

STAFFING METHODOLOGY FOR VHA NURSING PERSONNEL

- 1. REASON FOR ISSUE:** This VHA directive defines the processes and principles all VHA facilities must follow to determine appropriate levels of nursing staff (numbers and types). It incorporates updates to VHA Directive 2010-034.
- 2. SUMMARY OF MAJOR CHANGES:** Major changes include:
 - a. Increased emphasis on Veteran access to care;
 - b. Updates to responsibilities of the Office of Nursing Services; Office of the Chief Nursing Informatics Officer; Medical Center Directors; Associate Directors for Patient Care Services/Chief Nurse Executive (ADPCS/CNE); and Chief Nurses and Nurse Managers with respect to implementation and support of the nurse staffing methodology; and requirements of additional review and oversight of replacement factor and nursing hours per patient day (NHPPD) targets.
- 3. RELATED ISSUES:** VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook.
- 4. RESPONSIBLE OFFICE:** The Office of Nursing Services (10A1) has responsibility for the content of this directive. Questions may be addressed to 202-461-6700.
- 5. RESCISSIONS:** VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel, dated July 19, 2010 is rescinded.
- 6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of December 2022. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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STAFFING METHODOLOGY FOR VHA NURSING PERSONNEL

1. PURPOSE

This Veterans Health Administration (VHA) directive provides a nationally standardized method of determining appropriate direct care staffing for the Department of Veterans Affairs (VA) nursing personnel. Nurse staffing in Patient Aligned Care Teams (PACTs) will follow the VHA Handbook 1101.10 (PACT). **AUTHORITY:** Title 38 United States Code (U.S.C.) 8110, 7421, and 7422; title 5 U.S.C. 7106(b)(1).

2. BACKGROUND

a. VA provides high-quality health care to Veterans. Given the VHA's mission and structure; workforce, recruitment and availability of highly qualified nursing staff; and requirements related to accreditation, VHA must have a flexible and adaptable methodology to relate staffing levels and staff mix to clinical outcomes, effectiveness, and efficiency; and to determine long-range staff planning and budget projections.

b. Staffing decisions require the use of research and non-research sources of evidence, professional judgement, critical thinking, and flexibility. This methodology incorporates available evidence with staffing standards of nursing professional organizations, established VHA team staffing models and, VHA and facility strategic directions to ensure safe and effective nursing care for Veterans.

c. Staffing needs are individualized to specific clinical settings and cannot rely solely on ranges and fixed staffing models, staff-to-patient ratios, or prescribed patient formulas. The staffing methodology described in this directive requires the systematic collection of a minimum set of core data and unit based operations assessment to support staffing decisions. Professional nursing organizations' staffing standards and recommendations, where they exist, provide the basis for the ONS-developed tools.

d. Patient access in all inpatient, residential and outpatient settings must be the primary consideration in the development of nurse staffing model development for all patient care settings.

e. Nursing sensitive indicators in a variety of VA and non-VA comparative databases will be used to guide recommendations. For example, Resident Assessment Instrument (RAI) Minimum Data Set (MDS) is used in long-term care facilities nationwide to assist in planning care and monitoring quality data. Information management systems continue to grow in sophistication to support development of standardized data for health care providers in varied care settings. The intent is to use standardized information data management strategies that facilitate analysis of the relationships among staffing numbers, mix, care delivery models, and patient outcomes for multiple points of care. The goal is to develop an approach that uses best available evidence to determine staff budget plans that support high-quality patient and resident care in the most effective manner possible.

f. Resources for the Staffing Methodology process will be available and updated on the following Web site, <http://vaww.va.gov/nursing/staffing.asp>. **NOTE:** *This is an internal VA Web site that is not accessible to the public.* Tools evaluated by the Office of Nursing Services will be utilized as they continue to be tested and deployed. Staffing requirements determined through this methodology support a standardized approach to ensuring appropriate nursing personnel across the organization.

3. DEFINITIONS

a. **Direct Care.** Direct care is defined as all patient- or resident-centered nursing activities performed by staff assigned to the unit in the presence of the patient or resident, and patient- or resident-related activities that occur away from the patient or resident. Examples include: Nursing assessment; planning, treatment, and preparation time; medication orders and administration; nursing rounds; admission, transfer and discharge activities; support of procedures on inpatient units or in designated outpatient areas; patient or resident teaching; patient or resident communication; coordination of patient or resident care; evaluation of patient responses to care, treatment, and documentation.

b. **Expert Panel.** An expert panel is an advisory group comprised of individuals with in-depth knowledge of factors and variables impacting staffing needs at the point of care. The panel is best qualified to make judgments to deliver recommendations regarding staffing levels, overseeing outcome analysis, and modifications to staffing recommendations.

