STAFFING CAPACITY REPORTING

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

HHS Required Reporting of Crisis Staffing

Disciplines required to be reported on for HHS: Environmental, Nursing, respiratory therapists, pharmacists and pharmacy techs, physicians, other licensed independent practitioners; temporary physicians, & other critical healthcare personnel

Reporting process: The required staffing report, sent centrally from System Office, will default to "NO". If there is a "YES" to a crisis staffing shortage of any of the roles noted above, the identified ministry/site leader will send an email to trinityVMS@trinity-health.org - by 9:30 AM 7 days a week.

- Include in subject line "Critical Staffing Shortage" AND clearly indicate which discipline/role in the body of the email.
- When a "YES" is reported, the Site will need to continue to report daily until they confirm they are back to the default of "NO".

Definitions		
Conventional Capacity – The spaces, staff, and supplies used are *consistent with daily practices* within the institution and expected standards of care.	**Contingency Capacity** – The spaces, staff, and supplies are not consistent with daily practices, but provide care to a standard that is *functionally equivalent* to usual or safe practices.	**Crisis (Critical Staffing) Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care; provide *sufficiency* of care only typical in the setting of a catastrophic disaster and/or pandemic response (i.e., provide the best possible care to patients given circumstances and resources available). Critical capacity constitutes a significant adjustment in the standard of care. Meeting the critical staffing capacity definition (**see indicators below**) would require the above process for reporting.
	Normal staff to patient ratios stretched or exceeded Specific staff expertise/ability to meet role requirements difficult to meet or at times exceeded.	**Critical Staffing Indicators:** Unable to safely provide patient care and/or to meet essential/required standards of care. Critical lack of qualified staff for meeting specific and essential care needs, or other essential role-defined activities – AND no alternatives available. Lack of available staff, including no possible alternative care model staffing, which subsequently necessitates closure of a unit or service.
Actions (Including Reporting Requirement for Critical)		
Conventional – Plan for ongoing staffing needs that may, or may not, exceed facility resources. Determined staff shortage triggers and length of time to obtain resources.	**Contingency –** Communicate staffing barriers (# of staff short for next 24 hours and/or upcoming week) through normal facility channels. Determine additional resources needed and secure those available.	**Crisis (Critical) –** Report critical staffing shortage("YES) to Incident command per above email procedure. Include the discipline/role that is in critical shortage.

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Recommendations
Staff Planning Assure facility has process and supporting policies for disaster credentialing and privileging - including degree of supervision required, clinical scope of practice, mentoring and orientation, electronic medical record access, and verification of credentials. Monitor turn-over and vacancy and proactively address. Communicate with System Staffing Team staffing needs as they arise. Utilize the VMS or QuickBase.
Focus Staff Time on Core Clinical Duties Minimize meetings and relieve administrative responsibilities not related to care. Plan and consider when (i.e. if you further decline to crisis capacity) to implement efficient medical/clinical documentation methods appropriate to the surge/critical capacity.
Use Supplemental Staff Hire/bring in experienced/trained staff (critical care nurses, PACU, etc.). Hire appropriate staff of all types for vacant positions. Bring in contingent staff from FirstChoice/Redeployed/or Agency when necessary Repurpose/redeploy equally trained staff from administrative positions (nurse managers). Adjust personnel work schedules (longer but less frequent shifts, etc.) - if this will not result in skill/PPE compliance deterioration. Use alternative staff to provide basic patient hygiene and feeding – releasing staff for other duties. Cohort patients to conserve PPE and reduce staff PPE donning/doffing time and frequency.
Focus Staff Expertise on Core Clinical Needs Personnel with specific critical skills (ventilator) should concentrate on those skills; specify job duties that can be safely performed by other medical professionals. See guidelines for team model. Have specialty staff oversee larger numbers of less-specialized staff and patients (e.g., a critical care nurse oversees the intensive care issues of 9 patients while 3 medical/surgical nurses provide basic nursing care to 3 patients each). Deploy Team models of care. Limit availability/indications for non-critical laboratory, radiographic, and other studies. Reduce documentation requirements. Restrict elective appointments and procedures.
Use Alternative Personnel to Minimize Changes to Standard of Care Use less trained personnel with appropriate mentoring and just-in-time education (e.g., health care trainees, support personnel, Volunteer health care workers, retirees). Use less trained personnel to take over portions of skilled staff workload for which they have been trained. Implement Buddy Model. Provide just-in-time training for specific skills. Cancel most sub-specialty appointments, screening endoscopies, etc.; and divert staff to emergency duties including in-hospital.

Note: Recommendations may be appropriate for any level/staffing capacity. Situationally based and/or ministry determined.