

Thank you to all the nurses who attended our special Title 22, staffing and acuity webinar last Wednesday. Much information was shared, and many nurses followed up with additional questions. There were requests to make the information available for all nurses. Please read this newsletter to learn more.

Staffing by Ratios and Acuity of Patients

Nurse to patient staffing ratios are only a *minimum* baseline for staffing. Every unit must have a patient classification system (acuties) that defines how units are staffed. Every Resource Nurse should be knowledgeable about the patient classification system. If you haven't seen the patient classification system for your unit, ask your manager.

The CRONA contracts also specify that a Resource Nurse may use professional judgement to determine staffing needs – keep reading for more information.

Does this mean that the total patients assigned to a nurse could be fewer than the basic ratio?

Yes. Staffing is determined by patient acuity according to the patient classification system. Depending on patient acuity, staffing needs may be more than the minimum according to ratio. For example, if patients are high acuity then the maximum number of patients assigned to a nurse in an ICU may be 1:1 instead of 1:2. How would a bedside nurse know if her assignment is excessive? By understanding the acuity of the patients.

The [CDPH](#) (California Department of Public Health) is the state agency responsible for public health, including licensing of hospitals and other health facilities, and enforcement of some California Health and Safety Codes. CDPH said this about staffing to patient acuity and ratios:

“It is imperative that hospitals staff according to patient acuity...It is far more important that hospitals pay attention to the patient classification system and the needs of the patient rather than the minimum staffing requirements.” -CDPH All Facilities Letter 07-26

What type of staff are included when determining staffing ratios?

Only the licensed nurses assigned to provide direct patient care to particular patients. There may be no averaging of the total licensed nurses on a unit. A nurse who is on a rest or meal break is not counted in the ratio while on break. A nurse who is off the unit to transport a patient (such as to CT scan or other testing) is not counted in the ratios for the patients who remain on the unit. A supervisor, manager, or Resource Nurse (Charge Nurse) may not be counted unless providing direct patient care. Float/breaker/Team Lead nurses are not counted in the ratios. When a Resource Nurse, float/breaker/TL nurse, or supervisor relieves a bedside nurse for a break, meal, or other routine absence from the unit, the Resource Nurse or other relieving nurse assumes full responsibility for the patient assignment and is counted in the staffing ratio only for the time spent relieving the bedside nurse.

Nursing assistants, unit clerks, and other staff are not counted in nurse to patient staffing ratios. Staffing for nursing assistants, sitters, patient companions, unit clerks, and other staff are determined by the unit's patient classification system. A unit is still understaffed if the patient classifications system calls for non-nurse staff and those staff are not provided.

Who determines the patient classification system?

The hospital is required to have a written patient classification system. The reliability of the patient classification system for validating staffing requirements must be reviewed annually by a committee; at least half of this review committee must be bedside nurses. The hospital must have a documented process by which all interested staff may provide input about the patient classification system, the system's required revisions, and the overall staffing plan. If you are interested in providing input about the patient classification system and do not know how to do this, ask your manager.

SB 227 Health and Care Facilities: Inspections and Penalties

Why does SB 227 matter? The short answer is money. When first enacted, Title 22 had no teeth. Hospitals could be cited for violations but there were no fines. SB 227 changed the law to impose fines if hospitals are found to be in violation of staffing requirements by both ratio and acuity, or if there is a deficiency that constitutes an immediate jeopardy violation. "Immediate jeopardy" means a situation in which noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Fines range from \$15,000 for first violation, then \$30,00 for second and subsequent violations of staffing ratio laws; immediate jeopardy violation fines start at \$75,000 for first violation, then \$100,000 for second violation and \$125,000 for third and subsequent violations. SB 227 was signed into law on October, 2019.

To read SB 227 for yourself: [SB-227 Health and care facilities: inspections and penalties](#)

To read the nurse-to-patient ratio language: [Title 22, Division 5, Chapter 1, Article 3, Subsection 70217](#)

CRONA Nurses have additional protections

Our contracts provide that a nurse's *professional judgement* is included in staffing decisions, combined with acuity and staffing matrices. Section 32.3.3.a (LPCH) or 33.3.3.a (SHC): "In meeting the staffing needs of the unit, the Resource Nurse is permitted to use judgment in adjusting staffing levels that may not be fully addressed by the acuity and staffing matrix."

