffing should reflect patient acuity. In general, a 1:2 nurse-patient ratio in Phase 1 allows for appropriate assessment, planning, implementing, and evaluation for discharge, as well as increased efficiency and flow of patients through the Phase 1 area. • The need for additional Phase 1 RNs and support staff is dependent on patient acuity, complexity of patient care, patient census and the physical facility. • This also allows for flexibility in assignments as patient acuity changes. • New admissions should be assigned so that the Phase 1 peri-anesthesia registered nurse can devote attention to the care of that admission until critical elements are met. • Staffing patterns should be adjusted as needed, based on changing acuity and nursing requirements and as discharge criteria are met. • For the patient with isolation requirements (negative or positive), plans must be made to provide a safe environment with recommended staffing ratios maintained based on the acuity of the patient and type of isolation precautions. • The peri-anesthesia registered nurse will maintain appropriate staffing recommendations when planning for transport of patients in our out of the unit.

At NDH, we follow the ASPAN nursing standards:

CLASS 1:2 – ONE NURSE TO TWO PATIENTS

Examples may include, but are not limited to, the following: 1) Two conscious patients, stable and free of complications, but not yet meeting discharge criteria, 2) Two conscious patients, stable, eight years of age and under, with family or competent support staff present, but not yet meeting discharge criteria, and 3) One unconscious patient, hemodynamically stable, with a stable airway, over the age of eight years and one conscious patient, stable and free from complications.

CLASS 1:1 – ONE NURSE TO ONE PATIENT

Examples may include, but are not limited to, the following: 1) At the time of admission, until the critical elements are met; 2) Airway and/or hemodynamic instability. Example of unstable airway include, but are not limited to, the following: a) Requiring active interventions to maintain patency such as manual jaw lift or chin lift or an oral airway, b) Evidence of obstruction, active or probable, such as gasping, choking, crowing, wheezing, etc., c) Symptoms of respiratory distress including dyspnea, tachypnea, panic, agitation, cyanosis, etc.; 3) Any unconscious patient eight years of age and under, a second nurse must be available to assist as necessary, 4) Patient with contact precautions, until there is sufficient time for donning and removing personal protective equipment (PPE) – e.g. gowns, gloves, masks, eye protection, specialized respiratory protection – and washing hands between patients.

CLASS 2:1 – TWO NURSES TO ONE PATIENT

Example may include, but not be limited to, the following: One critically ill, unstable patient.

POST-ANESTHESIA CARE UNIT (PACU)

- PACU is located on the third floor of the Sosnoff Tower adjacent to the Ambulatory Surgery Unit and across from the Operation Rooms.
- The unit is a large room with nine individual bed areas and one isolation room (negative pressure room). Two swing rooms are available.
- The unit is staffed by FT/PT RNs (8). Team Lead to oversee daily operations and address staffing schedules and assignments. Per diems utilized as needed. Daily coverage from 7:00am – 7:00 pm or until patients are fully recovered. The nurses take weekend call from 9:00 am – 7:00 pm and weekend call from 7:00 pm –11:00 pm.
- ICU (Intensive Care Unit) staff recover patients during off-hours unless census warrants PACU extension of hours. If census is high in ICU, PACU RNs (2) open PACU on the third floor for emergency recoveries as needed.
- PACU RNs provide Phase 1 recovery to support Cardioversions and TEE procedures from IR department.



Northern Dutchess Hospital Endoscopy

SCOPE OF SERVICE

The Endoscopy Suite is located on the third floor of the Rosenthal Pavilion. The Endoscopy Suite supports (2) rooms dedicated to all procedures for upper and lower GI procedures. It is fully equipped to handle both elective and emergent cases. Endoscopy elective procedures are scheduled Monday – Friday 7:00 – 3:00 pm and staffed by ACLS RNs trained to perform all aspects of care. On-Call RN's provide coverage daily 3 pm – 7 am; Saturday and Sunday 24 hours coverage. Additionally, an Endoscopy Technician is trained and certified in scope reprocessing, located adjacent to both Endoscopy Suites.

