Nurse-to-Patient Staffing Ratios for General Acute Care Hospitals

Frequently Asked Questions

(January 2004)

The California Department of Health Services, Licensing and Certification Division will provide periodic updates to the following Frequently Asked Questions (FAQ's) and answers related to the implementation of the new nurse-to-patient ratio regulations for General Acute Care Hospitals.

These questions and answers are organized into the following categories:

1. **Questions of General Concern**

   A. **Enforcement of the Ratios**
   B. **Program Flexibility**
   C. **Healthcare Emergency/Influenza Season**
   D. **"At all times" Requirement**
   E. **Record Keeping Requirements**
   F. **Counting Patients in the Ratios**
   G. **Patient Placement**
   H. **Outpatient and Inpatient**
   I. **Patient Classification System**
   J. **RNs/LVNs/Team Nursing**

2. **Specific Unit Questions**

   A. **Post Anesthesia Care Unit (PACU)**
   B. **Pediatrics Unit (Peds Unit)**
   C. **Rehabilitation Unit (Rehab Unit)**
   D. **Emergency Department (ED or ER)**
   E. **Neonatal Intensive Care Units / Nurseries (NICU/Nurseries)**
   F. **Chemical Dependency Recovery Units and Hospitals (CDRU/CDRH)**
   G. **Psychiatric Unit (Psych Unit)**

3. **Other**
   A. **SNFs and HBPDs**
   B. **CNAs**
   C. **Nurse availability**
   D. **Rural hospitals (To view the list of hospitals designated as "rural hospitals" by the Office of Statewide Health Planning and Development, *click here.*)**

1. **Questions of General Concern:**

A. Enforcement of the Ratios

1. **Q:** ***How will CDHS approach enforcement of the ratios?***

A. CDHS will enforce the provisions of these regulations in the same general manner as we have enforced the ratios that have existed for 28 years for Intensive Care and Critical Care Units. There are two ways in which the department will verify compliance with the regulations.

Compliance with the regulations may be verified during a periodic survey. Although CDHS does not automatically verify compliance with the ratio requirements during a survey, observation or interview may lead to concerns about staffing and cause CDHS to verify compliance with the ratios and other staffing-related requirements.

Compliance with the regulations may also be verified by investigating a complaint that is specific to staffing or staffing ratios. Although there is no statutory timeframe within which CDHS must initiate an on-site investigation to respond to a complaint against a General Acute Care Hospital, by existing policy CDHS will initiate an investigation within 48 hours if a credible allegation of serious and immediate jeopardy to patients is received. If the allegation does not constitute serious and immediate jeopardy, the complaint will be investigated during the next periodic survey or along with the next "serious" complaint.

Should a violation of the ratio requirements occur, CDHS will issue a deficiency to the hospital and require an acceptable plan of correction. CDHS may verify that the plan of correction has been implemented and the deficiency corrected during any subsequent complaint investigation or periodic survey.

There is no penalty or monetary fine for a violation of the ratio regulations. However, should the CDHS conclude that the violation of the ratios is so severe that it poses an immediate and substantial hazard to the health or safety of patients, CDHS may order the hospital to reduce the number of patients or close a unit until additional staffing is obtained.

2. **Q:** ***What is CDHS's expectation for provider self-reporting? Do you expect a provider to notify you whenever they are out of compliance with the ratio regulations? After all, the ratios are supposed to be the minimum***

requirements to protect patient safety, and 22 CCR 70737 requires that Any…unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors shall be reported as soon as reasonably practical….to the Department."

The reporting requirements at 22 CCR 70737 were established to ensure that the Department will be made aware of all occurrences that disrupt the operation of the facility or are reportable events, such as earthquake, fire, a walkout by a substantial number of employees, power outage, epidemic outbreaks, major accident, disaster, or other catastrophe. They were not intended to compel providers to self-report all events that could be cited by the Department as deficient practices. Hospitals are not required to seek prior approval from DHS L&C if licensed nurse staffing levels fall below what is required in regulation during a healthcare emergency. However, a hospital may be required to report a healthcare emergency, as defined at 22 CCR 70217(q), if the healthcare emergency results in a "Disruption of Services" as defined at 22 CCR 70746, and/or meets the criteria of a "Reportable Disease or Unusual Occurrence" as defined at 22 CCR 70737(a).

B. Program Flexibility

1. **Q:** ***Please explain program flexibility. When does it apply, and who is eligible?***

   A: Program flexibility is defined for basic services in 22 CCR 70129 and for supplemental services at 22 CCR 70307. It exists because CDHS does not want its requirements to "prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department." Program flexibility, then, recognizes that regulations cannot keep pace with advances in health care, and often new alternatives, approaches, and techniques *which meet the intent of the regulation* are as appropriate, or even preferable, to strict compliance.

