CRONA Newsletter January 19, 2020

Announcement: CRONA Scholarship Recipients

CRONA continues to strive to support nurses in their work and the development of their nursing profession. Each year CRONA awards 12 educational scholarships of $500 each to help defray the costs of continuing studies in nursing or a related field at the Bachelors, Masters, or Doctorate level. It's exciting to see that each year we continue to have many more applicants from previous years. The following criteria is used to determine the awardees: 1) seniority based on adjusted hire date; 2) worked at SHC and/or LPCH more than 12 months at the time of application; 3) CRONA member in good standing; 4) enrolled in the study of nursing or related field; and 5) priority is given to those who have not previously received a CRONA scholarship.

We are pleased to announce this year's recipients:

Vanessa Nevarez
Brian Lee
Rechille Realse
Sandra Wicks
Thomas Carella
Riki Przytula
Jan Leslie Bunting
Whitney Weyhing
Sierra Kline
Arielle Binsky
Tiffany Tan
Ryan Seeberger

Thank you for your continued support and dedication to CRONA. Wishing you all peace, love, and prosperity this year.

Sincerely,
The CRONA Board

Check Your Paychecks

In the last newsletter we discussed doing a review or your retirement savings contributions to make sure you are set up to take advantage in the annual increase in IRS maximums for pre-tax 403(b) retirement savings.

Several nurses were prompted to also review their entire paychecks, and discovered errors in PTO accrual and incorrect deductions for the optional legal plan. Let this be a reminder that it is always a good idea to *check your paychecks* for accuracy. If you find an error you must open a ticket with HR and we *strongly suggest* that you also notify CRONA. If you send an email, copy crona@crona.org on the email. It has happened in the past that a nurse found an error that was addressed as a one-off by HR and it turned out to be a system error affecting multiple nurses. CRONA was able to follow up with the hospital about the systems issue only because we started hearing the same errors from multiple nurses. Letting CRONA know about errors is how you can help us help other nurses. Thank you to everyone keeping lines of communication open.

*IRS Limits On Contributions Increased For 2020 **(LINK)***

The limit on elective deferrals - the most an employee can contribute to a 403(b) account out of salary - is $19,500 in 2020 ($19,000 in 2019). Employees who are age 50 or over at the end of the calendar year can also make catch-up contributions of $6,500 in 2020 ($6,000 in 2015 - 2019) beyond the basic limit on elective deferrals.

Update On LPCH-Fidelity Issues

** If you have an issue with your retirement account, you must submit a ticket through Ask Payroll **

CRONA and the hospitals have come to an agreement regarding how the hospitals will be addressing various issues with errors made to some nurses' Fidelity accounts. LPCH Nurses can expect to receive a letter from the hospital with more details this month. These issues were brought to CRONA's attention by nurses who regularly review their paychecks and retirement accounts for accuracy. Every nurse should review every paycheck for accuracy, and check your retirement accounts.

Kin Care/CESLA Hours Reset January 1st

You are entitled to use one-half (1/2) of the annual accrual of the paid leave for Kin Care/CESLA in any payroll year, provided you have enough accrued leave available. Employers may not retaliate or take disciplinary action based on an employee's use of Kin Care leave. You do not receive attendance points for Kin Care/CESLA absences. You may use this leave for a full or partial shift, depending on your need. To use Kin Care/CESLA leave, you must state that you are using the leave and identify the category of eligible family member for whom you are taking the leave. For example, "I am calling out Kin Care for my spouse."

Make sure your time is coded correctly on your time card. At SHC, it is called PTO – KIN in API; at LPCH it is called PTS CESLA in KRONOS.

To know how many hours you may use in a year you must know your FTE and accrual rate, since the time you may use is half the hours of PTO you would accrue in a year or ESL you would accrue in a year. See the table for PTO accrual from the CRONA contract (LPCH Section 9.1.3/SHC 10.1.3):

Years of Service	Time Accrued Per Hour Worked	Projected Annual Hours For Full-Time 8-Hr Employee	Projected Annual Days For Full-Time 8-Hr Employee
First year of employment	.1000	208	26
2nd through 3rd year	.1193	248	31
4th through 9th year	.1385	288	36
10th & subsequent years	.1500	312	39

ADO: Assignment Despite Objection

Asking For Help In Real Time, Help Identify System Issues

Submitting an ADO when there is an issue should be part of the nursing culture at Stanford and Packard hospitals. They are intended to document a nurse's request for help or identifying issues in real time, and to bring high-level attention to system issues.