c. **Local System-Wide Nurse Staffing Plan.** A local system-wide nurse staffing plan is a document providing recommendations initiated by the facility expert panel representing respective clinical sections and approved by the Associate Directors for Patient Care Services/Chief Nurse Executive (ADPCS/CNE) in collaboration with Nursing Chiefs; it combines all unit level plans into one local system-wide staffing plan. The plan is based on a facility/health system approach to review staffing plans for full-time equivalent employment (FTE) requirements. It includes recommendations and accompanying justifications for personnel and workload opportunities, resource allocations, and enterprise/unit/process improvement opportunities, while identifying potential barriers to implementation of the plan, local system/unit level expectations, and expected outcomes. The resulting nurse staffing plan is presented by the ADPCS/Chief Nurse Executive to the facility/system Director and Executive Leadership team to garner sufficient resources to implement the approved plan.

d. **Nursing Hours Per Patient Day.** Nursing Hours Per Patient Day (NHPPD) is the total number of nursing hours of care available divided by the number of patients, in a 24-hour period. NHPPD is a nurse staffing ratio proxy and can be proportioned by skill mix and shift distribution. **NOTE:** *See Appendix A for guidance in determining NHPPD in Spinal Cord Injury/Disorder (SCI/D) units.*

e. **Nursing Sensitive Indicators.** Nursing sensitive indicators are designed to capture care processes or associated outcomes most affected by nursing care.

Researchers have discovered that these indicators are related to, or heavily influenced by nursing care, and have developed their definitions based on the aim of detecting clear linkages between nursing interventions, staffing levels, and positive patient outcomes, including the patient's perception of the health care experience.

f. **Patient and Resident Outcomes.** Patient and resident outcomes are measures that describe a patient or resident's health status or level of functioning following, or during, an episode of health care or component of care delivery.

g. **Performance Indicators.** Performance indicators are measurement tools used to monitor and evaluate the quality of important functions. It is numerical information that quantifies input, output, and performance dimensions of programs, projects, and services.

h. **Performance Measures.** Performance measures are indicators that are used to quantify achievement of established performance based targets.

i. **Points of Care.** Points of care are the locations in which patient or resident health services are provided. Location-specific care delivery can also be described and quantified in nomenclature for treating specialties, Resource Utilization Groupings (RUGs), Current Procedural Terminology (CPT) codes, and stop codes among others. Examples include inpatient units, ambulatory clinics, specialty treatment and diagnostic areas, Community Living Centers (CLCs), SCI/D, home care, residential treatment, and telehealth media such as secure messaging, telephone, or videoconferencing.

j. **Projected Census.** Realistic estimate of future census/access levels by unit. It is used in analyzing historical and projected daily census trends, access requirements, access issues, and programmatic changes. The projected census can also be utilized to set initial staffing levels for new units.

k. **Relative Value Unit.** A Relative Value Unit (RVU) is a comparable service measure used by hospitals to permit comparison of the amounts of resources required to perform various services within a single department or between departments. It is determined by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render patient services.

l. **Replacement Factor.** A replacement factor is a multiplier that calculates the additional staff required to backfill direct care hours when the required staff is away from their direct care role.

m. **Resident Assessment Instrument Minimum Data Set.** The Resident Assessment Instrument (RAI) Minimum Data Set (MDS) is a standardized, valid, reliable, and interdisciplinary assessment used for residents in CLCs for treatment planning and follows a process incorporating assessment, problem identification, care planning, care delivery, and evaluation of outcomes. The MDS is the assessment portion of the process.

n. **Resource Utilization Groups.** Resource Utilization Groups (RUGSs) are an industry-accepted metric that measures the interdisciplinary resources required for a nursing home resident. Derived from the RAI MDS, they reflect both the Case Mix Index (CMI) and the Activities of Daily Living (ADLs) in determining the group.

o. **Staffing Methodology.** Staffing methodology is a budgeting and forecasting process to determine resource requirements based on an analysis of multiple variables to include Veteran care needs, environmental factors, organizational supports, trends in performance metrics and professional judgment to provide safe, effective, quality care at various points of care. **NOTE:** See Appendices B and C.

p. **Staff Scheduling.** Staff scheduling is a process of deploying available staffing resources for the patient care needs of all clinical units of a health care organization. Scheduling parameters recognize variations of workflow across the operational hours and days. Scheduling of staff relies on managerial judgment to match patient needs with available resources while ensuring that time, leave, pay rules, and labor-management requirements are met. The results of the scheduling are the actual delivered daily NHPPD or Hours Per Patient Visit or staffed procedural rooms.

q. **Target Workload Hours.** Target Workload Hours represent the goal workload hours to provide the appropriate level of care to the target patient population on a daily basis (i.e., NHPPD, NHPPV, operational hours, length of stay, etc.).