The contracts also require each hospital to have a Nurse Practice committee, a joint CRONA-Nursing Administration committee that may review each unit's current acuity and matrix tool, and monitor the appropriateness of staffing levels by reviewing the Nursing Department's benchmarks and quality indicators.

Who is on the Nurse Practice committee?

Regular readers of CRONA newsletters may recall that in July, CRONA requested volunteers to serve on the Nurse Practice Committee. At SHC, the CRONA members of the Nurse Practice committee are Colleen Borges, CRONA President; Kathy Stormberg, CRONA Vice President (Imaging Services Float Pool); Charon Brown (ICU J2, cardiac), and Annamarie Varo, CRONA Secretary (Operating Rooms). At LPCH, the CRONA members of the Nurse Practice committee are: Colleen Borges, CRONA President (Bass Center, pediatric hematology/oncology/BMT); Eileen Pachkofsky, CRONA Vice President (Bass Center, pediatric hematology/oncology/BMT); Carrie Bommarito (Neonatal Intensive Care Unit); and Nancy Uschersohn (Intermediate Care Nursery).

Competency: Required by law

By law, in order to be assigned to provide care, every nurse must demonstrate current competence in providing care in that area, and have also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. Even for providing breaks, a manager or supervisor must have demonstrated current competence in providing care on a particular unit.

Meal and Rest Breaks

The hospital is required to provide you all of your rest and meal breaks on each shift. Staffing ratios must be maintained while you are on your break. A nurse who is on a break is not counted in the staffing ratios for the duration of the break. If you are not provided opportunities to take all your breaks, you are entitled to missed meal/missed break penalty pay. Penalty pay is one hour of straight-time pay for missing a meal break; penalty pay for one or more missed rest breaks is one hour of straight-time pay total. **Not receiving all of your breaks is also a reason to file an ADO.** Breaks should also be provided at reasonable time intervals. For more on breaks, read [this article on breaks](#) from CRONA's newsletter archives.

Webinar Q & A

By request, questions and answers from this week's webinar

Q: I think one of the issues in the ICU is that we are currently handling the situation but we are worried that if a code should happen or a crisis happens with 2 patients at the same time, we don't have the resources to cover the situation with such a tight matrix.

A: You should be concerned; this could affect patient safety. We create work arounds for ourselves but we need to stop this behavior and write out an ADO. The more we ALL speak up the better we will be heard. Also, the Resource Nurse does have the ability to go up on staff if necessary, in her/his judgement.

Q: Hi, good evening everyone. Lane OR staff was asking how do we apply Title 22 in the Operating room?

A: Title 22 ratios include the OR: *"The surgical service operating room shall have at least one registered nurse assigned to the duties of the circulating nurse and a minimum of one additional person serving as scrub assistant for each patient-occupied operating room. The scrub assistant may be a licensed nurse, an operating room technician, or other person who has demonstrated current competence to the hospital as a scrub assistant, but shall not be a physician or other licensed health professional who is assisting in the performance of surgery."* The nurse assigned to a particular case must be competent for the assignment. For example, a nurse who is only trained for Orthopedic cases should not be assigned to a case in the Cardiac service.

Q: Management states "q30 interventions for 2 hours or more" constitutes criteria for 1:1 staffing in the ICU, but what constitutes interventions? Turns? Hanging meds? Clean ups? Or just drip titrations, starting CRRT etc? Very unclear.

A: CRONA agrees that this is unclear. Everything you listed sounds like an intervention to CRONA. The Director of Nursing for ICU was asked to attend the next Nurse Practice committee meeting to discuss patient classification in the ICU. CRONA was provided with a document from the ICU that states the criteria for 1:1 assignment, but it is unclear and one part of it appears to violate the law.

Q: What do you do if you are being questioned/interrogated if you question an assignment safety or take a "late" break?

A: Fill out an ADO, including the manager's response to you. Also file for missed break in API. If they question further copy CRONA in an email so we can take it up the chain of command.