When there is a situation that calls for an ADO, first try to get help *in real time* by following the chain of command: Resource Nurse, Manager on Duty, Nursing Supervisor. To escalate further, contact the Director on Duty. Provide the information about the situation and specify what is needed to resolve the situation. Document your request and the response received on the ADO form.

Resource Nurses, you should all know how to request staffing assistance – including notifying the Nursing Supervisor and your manager on duty. You should all know that all breaks must be provided according to the law. You should remind nurses who do not receive their breaks in accordance with the law to add a missed break to API (SHC) or add the missed break to the staffing sheet (LPCH). The nurses assigned to direct patient care rely on your leadership and example.

Here are some of the issues for which submitting an ADO is appropriate:

- Violation of staffing ratios, *including during rest and meal breaks*
- Not trained or experienced in the area assigned (including equipment such as ECMO or CRRT)
- Inadequate staff for patient acuity (acuity may require more staff than minimum ratios)
- Equipment and/or supplies were inadequate for patient care
- Patients admitted or transferred without adequate or qualified staff
- Involuntarily required to work beyond scheduled shift
- Unit staffed with excessive travelers or unqualified personnel
- Other (please describe)

Need the ADO form? It is on the CRONA website at the top of the home page, or click HERE for ADO form.
http://crona.org/resources/forms/

Your Questions & Our Answers From January Member Webinar

Q: My concern with the APCMs and educators on the floor (which is very helpful, don't get me wrong) is that the staffing need is not being reflected. Our unit was full with 10 pts, and we had 8 nurses, but two managers and two educators were on the floor actively performing patient care — so a total of 12. That's not being reflected because of the grid. So how Do we get that point across?
A: There was an AAU whose grid actually stipulated use of managers and educators in the count. That does not make sense; they have their own jobs to do and shouldn't be part of staffing as a matter of routine. SHC has decided to review grids. The individual complaints of nurses and ADOs filed led to nursing administration actually looking at the grids and discovering they are not good or consistent across units. It is OK to write an ADO when staffing needs are being covered by consistently using managers and educators. It brings the staffing problem to a higher level of attention. It may be your manager isn't being allowed to have additional FTEs and this can help your manager advocate for additional staff. Keep speaking up and writing ADOs!

Q: What is our job as the bedside nurse when we feel our assignment is unsafe? We let our charge RN know…then what? Do we personally contact our manager? supervisor?
A: Yes, you may do that if you feel the issue is not being resolved. Over and over, managers say they want to be notified if there is an issue. Also let your Resource Nurse know that you are writing an ADO, and specify what you need. For example, "I need my assignment to be split".

Q: Okay, so if the charge RN is unable to fix the problem, then we need to ask for the name and number of the on-call APCM and call them personally?
A: Yes, you can do this. When we meet with the managers, they all say they want to hear from nurses if there is an issue. It is nothing against the Resource Nurse, either. Ask the question of your Resource, "have you notified the manager on call?"

Q: Many are wondering why it is so difficult to for management to get nurses ECMO certified. Their response is that it is hard to put together lecturers especially MDs. Can the MD group and Dale help in making sure the certifications get done sooner?
A: Thanks to the many nurses who wrote ADOs in the last few weeks, CRONA had significant documentation to advocate for additional ECMO classes. The CNO did finally take an interest in the ECMO training issue. The MD group has agreed to having a class in January, in addition to the class scheduled in March.

Q: We often have three nurses all breaking each other especially on the night shift. Two RN with 1:1 assignment while the other has a 2:1 assignment. This is done pretty often in our unit to fit the grid, and free up floats for the other RNs. Isn't this a violation of title 22 if I'm understanding correctly?
A: Yes, this is a violation of Title 22. First, you must staff by not only ratio but also acuity. That means that if your patient is staffed as 1:1 because of acuity you must only be relieved for break by another nurse who does not have *any* other

patient assignment. If two nurses each have a 1:1 assignment because of patient acuity they may not relieve each other for break. Please speak up if you are asked to do this and write an ADO so CRONA can follow up with your management.

Q: Will you be able to look into the amount of call the Interventional platform is requiring from staff to fully staff a work day? It seems like the hospital does not honor your original work commitment when now you are working more than ever. Managements response is "people want the money."
A: If management is responding with, "people want the money" then obviously they are not listening to you. Unfortunately, the hospital has the right to determine the number of on call hours are needed. In 2016 we negotiated that you may not be assigned mandatory on-call for more than 12 hours a week. When you sign up for on-call you are volunteering so that doesn't count. They must honor your work commitment for the number of scheduled hours that are not on-call.