4. POLICY

It is VHA policy that each VA medical facility use the staffing methodology described in this directive to plan nursing personnel staffing levels. This will ensure that an appropriate nursing workforce is available to provide safe, quality and accessible healthcare to all Veterans. It will also ensure a standardized approach to nurse staffing throughout VHA.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring there is appropriate establishment and implementation of this directive across the entire VHA health care system.

b. **Deputy Under Secretary for Operations and Management.** The Deputy Under Secretary for Operations and Management is responsible for providing the necessary support and resources to Veterans Integrated Service Networks (VISNs) to implement the VHA Staffing Methodology for Nursing Personnel.

c. **VHA Chief Nursing Officer.** The Chief Nursing Officer is responsible for:

(1) Providing oversight for the ongoing development and implementation of a standardized staffing methodology for nursing personnel.

(2) Collaborating with internal and external stakeholders to assess trends in workforce and workload measurement systems in order to identify and implement additional metrics, information systems, and outcome measures.

(3) Providing resources for expert consultation to assist VISNs and facility leadership in appropriate implementation of Nurse Staffing Methodology.

(4) With support from the Office of the Chief Nursing Informatics Officer, developing standardized information data management strategies and analyses of the relationships among staffing levels, skill mix, care delivery models, and patient or resident outcomes for multiple points of care.

(5) Developing standardized evidence-based approaches to staffing and the use of such information to provide high quality patient and resident care that maximizes efficiency.

(6) Developing a systematic process for collecting and disseminating staffing methodology best practices.

(7) Developing a review of VA NHPPD targets in applicable care settings, and providing that to VA leadership for guidance, as units consider appropriate nursing hour per patient day recommendations to inform the work and recommendations of the unit expert panel.

(8) Developing and deploying oversight systems that identify, analyze and correct low and high outliers of those targets.

(9) Developing and implementing a documented process to assess facility compliance with the staffing methodology, including assessing facilities execution of staffing plans and defining the role and responsibilities of all organizational components.

d. **Chief Nursing Informatics Officer (CNIO)**. The CNIO is responsible for:

(1) Coordinating and supporting the development and maintenance of standardized information data management reports and analyses of the relationships among staffing levels, skill mix, care delivery models, and patient or resident outcomes for multiple points of care. See paragraph 5.c.(4).

(2) Collaborating with stakeholders (e.g., Office of Nursing Services, VHA Office of Finance, VSSC) to develop and maintain additional data management reports as needed.

e. **VISN Director**. VISN Directors are responsible for:

(1) Ensuring there is appropriate implementation of the staffing methodology process.

(2) Collaborating with VISN nurse executives on recruitment, retention, recognition and budgeting strategies to fully implement the methodology in the facilities within the VISN.

f. **VA Medical Facility Director.** Each VA Medical Facility Director is responsible for:

(1) Supporting and implementing the local system-wide expert panel staffing methodology process in this directive.

(2) Reviewing and responding to the facility expert panel recommendations within the local executive approval process within 30 days of completion. An example of the approval process is on the <http://vaww.va.gov/nursing/staffing.asp>. **NOTE:** *This is an internal VA web site that is not available to the public.*

(3) Ensuring an annual review of the staffing plan is completed, and a full Staffing Methodology Process is conducted biennially to include approval/disapproval or recommended modification to the annual staffing plan to assure safe and effective quality patient care that is informed by the expertise of nurses in the staffing methodology process.

g. **Facility Associate Director for Patient Care Services, Chief Nurse Executive, or Deputy Associate Director for Patient Care Services.** The Associate Director for Patient Care Services, Chief Nurse Executive or the Deputy Associate Director for Patient Care Services is responsible for:

(1) Ensuring staffing levels, skill mix, and assignments of nursing personnel are consistent with the provisions of this directive and the facility strategic plan, regardless of organizational structure;

(2) Disseminating facility recommendations, justifications for recommendations, and action plans to the facility and unit based expert panels;

(3) Partnering with executive leadership on the development and review of the effectiveness of the local system-wide staffing levels and budget plans;

(4) Developing a facility expert panel to review unit recommendations;

(5) Ensuring that input is solicited from direct care nursing staff and interdisciplinary partners in determining required staffing levels and staff mix in alignment with the needs of all patient or resident care areas;

(6) Appointing a dedicated Staffing Methodology Coordinator through a collateral duty (generally from current nursing staff), or full time equivalent position;

(7) Ensuring first-line managers and service (traditional or product line) chiefs, or equivalent management positions undertake the development and implementation of staffing and plans for areas under their direction, to include: Collection of data; data

analysis; tracking and trending variations in patient and resident outcomes; performance indicators and monitors to assess their effectiveness;

(8) Establishing acceptable ranges of NHPPD based on target workload hours determined for each unit.