The workflow includes RN (2) alternation between the two rooms. RN (1) is responsible for documentation and room turnover while RN (2) assists the provider with specimen collection, patient care and transport. An Endo Technician retrieves and processes all scopes and transports specimens to the lab. This facilitates an expedited process with an average room turn-around-time of 11.6 minutes per case, minimizing staffing expectations. (4) Physicians are credentialed to perform services. Patients are admitted and discharged in the Rosenthal Pavilion. Endoscopes are reprocessed in a decontamination room located adjacent to the Endoscopy suite under the regulatory guidelines of CMS and SGNA. All emergent foreign body GI cases are intubated and include Phase 1 recovery in PACU.

Endoscopy Staffing Guidelines

ADC - 8	RN	Endo Tech
7a – 3p	2	1

- Open Monday - Friday, 7a-3p
- Off-hours and weekends covered by on-call RN
- Endo Tech is trained and certified in scope reprocessing
- Patients admitted and discharged by ASU staff in Rosenthal Pavilion.
- Staffing is in accordance with CMS and SGNA guidelines.



Northern Dutchess Hospital Pain Management

SCOPE OF SERVICE

Pain Management patients are received on OPU in the Rosenthal pavilion for intake and recovery. (1) RN and (1) Surgical Tech rotationally assists in Pain room and is responsible for maintaining supplies to support (1) Provider. Ambulatory RNs admit and recover Pain Management patients. Pain Management is provided on Tuesdays from 7:30 am until 3:00 pm three Tuesdays a month. The pain room is adjacent to IR suite in Rosenthal wing. Radiology C-Arm supports service weekly. 14 patients are the average census each Tuesday.

Pain Management Staffing Guidelines

ADC – 14 (1 day/wk.)	RN	Surgical Tech	Radiology Tech
7:30a – 3p	3	1	1

- Open Tuesdays, 7:30am-3:00pm, 3 times a month.
- 1 RN and 1 Surgical Tech rotationally assist in pain room.
- Radiology Tech provides support when needed for procedure.
- Ambulatory Surgery RNs admit and recover the patients.
- There is a scheduler who provides support to this unit.





Northern Dutchess Hospital Interventional Radiology

SCOPE OF SERVICE

Interventional/Diagnostic Radiology is a medical specialty that focuses on diagnosis, treatment, and clinical management of patients using minimally invasive procedures guided by medical imaging.

Interventional radiology services support adult inpatients and outpatients in cancer care, urology, women's health, gastroenterology, musculoskeletal, endocrinology, cardiology, and nephrology. Our team uses X-rays, arteriography, computerized tomography (CT), fluoroscopy, magnetic resonance imaging (MRI), mammography, ultrasound, venography, and other advanced imaging techniques to obtain images in order to understand, visualize, and diagnose the full scope of disease.

There is a dedicated Interventional radiology suite located on the third floor Paul Rosenthal Pavilion. Additional procedures occur in radiology suites on the first floor Sosnoff Pavilion. IR/Diagnostic radiology procedures are scheduled Monday thru Friday, 6a-5pm.

EMPLOYEE OVERVIEW

The IR Leadership team is comprised of the Medical Director for Imaging Services, Director of Patient Care Services, Director of Diagnostic Services and Manager of Radiology.

In addition, the team consists of (3) Radiologists (2) Cardiologists (1) Breast Surgeons (4) Physician Assistants (7) Registered Nurses (15) Radiology Technologists covering multiple imaging modalities and (1) Scheduler.

Intake and Phase 2 Recovery are supported by ASU team when needed.

Northern Dutchess Hospital Interventional Radiology Staffing Guidelines

ADC - 15	RN	Tech
6a – 5p	4	3

- Staffing is adjusted to patient/procedure volume.
- One RN and one imaging tech (when needed) are assigned to each procedure.
- Procedures requiring sedation without an anesthesiologist require a second RN.
- This department is supported by an administrative scheduler.
- Tuesday and Thursdays an additional RN is scheduled to accommodate cardiac catheterization procedures.
- Procedures requiring hemodynamic monitoring require an additional RT or RN.



Northern Dutchess Hospital Wound Care Center

SCOPE OF SERVICE

Outpatient Wound Care Center and Hyperbaric Medicine
Open Mon-Fri from 8:00 am to 4:30 pm

Includes a team of doctors and nurses specially trained in wound healing and providing innovative, comprehensive, and compassionate care. Treatments include evidence-based wound care, bioengineered tissue/skin graft, wound evaluations and management, pressure off-loading, debridement, non-invasive vascular testing, infection control, nutrition counseling, hyperbaric oxygen therapy, specialty wound dressings, negative pressure wound therapy and lymphedema management.