Q: Kindly reiterate that it is not a real break if nurses chart during their breaks so they will not stay over.
A: It is not a break if you work during your break. When nurses give up their breaks voluntarily it creates the impression that staffing and workload are well-balanced and there is no need to increase staffing or reduce workload. Nurses who do not chart on their breaks have even been called in for an investigation into their "time management" because they are the only ones staying over to chart while other nurses use their breaks to chart or clock out and then finish charting. When you chart on your break or clock off after your shift before you finish charting *you are hurting the nurses who are honest* about their activities. Please stop doing this.

Q: In our huddle, we were told by management to not tell patients that we are 5:1 or that we are short staffed.
A: You do not have to "lie". It can make patients anxious about the quality of their care if you describe our staffing problems. It is better to say something that is true but more ambiguous like, "it's a very busy shift tonight but I will be doing everything I can to take good care of you."

Q: I spoke with one of our attendings and he said he asked the directors to declare a state of emergency for staffing. Is that a thing, and what does it take to be in that position? Because it sure seems like we are there…
A: There is something called a Critical Staffing Shortage (see appendix A of the Floating Policy) that is declared on a shift-by-shift, unit-by-unit basis by the Nursing Supervisor. It is a requirement that CRONA be informed if this happens. It has not happened in many years. If your unit is in crisis and you think this should happen, the Resource Nurse should call the Nursing Supervisor to discuss.

Q: Why has a critical staffing shortage not been called on J2? Is there any reason management would avoid doing this?
A: I do not know, the ADOs we received over the holidays indicated that there was a huge staffing problem on some shifts. This is a question to ask Nursing Supervisors.

Q: For CVICU at LPCH, how do we go about getting the additional staff for appropriate break coverage? Should we have a discussion with the managers and CRONA to determine how many additional break nurses we will need to maintain staffing based on acuity? Or do we start filling out ADOs right away? I previously sent an email and thank you for your reply.
A: If you do not have sufficient staff for break coverage within ratio and acuity, the RSN should notify the manager on call and the nursing supervisor, and request assistance. Write an ADO. *Every time.*

Your staffing grids are part of the "patient classification system" that is required by Title 22. Title 22 requires that the patient classification system be reviewed at least annually by a group that is at least 50% bedside nurses. Also required by Title 22 is that there be a way for every nurse to provide comments about the patient classifications system. Ask your manger how you can do this by sending an email and Cc CRONA on the email. Likely your manager will not know and CRONA leadership can follow up with senior nursing leadership. We've already found at Stanford that no one seems to know how this provision of Title 22 works. We all need to keep asking the questions that nursing leadership is supposed to know the answers to.

Q: Yes. We were guilty of doing these breaks at E29 mainly because we did not know any better and we thought we were helping each other. We realized at J2 that this is a risk and a safety issue because we no longer have a direct line of vision and access in the now private rooms. We cannot rely on monitors in a high acuity setting alone.
A: Exactly…. do not "float" for each other! Safety first, protect your patient and protect your license.

Q: I work in the AAU float pool and float between 300 & 500P. I've noticed since the new hospital opening on medicine, med surg & oncology floors we are often receiving assignments with 4 or 5 patients and no NAs. Meaning that we have all total cares. Is this the new trend or are certain units not staffing appropriately with the new grid? The step downs like J5, J7 etc... seem to always have an NA or two. Is fewer NA support something we should expect with the new grid?
A: Because of ADOs and concerns raised by the AAU nurses directly to senior nursing leadership, the Stanford nursing senior leadership is now aware that the staffing grids have a lot of unit to unit variability. There was also an AAU that was trialing a staffing model of no Nursing Assistants…. it was a huge failure and CRONA was informed that it is going to be discontinued. Nursing leadership is now looking at the grids. Nurses need to continue to be vocal and ask about being included in review of grids as it is required by law to have 50% bedside nurses when reviewing the patient classification system.

Q: Can they force us to be a charge nurse to another unit, example from Lane OR to 300P OR? Even if you don't want to!
A: There is no more "Lane OR" or "300P OR" as separate units. This is a decision the hospital has the right to make. If you are a Resource Nurse in the OR, you may be assigned to any of the three locations. If you do not have enough knowledge about the area you should speak up and ask for additional training before being assigned.