(9) Reevaluating the staffing plan and associated nurse sensitive access and quality indicators, at a minimum of annually, within their facility in conjunction with the facility executive leadership team;

(10) Conducting the full unit and facility expert panel staffing methodology at a minimum of every two years within their facility (or more frequently as needed); and

(11) Evaluating the facility expert panel's recommendations and providing written concurrence/non-concurrence or other recommended actions to the VA medical facility Director.

(12) Ensures Nursing Unit Mapping Application (NUMA) reviewed and/or updated annually or with changes to unit targeted NHPPD and authorized staff ceilings.

h. **Facility Staffing Methodology Coordinator.** The Facility Staffing Methodology Coordinator at each facility is responsible for the following at the VA medical facility level:

(1) Ensuring facility leadership and unit expert panels are educated on the requirements to meet full implementation compliance with this directive;

(2) Facilitating the Facility Expert Panel;

(3) Reporting facility level data to the Office of Nursing Services through the VISN as required;

(4) Training facility stakeholders; and

(5) Remaining current with nurse staffing methodology processes, tools, and resources.

i. **Facility Nurse Manager/Service Chief.** The Nurse Manager/Nursing Service Chief or equivalent is responsible for:

(1) Developing a Unit-based Expert Panel consisting of nursing staff that:

(a) Work on the unit;

(b) Represent all existing nursing roles on the unit, e.g., Registered Nurse, Licensed Practical/Vocational Nurse, Nursing Assistant, and Health Care Technicians; and

(c) Express a desire and willingness to actively participate in the unit expert panel.

(2) Leading the Unit-based Expert Panel and ensuring its completion of the following activities:

(a) Supporting data collection of nursing sensitive indicators;

(b) Conducting a comparative analysis of staffing needs using appropriate measures, for example, NHPPD and RVUs as appropriate for the care setting;

(c) Conducting an analysis of the multiple nurse sensitive and workload variables and providing recommendations based on unit specific factors used to develop FTE requirements, staffing levels, and budget plans;

(d) Calculating FTE requirements using the tools provided, using professional standards, expert judgment and analysis of comparative community data; and

(e) Developing and providing the Facility Expert Panel a valid, data driven staffing level and budget plan with logical justifications.

(3) Developing and implementing the final staffing plan that has been approved by the Medical Center Director and or his designee for areas under their direction.

(4) Completing the Unit Narrative Report and workbooks associated with the development of the staffing plan;

(5) Coordinating the presentation, with clear justification of the staffing plan for their area to the Facility Expert Panel. A clear analysis of nurse sensitive, unit level expected patient outcomes should be represented in this justification;

(6) Approving Unit-based Expert Panel staffing level and budget plan recommendations or recommending alternative plans based on review panel knowledge and expertise;

(7) Preparing facility nursing staffing level and budget plan summary report; and

(8) Presenting the nursing staffing methodology summary report to the Nurse Executive.

(9) Conducting daily review of target NHPPD on all units and taking appropriate action when target ranges are not being met.

6. REFERENCES

a. 38 U.S.C. 8110, 7421, and 7422.

b. 5 U.S.C. 7106(b)(1).

c. VA Directive 5001, General Introduction and Administration.

- d. VHA Handbook 1101.10 Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014, or subsequent policy.
- e. Government Accountability Office (2008). *VA health care: Improved staffing methods and greater availability of alternate and flexible work schedules could enhance the recruitment and retention of inpatient nurses*. (No. GAO-09-17). Washington, DC: Government Accountability Office.
- f. Office of the Inspector General, Department of Veterans Affairs (2004). *Healthcare inspection: Evaluation of nurse staffing in Veterans health administration facilities* (No. 03-00079-183). Washington, DC.
- g. Office of Nursing Services. Staffing Methodology <http://vaww.va.gov/nursing/staffing.asp> with templates and sample documents used in the staffing methodology. <https://vaww.vha.vaco.portal.va.gov/sites/ONS/Workforce/SM/SitePages/Home.aspx>. **NOTE:** This is an internal VA Web site note available to the public.
- h. Fasoli, D.R., Fincke, B.G., & Haddock, K.S. (2011). Going beyond patient classification systems to create an evidence-based staffing methodology. *Journal of Nursing Administration*, 41(10), 434-439. doi:10.1097/NNA.0b013e31822edd8e.
- i. Taylor, B., Yankey, N., Robinson, C., Annis, A., Haddock, K., Alt-White, A., Krein, S., Sales, A. (2015). Evaluating the Veterans Health Administration's Staffing Methodology Model: A Reliable Approach. *Nursing Economics*, 33(1)

**NURSING HOURS PER PATIENT DAY GUIDELINES/RANGES FOR SPINAL CORD
INJURY/DISORDERS CENTERS**

1. Spinal Cord Injury/Disorders (SCI/D) inpatient Nursing Hours Per Patient Day (NHPPD) are based on care needs associated with the patient's functional status, complications, co-morbidities, and patient condition.