Q: What about manager telling the Resource Nurse that the office assistant is going to cover the Resource Nurse while the RSN takes a full patient assignment to avoid a staffing problem and the office assistant will manage the RSN phones?

A: That sounds like one of the craziest things we've ever heard. An office assistant cannot replace a Resource Nurse. If the Resource Nurse takes an assignment, s/he cannot remain Resource. The manager on duty would need to come in and take over Resource duties. That's part of their job. At this point, the Resource should already have called Staffing, called the manager on duty. When seeking help, describe the situation, and specifically ask for what you need. "We are short two nurses. I called Staffing and there are no Float Pool nurses available. The Nursing Supervisor is not able to move any patient to another unit or provide additional assistance. I have called 20 nurses to ask for SNC and no one can come in. I need you to come in and help." **And write an ADO.**

Q: On J2 (Cardiac ICU), newer nurses who are in line to do formal ECMO education are being told to break nurses with ECMO patients in order to give them experience with ECMO. They've been told by management that it's safe because there are resources (other nurses with ECMO experience & training). The newer nurses think that the formal training will not be given to them if they speak up.

A: This is very wrong. A nurse who has not completed training is not competent to provide care. Speaking up about this protects the patient, protects the nurse, and protects the hospital from liability. Politely inform the manager that as an ECMO trainee you cannot be considered "in the count" for an ECMO patient. Write an ADO about this attempted assignment. CRONA will be happy to provide education for your manager at Nurse Practice, and senior hospital administration will also not want the hospital exposed to liability by having a nurse without appropriate competencies caring for an ECMO patient.

Q: I was pulled into the office and spoken to because I questioned the safety of two Nurses with ECMO patients were supposed to break my 2-patient assignment. I then had my nursing capabilities questioned because it had been done a few days in a row, and why can't I handle it. It has gotten to the point that I feel threatened to speak up because I feel like I am in trouble of getting in written trouble, or have my advancement on the unit blocked.

A: This is very sad; it is a good example of how when we nurses accept inappropriate assignments, we hurt other nurses as well as compromising patient safety and breaking the law. When you "take one for the team" you're really "sticking it to the team". One response could be to tell your manager that you are not willing to take a break in a way that violates the law, and it sounds like there is some education needed for the unit. **Write an ADO** so that your manager will be required to attend a Nurse Practice committee meeting and receive education from CRONA and senior Nursing leadership.

Q: Sometimes, even if we get our meal breaks, we still need extra help in the room at night. The float can be busy with 4 rooms and we don't have NAs. What if staffing can't give you NA?

A: If your staffing grid calls for a Nursing Assistant and Staffing cannot provide one, then you are short-staffed. Ask the Resource Nurse to ask for another nurse if there is no NA available. If no help is available, please remember to write an ADO.

Q: This may seem redundant, but to clarify, if I have a 1:1 assignment I should legally NOT be the break nurse for my neighbor who also has a 1:1 assignment?

A: Correct! If the patient classification system/acuity calls for 1:1 assignment, you may only be provided a break by a nurse who is not assigned to any other patient.

Q: What is the competency policy on nurses not trained on ECMO taking care of an ECMO because they are next in line to be trained or attend a class?

A: Tell the manager immediately that you are not qualified for the assignment. **Write an ADO.** The hospital requires that a nurse caring for an ECMO patient must have the ECMO competency. A nurse without the competency may only care for an ECMO patient as a preceptee working with an ECMO-competent preceptor.

Q: Our manager asks our RSN to let the NA go home at 2-3am because we are over the grid. Then they want us to have early mobility at 0600.

A: If you require the NA for early mobility at 0600 the Resource Nurse can make the determination to keep the NA by explaining to the manager the very specific needs of the patients and then document this on the staffing sheets. Some managers can't see beyond their budget paperwork to the safe patient care we must provide.

Q: What does it mean to be "trained on equipment"? Does this mean you have to take a class? Does quick one-on-one education count? More specifically, can you take an ECMO patient without taking an ECMO class and are educated during your shift?

A: You have to take a class...period! We have been designated as an ECMO Center for Excellence; we require a formalized class and competency now.