   CDHS welcomes the opportunity to work with providers as they seek to continuously improve the care they offer by exploring innovative ways to deliver safe and adequate care. Although the nurse staffing ratios would be a difficult requirement to "flex", we encourage hospitals to work with their local Licensing and Certification district office on program flexibility requests.

2. **Q:** ***What is the process and timeframe for CDHS to consider program flex requests for these nurse staffing ratio regulations?***

   A: L&C has established an internal process to expedite program flexibility requests related to these regulations and to provide for consistent application of

standards for program flexibility throughout the state. The total timeframe for review and rendering a written decision on program flexibility will not exceed 15 working days. In addition, review of program flexes will be coordinated between the district office and a central office subject matter expert to promote consistent interpretation and application of the regulations.

C. Healthcare Emergency/Influenza Season

1. **Q:** ***What happens if there is a flu epidemic and the hospital must admit large numbers of flu patients? What does the hospital do about meeting the nurse staffing ratios?***

   A: Title 22 CCR 70217(q) requires hospitals to plan for routine fluctuations in patient census. A flu epidemic might qualify as a healthcare emergency, which is defined in the regulation as, "an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care." A healthcare emergency may be reportable to the department if it meets the definition of a "Disruption of Service" (22 CCR 70746) or is a "Reportable Event or Unusual Occurrence" (22 CCR 70747.) If the hospital can demonstrate that it made prompt efforts to try to maintain required staffing levels, then CDHS will not consider the hospital to have violated the regulations during the period of the health care emergency. However, the influenza season cannot be used as an excuse for a failure to plan or to otherwise fail to meet the requirements.

2. **Q:** ***What concerns are you hearing about patients being held in the ED awaiting a medical/surgical bed and the back up of the entire county emergency medical system when this happens county wide. At what point can facilities have program flexibility to admit those patients knowing they will be out of compliance?***

   A: We added Title 22 CCR 70217(q) to the regulations to address the need for flexibility during a healthcare emergency. Please see the definition of healthcare emergency" discussed in C1 above. It is likely that a problem that caused the entire county emergency medical system to back up would meet the criteria of a "healthcare emergency".

D. "At All Times" Requirement

1. **Q:** ***Is the Department aware of any ways that facilities might be able to comply with the "at all times" requirement?***

   A: There are several techniques that a hospital can use to ensure compliance with this requirement. Hospitals do not need to seek our approval for any of the following options:

- The regulations specifically permit a Charge nurse, or nurse manager to fill in for a licensed nurse during breaks or lunches.
- In a Post Anesthesia Recovery Unit (PACU) an OR nurse can cover if there are no surgeries as long as the nurse has current competence in the PACU.
- Any nurse in the hospital can "float" between units to cover as long as that nurse is competent to perform tasks required in that unit.
- Nurses from a "higher acuity" unit can always cover for a nurse in a unit with lower acuity patients.
- If a patient is being taken for tests and can be accompanied by a technician, that may reduce a nurse's assignment on a temporary basis, so they could assist another nurse.
- A hospital can delay new admissions or cancel elective surgeries that would result in new admissions. Hospitals have done this when they didn't have sufficient numbers of critical care nurses.
- Hospitals could contact physicians to see if any patients could be safely discharged sooner than scheduled. Often hospitals discharge patients at certain times of the day, even though the patient could go home or to another level of care sooner.
- Except for patients who might be admitted through the ER, hospitals know the number of new admits or possible discharges at any given time. Each charge nurse plans for staffing the next shift prior to the end of the current shift. This is a normal and continuous process that can be adjusted to accommodate available staff.

2. Q: ***When patients are off the floor for procedures and therapy some nurses will not have their full complement of patients. Utilizing existing staff, nurses would be asked to do tasks for those remaining patients under the care of the licensed staff who has gone on a break. Any thoughts on coverage?***

A: As in 22 CCR 70217(a), "Nothing in this section shall prohibit a licensed nurse from assisting with specific tasks within the scope of his or her practice for a patient assigned to another nurse. "Assist" means that licensed nurses may provide patient care beyond their patient assignments if the tasks performed are specific and time-limited." So, a nurse who temporarily does not have his/her full complement of patients may certainly assist with tasks for patients assigned to another staff nurse.

However, the nurse can never be given an assignment that exceeds the ratio for the maximum number of patients the nurse can care for on the unit on which she/he works. So, if two medical/surgical nurses each had six patients, and two patients assigned to each nurse were temporarily off the unit for procedures, one nurse could assist the other nurse's patients with time limited tasks as their needs arose. However, one nurse could not assume the other nurse's full assignment while that nurse went on a break, because the nurse remaining on

the unit would then be responsible for the care of eight patients during the break period, and that would be a violation of these regulations.