2. Definitions:

a. Functional Status.

(1) Independent: able to safely perform all activities of daily living without modification, but may need assistive devices and/or aids. No assistance is required.

(2) Supervision/Setup: able to safely perform all activities of daily living but needs prompting, coaxing, and/or stand-by assistance with setting up items to complete tasks. No physical assistance other than set-up is required.

(3) Minimum Assistance: the patient requires a small amount of physical help to accomplish the task. Nursing care requirement: will consist of 25% physical assistance from others in performing functional tasks.

(4) Moderate Assistance: will consist of 26% to 50% assistance from others in performing functional tasks.

(5) Highest Assistance: the patient contributes minimal functional tasks.

(a) Maximum Assistance: will consist of 51% to 75% assistance from others in performing activities of daily living.

(b) Total Assistance: will consist of 75% assistance from others in performing activities of daily living

b. Complications and comorbidities: In addition to the functional status of the patient, complications and comorbidities are important factors when calculating the NHPPD. Complications and comorbidities that are common in this population include pressure ulcers, urinary tract infections, pneumonia, and autonomic dysreflexia.

c. Patient Condition: Patient conditions are used to describe a patient's decline or improvement in clinical status.

(1) Good: Vital signs are stable and within normal limits, patient is conscious and comfortable, indicators are excellent.

(2) Fair: Vital signs are stable and within normal limits, patient is conscious but may be uncomfortable, indicators are favorable.

(3) Serious: Vital signs may be unstable and not within normal limits, patient is

acutely ill, and indicators are questionable.

(4) Critical: Vital signs are unstable and not within normal limits, patient may be unconscious, and indicators are unfavorable.

3. NHPPD Ranges for SCI/D Patients.

The following NHPPD ranges for SCI/D patients were developed in conjunction with the SCI/D Center inpatient nursing staff to provide comparison data. If workload hours are not previously established, the Nurse Manager determines baseline workload hours using the comparison NHPPD ranges as a guide in the table below. The NHPPD includes the level of function (independent, supervision/set-up, minimum assistance, moderate assistance, or highest assistance), assessment of complications and comorbidities, and the patient's condition (good, fair, serious, or critical).

Level of Function	NHPPD Ranges (Includes complications/ Comorbidities and patient condition)
Independent: able to safely perform all activities of daily living without modification but may need assistive devices and/or aids. No assistance is required.	7.3 - 10.2
Supervision/Setup: able to safely perform all activities of daily living but needs prompting, coaxing, and/or stand-by assistance with setting up items to complete tasks. No physical assistance other than set-up is required.	8.6 - 12.0
Minimum Assistance: the patient requires a small amount of physical help to accomplish the task. Needs up to 25% physical assistance from others in performing functional tasks.	10.6 - 12.8
Moderate Assistance: needs 26% to 50% assistance from others in performing functional tasks.	12.1 - 15.4
Highest Assistance: the patient contributes little to nothing in completing functional tasks. <ul style="list-style-type: none"> · Maximum Assistance: needs 51% to 75% assistance from others in performing activities of daily living. · Total Assistance: needs more than 75% assistance from others in performing activities of daily living 	15.3 - 18.4

THE STAFFING METHODOLOGY PROCESS

1. Nurse Manager and the Unit-Based Expert Panel Formulate Staffing Recommendations

a. The following standardized process identifies the steps required by facilities to determine appropriate nursing staff resources and allocation for all points of care. This process is to be followed at a minimum of every 2 years for purposes of projecting and budgeting nursing personnel, unless otherwise recommended by the ADPCS to conduct the process more frequently. The Nurse Manager and unit-based expert panel review the current staffing plan for the unit and note the current target workload hours (using workload hours appropriate for the care setting).

(1) If workload hours are not previously established, the Nurse Manager determines baseline workload hours using comparison data (e.g., Labor Management Institute (LMI), classification systems (e.g., Resource Utilization Groups), and/or Staffing Methodology tools (e.g., Nursing Hours Per Patient Day (NHPPD) converter). Comparison data can include internal (e.g., SCI/D NHPPD ranges in Appendix A) and external sources.

(2) If workload hours are established, the Nurse Manager reviews current target workload hours to comparison data for like units in the same facility, ranges of NHPPD in similar Department of Veteran Affairs (VA) units or broad community resources, (e.g., Labor Management Institute, SCI/D NHPPD ranges in Appendix A,) and/or classification systems (e.g., Resource Utilization Groups).