Q: Are we allowed to post CRONA info, such as ADO forms in our break room?

A: You are allowed to post information to your unit's CRONA Board, and every unit must be provided with a place to have a CRONA Board. If your unit does not have one, send your manager an email to ask about getting a CRONA Board and

make sure to copy crona@crona.org on the email. Earlier this week, when a nurse emailed a manager to ask about getting a CRONA Board and the manager denied the request, CRONA had been copied on the email and was able to respond immediately. The result was that the manager immediately agreed to provide a CRONA Board.

Q: The CAPR 300 Nurses were recently told that we were going to start floating to Lane surgery, main OR Pacu and also 500 P without any training. They said that since we had basically the same skill set.

A: CAPR 300, Lane PACU, and 500P PACU are all within the same region, so may float to one another per the hospital's Floating Policy. Assignments should be appropriate for the skill set of the nurse, and the nurse must be oriented to the physical location in order to be able to provide patient care safely.

Q: Has there been real life examples of nurses being deposed and did not have an ADO to protect them?

A: An ADO will not protect you from being held responsible if something happens to your patient. When nurses file ADOs to report issues, we create a work culture where unsafe situations are less likely to happen. Always act in defense of your nursing practice.

Q: Can resource have full float assignment? (ICU's)

A: No. The Resource Nurse is able to provide breaks but the definition of being the Resource Nurse is to be a resource to the entire unit.

Q: How long can we go out of ratio?

A: We can't! Ratios need to be maintained *at all times*, even during breaks or when a nurse has to leave the unit.

Q: Do you still write an ADO if manager tries to fix the situation? I was told you need to tell manager and if she doesn't fix the situation then write ADO?

A: It is still appropriate to write an ADO if the manager is contacted and fixes the situation. You would include that information in the ADO. The Nurse Practice committee still wants to examine what created the situation in the first place.

Q: We need that copy of SB 227 and Title 22!

A: See links above. Easy to find with a search of the internet.

Q: Basically, you said an ADO is done to get help. But what does it do then after a nurse exhausted all to ask for help to make an assignment safe and nothing was done or done in a timely manner and because of that something happens to a patient?

A: An ADO is documentation of a situation that brings attention to issues at a level above the unit. ADOs are used to address systemic issues. When we create a nursing culture of not accepting unsafe assignments without protest then we help create a working culture where unsafe patient care situations are less likely to happen.

Q: Is this webinar going to be available to point to for those RNs that were not able to see it or participate in it? I think this is exactly the information that needs to be spread to all the Resource and other RNs in the ICUs (J2, J4, M4, K4, and E2.) Especially with all of the brand-new Resource Nurses (literally 3 days of experience. and less than 1-year experience in the ICU.

A: This information will be made available in this CRONA newsletter. The newsletter will also be on the crona.org website.

Q: What if a nurse is scheduled on call after 12 hours of work, and they get off at 6 p.m. Management ask them to start there call early at 6 pm ... is it not double time or is it 1 and 1/2 times pay because call is paid at a different rate?

A: All time past 12 hours is paid as double time.

Q: Let's say we file a bunch of ADOs related to acuity-based staffing, and nothing changes... how do we get the state to stop by?

A: "The state" is CDPH, California Department of Public Health. They have a website with contact information.

Q: I work in an AAU unit primarily staffed at an IICU acuity. So for 22 beds we normally call for 8 and 11 at most. This is including one RSN and one float. Recently, I've noticed that the float is the one entirely required to break all the RNs

including the RSN, with the RSN going on break along with another RN who is also off the floor. I have brought up that it is not possible to send people on breaks timely with just one float to break all RNs on top of helping support the rest of the floor as needed. Is this the new expectation.

A: If you have 11 nurses on the unit, including the float and RSN, that is 9 nurses assigned to patient care. Nine nurses multiplied by 1 hour 15 minutes total break time per nurse equals over 11 hours of breaks, plus the 2 ½ hours of breaks for the float and RSN. One float cannot provide that many breaks. The RSN can assist with breaks as time permits, but it sounds like the only way for all nurses to take their breaks is to break ratio which is not acceptable and should result in an ADO. If you are offered a break by a nurse who is already covering a different nurse's break and the total assignment for the break nurse puts the break nurse out of ratio for the duration of the overlapped breaks, then that is a violation of Title 22. In that case, you should politely decline to take the break until you can be given a break without breaking the law. If you do not get your break in a timely manner, file for a missed break.