EMPLOYEE OVERVIEW

- Clinical Staff consists of 1 Clinical Nurse Manager, 4 FT RNs, 3 PT RN, 3 Per Diem RNs and 1 Hyperbaric CHT Technologist.
- Admin. Staff: 1 FT Office Manager, 1 FT Front Office Coordinator (FOC) and 2 Per Diem FOC.

Wound Care Staffing Guidelines

ADC	RN	HBO Tech
>32	6	1
25-32	5	1
18-24	4	1
<18	3	1

- Open 8:00a-4:30p Monday - Friday, closed on weekends and holidays.
- Has a clinical nurse manager who provides oversight of daily operations, policies, and procedures. Can also provide clinical support when needed.
- Supported by front office clerical staff who provide secretarial support including scheduling, billing, insurance authorizations, homecare referrals.
- Two HBO-certified RNs whenever HBO patients are scheduled.



Title: Nursing Coverage Plan – NDH	Location/Owner: Administrative/Chief Nursing Officer
Approved by: See Ellucid	Effective Date: 10/2022
For Use At:	ID #'s if needed:
<input type="checkbox"/> Nuvance Health System <input type="checkbox"/> Other Nuvance Entities Not Listed <input type="checkbox"/> Danbury Hospital/New Milford (Campus) <input checked="" type="checkbox"/> Northern Dutchess Hospital <input type="checkbox"/> Norwalk Hospital <input type="checkbox"/> Putnam Hospital Center <input type="checkbox"/> Sharon Hospital <input type="checkbox"/> Vassar Brothers Medical Center	<input type="checkbox"/> Health Quest Systems, Inc. <input type="checkbox"/> HQ Home Care <input type="checkbox"/> HQ Medical Practice <input type="checkbox"/> Heart Center <input type="checkbox"/> Sharon Hospital Medical Practice <input type="checkbox"/> Thompson House <input type="checkbox"/> Other HQ Entities Not Listed

POLICY/PURPOSE:

A nurse staffing coverage plan will be implemented, assessed and evaluated on an annual basis in order to minimize usage of Mandatory Overtime (MOT) and be in compliance with New York State Laws and Regulations and the NYS Staffing Committee Regulations. The NDH Staffing Committee will participate in staffing decisions outlined by the law and the committee charter.

The plan will include:

- Electronic Scheduling System will display needs list on each nursing unit to fill vacancies
- Utilizing per diem staff, extra shifts, bonus shift and voluntary overtime as needed through broadcasting in the electronic scheduling system
- Evaluation of scheduled staff, skill set, and training to reallocate to high-need areas
- Maintaining a nursing float pool to fill sick calls and open shifts
- Maintaining a daily call log list of nurses called to prevent MOT

In the event that one of the following situations exists:

- A patient care emergency, as determined by the health care employer and used only as a last resort after the coverage plan has been implemented
- A federal, state, or county declaration of emergency in the county
- A health care disaster as reasonably determined by the health care employer
- 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

PROCEDURE:

The following process will be implemented to find replacement staff if needed to maintain safe patient care.

The staffing office will attempt to meet staffing needs by reassessment of needs and reassignment of staff on a shift-to-shift basis or by soliciting employees to work in following order:

1. Nursing floats
2. Per diem employees
3. Off duty part-time employees
4. Bonus shift
5. Off duty full-time employees

The Chief Nursing Officer will make the final determination as to whether it is necessary to utilize mandatory overtime.

Documentation Required:

1. Each incidence of MOT will be logged in the Nurse staffing shared drive. (see attachment A)

2. A hard copy will be printed with the call logs attached that indicate each step of the process noted above (reassignment of nursing staff and calls made to each of the other categories of nurse). This will be kept in a binder in the Staffing Office and be made available, upon request, to the nurse who is mandated.
3. The call log will document the staff member who called, the employee contacted, the date and the time of the call.
4. A broadcast to all eligible employees is stored in the electronic scheduling system.

The definitions of the applicable terms and the associated requirements referenced by the New York State Labor Law §167 Part 177.