(3) Target workload hour calculations must reflect direct care staff responsibilities based on the following guidelines:

(a) Direct care staff responsibilities are defined as all patient or resident-centered nursing activities performed by staff assigned to the patient or resident. Examples of such patient and resident-centered activities include:

1. Nursing assessment;
2. Planning, treatment, and preparation time;
3. Medication orders and administration;
4. Nursing rounds;
5. Admission, transfer and discharge activities;
6. Patient or resident teaching;
7. Patient or resident communication;
8. Coordination of patient or resident care;

- 9. Documentation;
- 10. Nurse led patient support groups; and
- 11. Safety rounds.

(b) Staffing categories included in the methodology are:

- 1. Assistant Nurse Manager while performing direct patient care activities;
- 2. Charge Nurses while performing direct patient care activities;
- 3. Clinical Nurse Leaders while performing direct patient care activities;
- 4. Staff Registered Nurses (RNs);
- 5. Licensed Practical Nurses (LPNs) or Vocational Nurses (LVNs);
- 6. Nursing assistants (NAs);
- 7. Patient care health technicians;
- 8. Surgical Technicians;
- 9. Intermediate Care Technicians (ICT); and
- 10. Sitters performing direct patient care (in proportion with their direct care assignment).

(c) Staffing categories excluded are:

- 1. Nurse Managers;
- 2. Assistant Nurse Manager while performing administrative activities;
- 3. Clinical Nurse Leader while performing administrative activities;
- 4. Charge Nurse while performing administrative activities;
- 5. Advanced Practice Registered Nurses (i.e. Nurse Practitioner, Clinical Nurse Specialist);
- 6. Unit secretaries or clerks;
- 7. Monitor technicians;
- 8. Sitters, whose only role is to observe the patient or equipment;
- 9. Escorts;

10. Students who are fulfilling educational requirements; and

11. Recently hired nurses in an orientation program, (i.e., RN Transition to Practice Program).

b. Nurse Managers and the Unit-Based Expert Panel determine unit workload as follows:

(1) Select a period of time within the past year that is representative of a unit's typical census and workload trends or projected census.

(2) Populate the calculator tools taking into consideration the impact of appropriate indicators.

(3) Develop a narrative summary describing the impact of appropriate indicators to reflect the overall complexity of care on the unit. The narrative will provide data driven, cogent justifications for all recommendations. A narrative template with recommended sections is available on the Staffing Methodology Web site located in the ONS intranet site. This is to be presented to the Facility Expert Panel in support of staffing recommendations.

c. Nurse Managers and the Unit-Based Expert Panel determine whether or not current target workload hours allows for completion of direct care responsibilities and other required duties to meet desired outcomes using:

(1) Analysis of common and unit-specific nursing sensitive indicators where applicable, and

(2) Comparative analysis between similar units using external and internal sources (Comparisons can be made using the VA reported average nursing hours annual inventory, SCI/D NHPPD ranges in Appendix A, National Database of Nursing Quality Indicators (NDNQI®) and LMI). Consideration of ranges of NHPPD in similar VA units should be available for comparison with unit panel recommendations. Recommendations not within those ranges of similar units will require detailed explanation and justification to the facility expert panel, the Associate Director for Patient Care Service/Chief Nurse Executive and Medical Center director if recommended for approval in order to detail the unique circumstances of that unit.

d. Nurse Managers determine the number of required employees using the FTE Calculator Tool that:

(1) Includes a required replacement factor which accounts for annual leave, sick leave, and holiday leave (if applicable), education offerings, and systems improvement activities (i.e., quality improvement, evidence-based practice, shared governance).

NOTE: *The replacement factor may be adjusted and applied using the worksheet replacement factor calculator and itemized replacement factor tool.*

(a) The replacement factor of 1.2 may be increased based on unique facility characteristics, but may not be decreased from 1.2. Replacement factors exceeding

1.24 in 24/7 units require specific emphasis and explanation in the narrative provided to the Associate Director for Patient Care Service/Chief Nurse Executive and the Medical Center Director.

(b) The education built in to the replacement factor accounts for general required Talent Management System (TMS) courses. Education outside of TMS should be considered in addition to the default 40 hours built into the calculations (i.e., courses for professional competency requirements not listed in TMS).

(c) Systems improvement includes time for shared governance, committee participation, and time devoted to evidence-based practice.

(2) Provides the required nursing staff for each of the identified organizational units based on skill mix (i.e., RN, LPN, NA, and Health Care Technician).

e. The Nurse Manager in conjunction with the nursing service chief or equivalent submits a completed unit-based expert panel package to the facility based expert panel at the facility established times, no less frequently than every two years. The completed package will contain the following:

(1) Narrative justification;

(2) Replacement calculator worksheet;

(3) FTE calculator worksheet; and

(4) Additional tools used to collect unit specific data.