Q: Is CRRT considered 1:1? When a patient is on HD, the dialysis nurse never leaves the patient. Should CRRT be considered the same?
A: If your patient's acuity is high enough to need 1:1 staffing. If you are assigned a CRRT patient and you think that patient's acuity should have been scored higher, you need to have a conversation with the Resource Nurse and give the specifics of why the assignment should be 1:1.

Q: What about if the CRRT patient is paired with another patient who is in another room, machine alarms are not audible in that other room? Isn't that a safety issue? We can pull up the alarms in the other room monitor, but the CRRT machine alarm doesn't go to the other room...
A: Yes, this does sound like a safety issue. You must bring this up in real time and be specific about what you feel will make your assignment safe. Then write the ADO. Document that you had a conversation with the Resource Nurse and that you notified the manager on duty in your ADO.

Q: At times, a J7 (former B2) nurse would go care for a high-risk OB patient for cardiac monitoring in L&D. However, L&D can't provide the breaks, so J7 would have to lose their one and only float nurse (justified by the grid) for the float nurse to go to L&D to provide a break to the floating J7 nurse. Which means during this 45-50mins (takes 15mins to walk round trip), J7 is short a nurse and breaks are to be provided 3 times a day.
A: Your breaks should be 4 times a day: three 15-minute breaks and one 30-minute break. You need to go up a nurse. The grid is just a tool, it is not the infallible holy book of staffing. The Resource Nurse may use her or his judgement to make this decision. Senior nursing leadership has stated again and again that the Resource Nurses may use their judgement. Your manager will likely want to be informed so they can explain in their management meetings. If you get pushback, write the ADO so CRONA leadership can follow up.

Q: Regarding that J7/L&D question, how does RSN ask for a 2nd break nurse as breaks are about every 4 hours. What would that 2nd break nurse do when not providing breaks? We would be intermittently "overstaffed" then?
A: The nurse can help with other tasks as needed. If there is truly that much downtime, there is time for HealthStream to fill the time. Once the breaks are finished, if the nurse is truly not needed for turns, baths, or other change of shift activities, whoever is up for A-time could be offered to go home early.

Q: For the ADO form, we download, print it, fill it out, and then how do we get it to CRONA? Scan and email?
A: Yes. It can be scanned and emailed to crona@crona.org (best method), photographed with a cell phone and emailed, or faxed (where fax machines still exist). There is a link to the form at the top of the crona.org home page.

Q: As new employees (still in our probationary period), how do we advocate for ourselves while not making ourselves a target during this period where we're not really protected?
A: If you are concerned about retaliation during your trial period, you can still encourage others to speak up. The Resource Nurse could write the ADO.

Q: What is the definition of float nurse does it apply in the OR (300p,500p and Lane) meaning one day in the 500p next day in 300p and next day in Lane?
A: Lane, 300P, and 500P are now considered one area by the hospital, with the nurses divided by service line rather than physical location. The best terminology to use is "rotation" and "float". Rotation is where you are scheduled to rotate among different sites: Lane, 300P, 500P. Float is when you are initially assigned to one location and then asked to instead report to a different location or asked to go to another location during your shift. The Floating Guidelines policy covers floating and is available on the hospital intranet.

Q: By "input to the acuity grid" do you mean charting that contributes to the acuity rating?
A: That is part of it; I am referring to the entire acuity system - what goes into deciding what the grid is. Every nurse is supposed to be able to provide commentary to the group that reviews the acuity system. My guess is that no one knows this and no one does this. That's why we want to publicize this language in Title 22. Read the policy "Patient Classification System" on the hospital intranet, it's really interesting.

Q: Is it OK for a manager to call a nurse into office to talk about ADO s/he wrote? Some nurses are intimidated and do not want to write an ADO.
A: It is necessary for your manager to talk to you about your ADO. Your manager has to report to the Nurse Practice committee and say what happened and what are their suggestions for improvement. The manager who does not ask you about your ADO is not doing her/his job.

Q: Can we write an ADO anonymously if we make sure the descriptions are clear?
A: If your description is clear it will be easy to figure out who wrote it. If it is anonymous it will not be taken seriously by the hospital.

Q: So, to clarify: ADOs are written at the end of or during our shift whether or not the issue got resolved, correct? That way the issue, whatever it was, is high-lighted. For example: Unit didn't have enough certified staff for ECMO, charge RN had to get pulled into the count to take a patient and an APCM had to come in to be charge. Someone here (the charge RN or really anyone working that shift?) would then write the ADO. Correct?
A: Yes, that is correct!