Restrictions on consecutive hours of work for nurses are detailed below:

Definitions:

1. **Emergency** shall mean an unforeseen event that could not be prudently planned for by a health care employer and does not regularly occur, including an unanticipated staffing emergency.
2. **Health care disaster** shall mean 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, as more fully explained in Section 177.3 of this Part.
3. **Health care employer** shall mean any individual, partnership, association, corporation, Limited Liability Company or any person or group of persons acting directly or indirectly on behalf of or in the Interest of the Employer, who provides healthcare services (i) in a facility licensed or operated pursuant to article twenty-eight of the public health law, including any facility operated by the state, a political subdivision or a public corporation as defined by section sixty-six of the general construction law, or (ii) in a facility operated by the state, a political subdivision or a public corporation as defined by section sixty-six of the general construction law, operated or licensed pursuant to the mental hygiene law, the Education law or the correction law. Examples of a health care facility include, but are not limited to, hospitals, nursing homes, outpatient clinics, comprehensive rehabilitation hospitals, residential health care facilities, residential drug and alcohol treatment facilities, adult day health care programs, and diagnostic centers.
4. **Nurse** shall mean a registered professional nurse, or a licensed practical nurse as defined by article one hundred thirty-nine of the education law who provides direct patient care, regardless of whether such nurse is employed full-time, part-time, or on a per diem basis. Nurses who provide services to a health care employer through contracts with third party staffing providers such as nurse registries, temporary employment agencies, and the like, or who are engaged to perform services for health care employers as independent contractors are also included.
5. **On Call** shall mean when an employee is required to be ready to perform work functions and required to remain on the employer's premises or within a proximate distance, so close thereto that s/he cannot use the time effectively for his or her own purposes. An employee who is not required to remain on the employer's premises or within a proximate distance thereto but is merely required to leave information, at his or her home or with the health care employer, where he or she may be reached is not on call.
6. **Overtime** shall mean work hours over and above the nurse's regularly scheduled work hours. Determinations as to what constitutes overtime hours for purposes of this part shall not limit the nurse's receipt of overtime wages to which the nurse is otherwise entitled.
7. **Patient care emergency** shall mean a situation which is unforeseen and could not be prudently planned for, which requires nurse overtime in order to provide safe patient care as more fully explained in Section 177.3 of this Part.
8. **Regularly scheduled work hours** shall mean 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 health care employer.
 - For purposes of this rule, for full-time nurses, "the budgeted hours allocated to the nurses' position" shall be the hours reflected in the employer's full-time employee (FTE) level for the unit in which the nurse is employed.
 - If no such allocation system exists, regularly scheduled work hours shall be determined by some other measure generally used by the health care employer to determine when an employee is minimally supposed to work.

- Regularly scheduled work hours shall include pre-scheduled on-call time and the time spent for the purpose of communicating shift reports regarding patient status necessary to ensure patient safety.
- For a part-time nurse, regularly scheduled work hours mean those hours a part-time nurse is regularly scheduled to work pursuant to the employer's budgeted hours allocated. If advance scheduling is not used for part-time nurses, the percentage of full-time equivalent, which shall be established by the health care employer (e.g., a 50% part-time employee), shall serve as the regularly scheduled work hours for a part-time nurse.
- For per diem, privately contracted, 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.

§ 177.3 Mandatory Overtime Prohibition

- A. Notwithstanding any other provision of law, a health care employer shall not require a nurse to work overtime. On-call time shall be considered time spent working for purposes of determining whether a health care employer has required a nurse to work overtime. No employer may use on-call time as a substitute for mandatory overtime.
- B. The following exceptions shall apply to the prohibition against mandatory overtime for nurses:
 1. **Health Care Disaster.** The prohibition against mandatory overtime shall not apply in the case of a health care disaster, such as a natural or other type of disaster unexpectedly affecting the county in which the nurse is employed or in a contiguous county that increases the need for health care personnel or requires the maintenance of the existing on-duty personnel to maintain staffing levels necessary to provide adequate health care coverage. A determination that a health care disaster exists shall be made by the health care employer and shall be reasonable under the circumstances. Examples of health care disasters include, but are not limited to, unforeseen events involving multiple serious injuries (e.g., fires, auto accidents, a 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 increases the need for health care services.
 2. **Government Declaration of Emergency.** The prohibition against mandatory overtime shall not apply in the case of a federal, state or local declaration of emergency in effect pursuant to State law or applicable federal law in the county in which the nurse is employed or in a contiguous county.
 3. **Patient Care Emergency.** The prohibition against mandatory overtime shall not apply in the case of a patient care emergency, which shall mean a situation that is unforeseen and could not be prudently planned for and, as determined by the health care employer that requires the continued presence of the nurse to provide safe patient care, subject to the following limitations:
 - Before requiring an on-duty nurse to work beyond his or her regularly scheduled work hours to address a patient care emergency, the health care employer 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 its Nurse Coverage Plan. The health care employer shall document attempts to secure nurse coverage through use of phone logs or other records appropriate to this purpose.
 - 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, typical levels of absenteeism, and time off typically approved by the employer for vacation, holidays, sick leave, and personal leave, unless a Nurse Coverage Plan which meets the requirements of Section 177.4 is in place, has been fully implemented and utilized, and has failed to produce staffing to meet the particular patient care emergency. Nothing in this provision shall be construed to limit an employer's right to deny discretionary time off (e.g.: vacation time, personal time, etc.) where the employer is contractually or otherwise legally permitted to do so.
 - A patient care emergency will not qualify for an exception to the provisions of this rule if it was caused by the health care employer's failure to develop or properly and fully implement a Nurse Coverage Plan.
 4. **Ongoing Medical or Surgical Procedure.** The prohibition against mandatory overtime shall not apply in the case of 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.