Q: Picking up a 4-hour or 8-hour ECB, what is the break times required?

A: One paid 15-minute rest break for a 4-hour shift; One unpaid 30-minute meal break and two paid 15-minute rest breaks for an 8-hour shift. It does not matter if it is a regularly scheduled shift or ECB.

Q: I was questioned this morning as RSN as to why my nurses that started at 5:30 am didn't start their patient prep until 0537 and 0548 even though we had 7 cases from 5:30 to 7am. I was told that this was not optimal and has to change. I explained that they were logging on and checking out their patients and checking out their orders. This is why the office assistant will be covering the RSN role in the morning as the RSN takes an assignment. This came from our Department manager.

A: Please send CRONA an email about this, with exactly who you spoke to, what time, what was said. You may also send the manager an email to confirm your understanding of what was said to you and copy CRONA on the email. An office assistant can answer phones but may not assume the RSN role. That is outrageous. Nursing units are run by nurses. Non-nursing staff should not be making patient assignments or having anything to do with clinical decisions or clinical activities. If a nurse is reviewing orders *that is patient prep* and the nurse should have charted starting prep before looking at the orders. The RSN can help bring patients back, assist nurses with tasks to allow them to process patients more quickly, handle situations with more challenging patients (mobility and language issues, complex families, missing/incorrect orders and consents, service animals, etc.). The RSN needs to be available in order to do this.

Q: Our manager said we can go out of ratio for up to 2 hours "in crisis" without violating CRONA contract. True or False?

A: That is absolutely false. If you go out of ratio it is the law that is broken, not the contract. When you hear something that sounds suspect, send the manager an email and ask for confirmation. Any manager who would say that needs to be educated.

Q: Can more than one nurse sign an ADO? Will it be available in our current form?

A: It has less of an impact if multiple nurses sign one form. It is better to have each nurse complete a form.

Q: If these specifics are written down in a format that can be printed can we then post that on our Non-existent CRONA boards in the breakrooms?

A: Yes, you may print this newsletter and put on your unit's CRONA board. If you do not have a CRONA board, email your manager and Cc crona@crona.org on the email. Let's get your unit a CRONA board.

Q: Can you talk about the new "acuity-based staffing" that is supposed to go into effect Jan 2020. I've been hearing about this recently but not in detail.

A: CRONA is not aware of something for acuity-based staffing going into effect in 2020. Staffing based on acuity has been part of Title 22 since the beginning over 15 years ago. It may be that you are hearing more about it from the hospital now because SB 227 was signed into law in October 2019 and now hospitals will pay large fines if found to not have appropriate staffing and not able to demonstrate adequate effort to have appropriate staffing.

Q: Where can I find this acuity-based staffing system at SHC. Is it a policy I can access?

A: It should be, every Resource Nurse should understand this. Please ask your manager and copy CRONA on the email or let us know your manager's response.

Q: Is there an acuity number that requires a patient to be a 1:1 in the ICU?

A: That would be part of the patient classification (acuity) system. This information should be readily available to every Resource Nurse, so any staff should be able to review also.

Q: Per manager statement that Lane, 300p and 500p are now one, staff can be assigned to any location as needed per skill, even without any proper orientation (a tour of the place is what we only had).

A: The lack of training for OR nurses to new areas is something that CRONA is already following. If you are given an assignment to an area that you have only toured, you should be provided an orientation before being required to work there. Examples of how lack of orientation affects staff and patient safety: do not know where to obtain supplies, leading to delays in retrieving supplies and increasing surgery time (unsafe for patient); do not know where gas shutoff, fire alarms, crash cart and emergency supplies located (unsafe for staff and patient).

Q: Our charge RN's are now in the position where they are choosing an RN over having a secretary to have a body that we desperately need on the floor. No float RN, no NA (on a very busy medicine floor). They are now covering the desk & breaks, on top of charge duties. However, technically this was their "choice" to sacrifice a clerk in order to have another body on the floor. Is this ADO appropriate?