Q: Even though technically the issue got sorted.
A: Yes. It is helpful to know when issues occur. If they are also occurring on other units there may be a pattern that can be identified. The lack of Nursing Assistants was a pattern recently identified when multiple AAUs wrote ADOs about it.

Q: How do we handle isolation patients not being isolated? We have isolation patients in interventional platform where 1) we don't have enough nurses or 2) not enough isolation rooms. What ends up happening is that we put isolation patients in bays and then clean/change the curtains after. Doesn't that make isolation a suggestion instead of a medical condition that we should follow to keep ourselves and our patients safe?
A: It depends on the type of isolation. You would have to refer to the isolation policy for that information. If you are asked to place a patient in a bay who should be in a negative pressure room, that is wrong and you should 1) not accept the patient, 2) complete a SAFE, 3) notify your manager, 4) write an ADO.

Q: For 500P pre/post, we opened with 2 on call staff on the weekend shifts. Now management has increased it to 3 on call staff/shift/weekend. Is that OK?
A: The hospital has the right to determine how many nurses to schedule. It makes sense, given the difficulty giving breaks with only 2 nurses working. A manager on that unit got in trouble last year for falsifying time cards when weekend nurses claimed penalty pay for missed breaks and the manager added fake lunch breaks to their time cards.

Q: J2 should call for critical staffing every day. Their poor unit is constantly being squeezed to death.
A: We agree. We have offered this multiple times to their leadership… it has not been done.

Q: We've had a couple of code situations lately where I feel like we do not have enough help. Although staffing may be good when every patient is well and stable, when an emergency situation occurs I do not feel like there are enough hands on deck especially now in my ICU was downsized and we have less float RNs now to help out. Because sometimes we have a patient actively coding in one room, and another patient who is also not doing well at the same time which requires more help, would this be justified to write an ADO?
A: Yes. There was a similar situation and the nurses wrote ADOs. Pharmacy staffing and operation is now something for which a task force has been developed. The units are so far apart, if the only code pharmacist is far away it can take significant time to reach the code. Also, for a 20 bed ICU the Resource Nurse should not have a float assignment. It is more difficult for the ICU that has only 10 beds open right now, but even on that unit the staffing decisions should be based on patient acuity rather than straight numbers.

Q: In E2 at one point we had 5-6 CRRTs and not enough staff to trained to take those patients. We had float nurses not trained in CRRT breaking those nurses and having the RSN listen out for the CRRT machine.
A: It does not seem safe to have a non-CRRT nurse caring for a CRRT patient. On E2 it used to be that CRRT was a requirement in order to be assigned to the float/FASST role. If there simply aren't enough, this is a reason for an ADO. Please write one.

Q: Can we write an ADO on behalf of someone else?
A: No, you should not. The other nurse needs to write his/her own or the hospital will say why is someone complaining for another person, but that nurse is not speaking up.

Q: What is Lane?
A: Lane Surgery Center, the OR on the 3rd floor of the Cancer Center. All the ORs at Stanford were merged into one "region", so now a nurse who reported to work for the last 20 years at Lane is now being told she will have to work at 300P or 500P on a daily rotating basis. Also, the former Lane OR will now have to work nights and weekends, which they have never done before because Lane was not open on nights and weekends. This has been very unpopular, as you can imagine.

Q: For patient safety and nurse safety we as a group need to have call be voluntary only. We know our limitations of how many hours we work per day, our fatigue limit. Truckers have a 12-hour legal limit for safety issues due to fatigue. But nurses have no limit? Some of us are not 20 anymore! Ha! Maybe next negotiations!
A: I do not see the hospital giving up the ability to decide it needs to have on-call, or only having on-call nurses when the nurses want to work. What we have to do is work on keeping nurses and patients safe. That is why we now have contract language that limits mandatory on-call to 12 hours per week. That is why we have language that if a nurse is too fatigued, s/he may ask to be relieved. If you have other ideas, we want to hear them.

Q: How does one write an ADO? Online form? Physical form?
A: It is a physical form you can pull down from the website. Here's the link:
http://crona.org/wp-content/uploads/2015/03/ASSIGNMENTDESPITEOBJECTION1.pdf

Q: I have the date and times of the on-call manager I notified a couple days and can fill out the ADO. Is this still OK to fill out even though it's has been greater than 24 hours?
A: Yes, please! When your manager complains that you submitted the ADO "late" we will respond and tell your manager that you did everything to get help in real time, which is the point, and that this is a learning experience for everyone.