2. Facility Based Expert Panel Review and Approval Process.

a. Nurse Managers in conjunction with the nursing service chief or equivalent submit the completed unit-based expert panel package to the facility expert panel for review.

(1) The expert panel is advisory to the facility Associate Director for Patient Care Services/Chief Nurse Executive who is ultimately responsible for the provision of nursing services.

(2) The expert panel is comprised of individuals knowledgeable in the uniqueness of the facility who are best able to make staffing judgment based upon the many factors involved. This includes at a minimum, representatives of the following staff categories:

(a) Staff nurses providing direct patient care;

(b) Deputy Nurse Executive and Nursing Service Chief(s) or equivalent having clinical area responsibilities;

(c) SCI/D Chief/ Designee when SCI/D center staffing is reviewed

- (d) Alternate tour supervisory staff;
- (e) Finance office leadership personnel; and
- (f) HR office leadership.

(3) The expert panel reviews, analyzes, seeks clarification from the unit-based expert panels, approves and prepares the facility nursing staffing level summary report. This report is forwarded to the Facility Associate Director for Patient Care Services/Chief Nurse Executive.

b. The Facility Associate Director for Patient Care Services/Chief Nurse Executive reviews the facility nurse staffing summary report submitted by the facility based expert panel and provides written concurrence/non-concurrence or other recommended actions to the Medical Center Director through the facility resource allocation process. This ADPCS/CNE develops a staffing action plan, which conforms to the approved local system-wide staff budget plan, and submits the action plan for approval through the local budget approval process. Final resource allocation decisions will be communicated back to the facility expert panel and local unit panels. The ADPCS must conduct an annual staffing review to determine if changes have occurred that require completion of a full Staffing Methodology process be conducted by any unit prior to the 2 year minimum requirement.

c. The Nurse Executive will establish monitoring systems that will include measuring the target workload to predetermined unit-specific variance thresholds.

d. The Medical Facility Director documents approval or disapproval with recommended actions to assure safe and effective quality patient care. The recommended actions will include a description that includes timelines for the actions that will be taken in order to provide safe, and effective quality patient care.

3. Ongoing Staffing Analysis

a. The Facility Associate Director for Patient Care Services/Chief Nurse Executive, Chief Nurses, Staffing Methodology Coordinator and other nursing managers must establish a timeline to evaluate the staffing plan annually, or more frequently if needed.

b. Review of the staffing plan is required when there are significant changes to the unit or when quality auditing and peer review activity suggests that outcomes may be impacted by staffing levels. Note: A Full Staffing Methodology Process must be conducted at least every two years. Examples of review triggers may include, but are not limited to:

- (1) Combining two units;
- (2) Any significant change in services;