A: Yes, absolutely. It was not a "choice" to have only unacceptable options. The secretary should not be included in the count of nursing staff. If you only have a Resource Nurse and no float or unit clerk then you are down 1 RN and 1 UA.

Q: Is there a way we can print the ADO forms and be kept in the unit? Sometimes we barely have time to chart in our busy ICU, that's why ADOs aren't filled up.

A: Yes, you may print and keep on your unit's CRONA board. Some areas have them at the front desk.

Q: Can we get a list of what constitutes an ADO? I had no idea if I am 1:1, I should not be floating for another 1:1 patient. That's the EXPECTATION.

A: It's basically any situation that potentially affects patient safety or violates a law. Your example would be violations of staffing ratios. From the ADO form, here are the options:

- I was not trained or experienced in the area assigned
- I was not given adequate staff for patient acuity
- New patients were transferred or admitted to unit without adequate or qualified staff
- I was given an assignment, which posed a potential cross-contamination risk to my patients
- I was involuntarily forced to work beyond my scheduled hours
- The unit was staffed with excessive registry
- The unit was staffed with unqualified personnel
- Equipment and/or supplies were inadequate for patient care
- Violation of staffing ratios (including break times)
- Other (please state):

Q: We do not have a CRONA board.

A: Email your manager to ask for a board, and copy crona@crona.org on the email.

Q: Are all 5150's 1:1? We have been told they are 1:1 only if psych puts a note in that recommends 1:1

A: All 5150 patients must have 1:1 supervision at all times. That may be a sitter at the bedside at all time or it could be a NA or RN; it should not be a patient companion (not allowed to touch patient). If the nurse is not the sitter and the patient does have a sitter, then the nurse may have other patients.

Q: So, should the Resource nurse not be giving meal breaks? or just not taking a full assignment?

A: The Resource Nurse may help give breaks when time permits, but should not have a patient assignment.

Anonymous Attendee 09:43 PM

Q: AAU units: if the float ends up taking a patient assignment with only one patient, will she be required to break another nurse with only 2 other patients. Does taking a patient, even if just one disqualify me from breaking staff and basically off the float role?

A: If the total assignment is within ratio for the float, then it does not matter how many nurses are being covered on breaks. As long as no single nurse has an assignment that is out of ratio – it is not permitted to average assignments. In the situation you describe, if both nurses go on break and turn their assignments over to a float who is now caring for 3 total patients in an AAU, that is acceptable provided that the total patient acuity calls for one nurse to care for those 3 patients.

Q: From an AAU: What if the ratio allows me to double break but the acuity doesn't? If as a float I have one patient but another RN has a two patient assignment than is a two patient because of their high acuity, how is that safe? Yes, that's within ratio but not acuity.

A: That is not a safe assignment and you should not take this assignment. Being out of acuity is the same as being out of ratio – it is a violation of Title 22. Here's another issue: if the hospital is fined due to violation of staffing laws in this situation, you may be disciplined for taking the unsafe assignment. You could be told that you should have known not to take that assignment.

Q: Lane Surgery Center and 300P been using off shift staff to fill up staffing for the morning, that's make off shift staff short to give breaks.

A: Then the off shift should ask for assistance giving breaks, such as asking an APCM to stay over and assist with breaks. Nurses who do not receive their breaks or do not receive their breaks at an appropriate time should file for missed breaks and write an ADO. The off-shift Resource Nurse should be asking for assistance and advising staff to file for missed breaks where applicable. CRONA has heard that nurses in your area who work 10-hour shifts are being required to take all their breaks for their shift in the first 5-6 hours of the shift, leaving a 4 or more hour span of time with no break – that is a violation of the law and these nurses should be putting in for missed breaks and writing ADOs.

* INFORMATION IN THIS ARTICLE IS CURRENT AS OF THE DATE OF PUBLICATION OF THIS NEWSLETTER. FOR MOST CURRENT INFORMATION, PLEASE REFER TO MOST CURRENT VERSION OF STATE AND FEDERAL LAWS AND THE CRONA CONTRACT.