Excerpts from Law, Regulation, and CRONA Contract

SB 227 (2019) *(LINK)*

Preamble: "Existing law specifically requires the department to adopt regulations that require a general acute care hospital, an acute psychiatric hospital, and a special hospital to meet minimum nurse-to-patient ratios and assign additional staff according to a documented patient classification system for determining nursing care requirements."

Health & Safety Code

1276.4(b) [excerpt] *(LINK)*

These ratios shall constitute the minimum number of registered and licensed nurses that shall be allocated. Additional staff shall be assigned in accordance with a documented patient classification system for determining nursing care requirements, including the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan and the ability for self-care, and the licensure of the personnel required for care.

Title 22 Regulations

§70053.2. [Definition of Patient Classification System] *(LINK)*

Patient Classification System (a) Patient classification system means a method for establishing staffing requirements by unit, patient, and shift that includes: (1) A method to predict nursing care requirements of individual patients. (2) An established method by which the amount of nursing care needed for each category of patient is validated for each unit and for each shift. (3) An established method to discern trends and patterns of nursing care delivery by each unit, each shift, and each level of licensed and unlicensed staff. (4) A mechanism by which the accuracy of the nursing care validation method described in (a)(2) above can be tested. This method will address the amount of nursing care needed, by patient category and pattern of care delivery, on an annual basis, or more frequently, if warranted by the changes in patient populations, skill mix of the staff, or patient care delivery model. (5) A method to determine staff resource allocations based on nursing care requirements for each shift and each unit. (6) A method by which the hospital validates the reliability of the patient classification system for each unit and for each shift.

§70217 *(LINK)*

Excerpts from (a):

"No hospital shall assign a licensed nurse to a nursing unit or clinical area unless that hospital determines that the licensed nurse has demonstrated current competence in providing care in that area, and has also received orientation to that hospital's clinical area sufficient to provide competent care to patients in that area. The policies and procedures of the hospital shall contain the hospital's criteria for making this determination."

"Licensed nurse-to-patient ratios represent the maximum number of patients that shall be assigned to one licensed nurse at any one time. "Assigned" means the licensed nurse has responsibility for the provision of care to a particular patient within his/her scope of practice. There shall be no averaging of the number of patients and the total number of licensed nurses on the unit during any one shift nor over any period of time. Only licensed nurses providing direct patient care shall be included in the ratios."

"Nurse Administrators, Nurse Supervisors, Nurse Managers, and Charge Nurses who have demonstrated current competence to the hospital in providing care on a particular unit may relieve licensed nurses during breaks, meals, and other routine, expected absences from the unit. Licensed nurses shall be included in the calculation of the nurse-to-patient ratio only when the licensed nurse has a patient care assignment, is present on the unit, and is not on a meal break or other statutorily mandated work break."

(1) The licensed nurse-to-patient ratio in a critical care unit shall be 1:2 or fewer at all times. "Critical care unit" means a nursing unit of a general acute care hospital which provides one of the following services: an intensive care service, a burn center, a coronary care service, an acute respiratory service, or an intensive care newborn nursery service. In the intensive care newborn nursery service, the ratio shall be 1 registered nurse: 2 or fewer patients at all times.

Excerpts from (b):

In addition to the requirements of subsection (a), the hospital shall implement a patient classification system as defined in Section 70053.2 above for determining nursing care needs of individual patients that reflects the assessment, made by a registered nurse as specified at subsection 70215(a)(1), of patient requirements and provides for shift-by-shift staffing based on those requirements. The ratios specified in subsection (a) shall constitute the minimum number of registered nurses, licensed vocational nurses, and in the case of psychiatric units, licensed psychiatric technicians, who shall be assigned to direct patient care. Additional staff in excess of these prescribed ratios, including non-licensed staff, shall be assigned in accordance with the hospital's documented patient classification system for determining nursing care requirements, considering factors that include the severity of the illness, the need for specialized equipment and technology, the complexity of clinical judgment needed to design, implement, and evaluate the patient care plan, the ability for self-care, and the licensure of the personnel required for care."

Excerpts from (c):

"(c) In no case shall the staffing level for licensed nurses fall below the requirements of subsection (a). The plan shall include the following: …."

AFL 08-07 *(LINK)*

Re: Licensed Nurse-to-Patient Ratios for Inpatient Rehabilitation Units

Excerpt – "Furthermore, Title 22 of the California Code of Regulations, Section 70217(b) requires that hospitals staff according to patient acuity in order to meet the needs of the patients."

CRONA Contract, Section 33.3.3.a. *(LINK)*

Excerpt – "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."

Our Unity Is Our Strength

#CRONAStrong