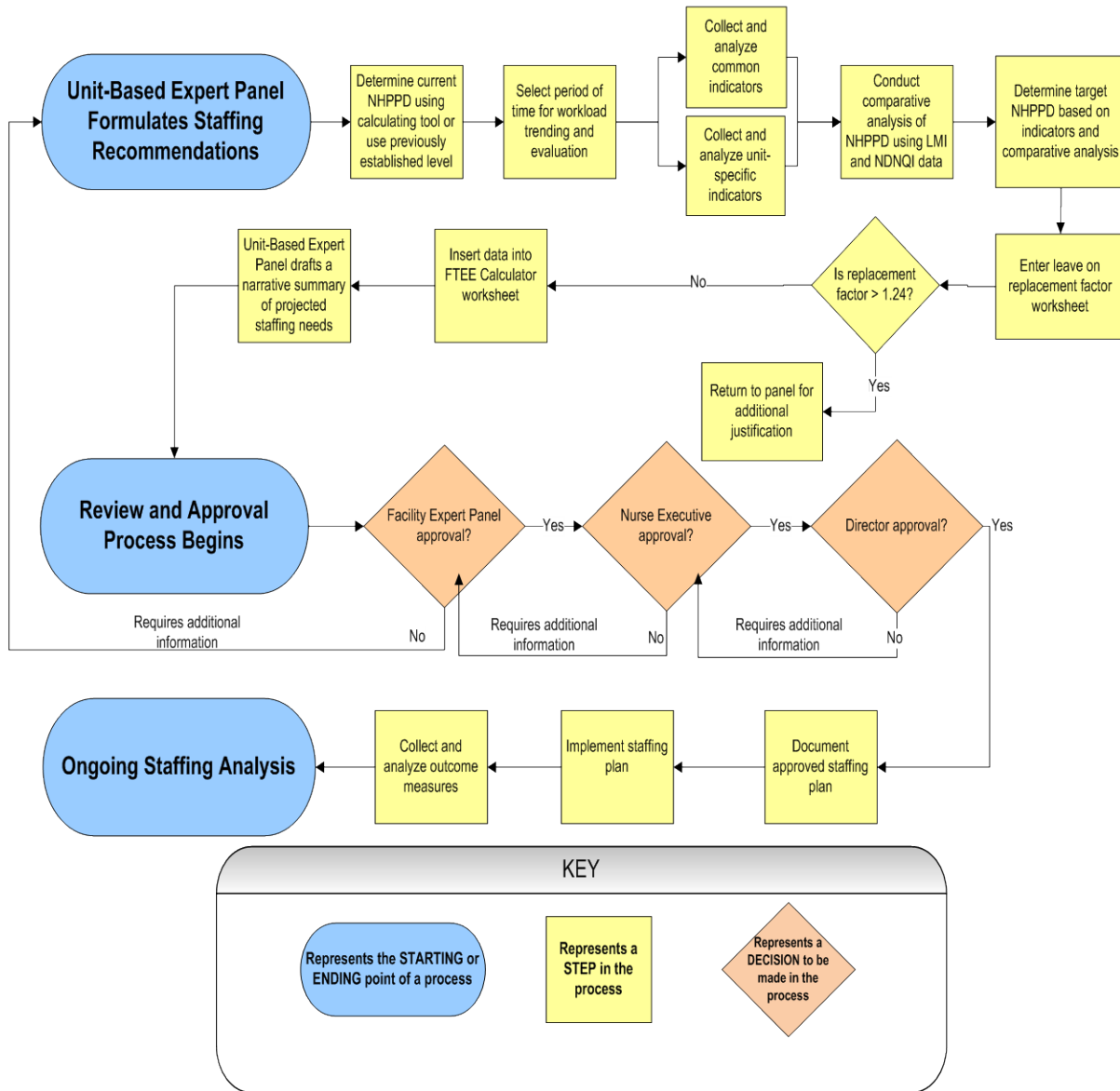
(3) Unusually-high staff turnover;

(4) Addition of a hospitalist (a provider whose focus is hospital medicine) or Intensivist (a physician who specializes in the care of critically ill patients); or changes in provider, resident, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) support; or

(5) Adverse patient or resident outcomes and changes in patient satisfaction/trust scores.

STAFFING METHODOLOGY PROCESS FLOW CHART

STAFFING METHODOLOGY FOR
VHA NURSING PERSONNEL



STAFFING METHODOLOGY PROCESS FLOW CHART TEXT

1. The process begins when the Unit-Based Expert Panel formulates Staffing Recommendations.

2. In the next step, the current Nursing Hours Per Patient Day (NHPPD) is determined by using the NHPPD Calculating Tool or by using a previously established level.
3. Next, a period of time for workload trending and evaluation is selected.
4. In the next step, both common and unit-specific indicators are collected and analyzed. Next, a comparative data analysis of NHPPD using, SCI/D NHPPD ranges in Appendix A for SCI/D care settings, Labor Management Institute (LMI) and National Database of Nursing Quality Indicators (NDNQI) data is conducted.
5. Then, a target NHPPD is determined, based on indicators and comparative analysis.
6. Next, leave is entered on the Replacement Factor Worksheet.
7. In this step, a decision needs to be made in the process: Is the replacement factor > 1.24?
 - a. If yes, then return to the Panel for additional justification.
 - b. If no, then proceed to the next step and insert data into the Full-Time Employment Equivalent (FTEE) Calculator Worksheet.
8. Next, the Unit-Based Expert Panel drafts a narrative summary of projected staffing needs.
9. Next, the Review and Approval process begins.
10. A decision needs to be made: Has the Facility-Expert Panel given approval?
 - a. If yes, then another decision needs to be made: proceed to step 12.
 - b. If no, then additional information is required. Return to step 1 to restart the process.
11. Decision: Has the Nurse Executive given approval?
 - a. If yes, then another decision needs to be made: proceed to step 13.
 - b. If no, then additional information is required. Once the additional information has been compiled, resubmit to the Facility-Expert-Panel for approval.
12. Decision: Has the Director given approval?
 - a. If yes, proceed to Step 14.

b. If no, then more information is required. Once the additional information has been compiled, resubmit to the Nurse Executive for approval.

13. The next step in the process is to document an approved staffing plan.

14. Update Nursing Unit Mapping Application (NUMA) with changes to unit targeted NHPPD and authorized staff ceilings.

15. Next, implement the staffing plan.

16. The next step is to analyze and collect outcome measures.

17. The process ends with conducting on-going staffing analysis.