Determinations regarding whether the nurse's continued active engagement in the procedure is necessary shall be made by the nursing supervisor or nurse manager supervising such nurse.

- C. Nothing in this Part shall prohibit a nurse from voluntarily working overtime. A nurse may signify his or her willingness to work overtime by either: a) agreeing to work a particular day or shift as requested, b) agreeing to be placed on an on-call roster.

§ 177.4 Nurse Coverage Plans

- A. Every health care employer shall implement a Nurse Coverage Plan, taking into account typical patterns of staff absenteeism due to illness, leave, bereavement and other similar factors. Such plan should also reflect the health care employer's typical levels and types of patients served by the health care facility.
- B. The Plan shall identify and describe as many alternative staffing methods as are available to the health care employer to ensure adequate staffing through means other than use of mandatory overtime including contracts with per diem nurses, contracts with nurse registries and employment agencies for nursing services, arrangements for assignment of nursing floats, requesting an additional day of work from off-duty employees, and development and posting of a list of nurses seeking voluntary overtime.
- C. The Plan must identify the Supervisor(s) or Administrator(s) at the health care facility or at another identified location that will make the final determination as to when it is necessary to utilize mandatory overtime. The Plan may require a nurse to assist in making telephone calls consistent with the Nurse Coverage Plan to find his or her own shift replacement but may not require a nurse to self-mandate overtime.
- D. The Plan shall require documentation of all attempts to avoid the use of mandatory overtime during a patient care emergency and seek alternative staffing through the methods identified in subdivision (b) of this Section. In the event that the health care employer does utilize mandatory overtime, the documentation of such efforts to avoid use of mandatory overtime shall be made available, upon request, to the nurse who was required to work the mandatory overtime provided, however, that the names and other personal identifying information about patients shall not be included unless authorized under State and federal law and regulations.
- E. The Plan shall be in writing and upon completion or amendment it shall:
- Be made readily available to all nursing staff through distribution to nursing staff, or conspicuously posting the Plan in a physical location accessible to nursing staff, or through other means that will ensure availability to nursing staff, e.g., posting on the employer's intranet site or its functional equivalent.
 - Be provided to the Commissioner of Labor, or his or her designee upon request

POLICY HISTORY:

Supersedes:

Original Implementation Date: 10/21/20

Latest Review Date:

Revision Date (List All):10/31/2022

Next Review Date: 10/24

Attachment A – MOT Report

APPROVAL:

VP Patient Care Service/CNO	Date: 10/21/2020
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MOT Report

Date	Unit	Shift	MOT Reason

Original Schedule Start Time	Original Schedule End Time	Total Schedule Time

Mandatory Overtime Start Time	Mandatory Overtime End Time	Total Mandatory Overtime

Supervisor	Staffing Coordinator	Employee

Nurse Coverage Plan Implemented

MOT Due to Unforeseeable Emergency

MOT Due to Unforeseeable Emergency Details

MOT Due to Unforeseeable Vacancies

MOT Due to Unforeseeable Vacancies Details

MOT Due to Any Declared National, State or Municipal Emergency

MOT Due to Any Declared National, State or Municipal Emergency Details

MOT Due to a Patient Care Emergency

MOT Due to a Patient Care Emergency Details