The regulations do provide that "Nurse Administrators, Nurse Managers, Nurse Supervisors, 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."

3. **Q:** ***Meal breaks continue to pose concerns for a number of facilities. Will DHS entertain program flexibility for ratio mandates during meal breaks?***

A: Program flexibility can be requested for any alternative method of meeting the intent of the regulation, and there may be special circumstances for which program flex may be appropriate. While this requirement would be a difficult requirement to flex, we encourage hospitals to work with their local Licensing and Certification district office on program flexibility requests. There may be other options or ideas that you might work through with the district office.

E. Record Keeping Requirements

1. **Q:** ***The documentation of staffing by patient is going to be very difficult on many units where patients are in and out, the statement of reason says this will not be financially harmful to hospitals but our read on it is that it will be very time intensive. Have you considered documentation by exception only? Meaning we only complete the form when we are out of compliance. We have attached the form we are sharing with hospitals – your thoughts please.***

A: There was no form attached for us to review.

It must be possible for CDHS to verify the licensed nurses' assignments to ensure that no individual nurse's assignment exceeds the maximum number of patients permitted for that unit type at any time. The regulations require that the hospital retain the nurse assignments, by staff licensure category, on a day-to-day, shift-by-shift basis, for a minimum of one year. This is necessary because, without this new provision, it would be impossible for CDHS or the public to know retrospectively whether the facility complied with these proposed regulations and would therefore make enforcement of these proposed regulations virtually impossible. Therefore, this recordkeeping requirement is necessary for the health and safety of California's citizens. HSC 1278 states that, "Any officer, employee, or agent of the state department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time ***to secure compliance with, or to prevent a violation of, any provision of this chapter."*** (Emphasis added.) Without this requirement, agents of the state department would only know in the aggregate the numbers of patients and nurses on each shift, and could calculate the average staffing, but would be unable to assess

whether a violation occurred, or prevent a violation of these proposed regulations which implement and make specific HSC 1276.4. For example, if CHDS received a complaint about inadequate staffing on a shift of a psychiatric unit, an investigation for compliance would be necessary. Without this requirement, the only information that would be available would be that which is already required by the PCS at subsections 1-3: the numbers of staff required, the number of staff provided, etc., and the nurse-to-patient staffing could appear to be adequate on average. However, if one or more of the patients had required 1:1 staffing, then the staffing ratio would be non-compliant, but would have appeared appropriate under current recordkeeping requirements. This requirement will enable CDHS to secure compliance with provisions of this chapter, in accord with statute. Although this recordkeeping is an expansion of existing record keeping requirements, it will not add any significant cost to providers.

There is no special form required for compliance with the record keeping regulation. Whatever the hospitals' current procedure is for documenting nurses' shift assignments will be acceptable to the Department as long as the nurses' patient assignments are documented and retained for one year. For example, it would be acceptable for a hospital to require nursing staff to leave their daily assignment worksheets at the hospital at the end of their shift. The hospital could also retain the charge nurse's assignment sheet, with admission and discharge notes. The decision to keep these documents on separate pieces of paper, in a binder or a notebook, electronically, or in some other form is entirely the prerogative of the hospital. The Department will accept any form or format that meets the regulatory requirements. However, charting by exception is not acceptable because it would not allow the Department to independently verify staffing assignments.

F. Counting Patients in the Ratios

1. Q: ***Many of our small and rural facilities have swing beds. When these beds are designated to provide care to post acute patients – those patients usually found in hospital based distinct part units- it is our understanding they are exempt from ratios. What is the number of patients a nurse can care for if caring for both DP and Medical Surgical patients?***

A: If the hospital is licensed pursuant to HSC 1250(a), then the ratio regulations apply to that hospital and to all units within that hospital. If there is a hospital unit that contains acute medical/surgical patients as well as patients in swing beds, and a nurse's assignment consists of both acute care hospital patients as well as skilled nursing level of care patients, then the maximum number of patients that nurse shall care for is six. Permitting otherwise would violate the intent of the statute, which is to limit the number of patients a nurse can care for when delivering care in an acute care setting. The Patient Classification System (PCS) is activated to ensure that the nurse is caring only for the number of patients

whose needs he/she can safely meet. If, however, a nurse is caring for skilled nursing level of care patients only, the ratio regulations do not apply.

2. **Q:** ***Do patients who have been discharged but not yet left the hospital count in the ratio assignment?***

   A: If a patient has been discharged by the hospital, that person is no longer a patient and is, therefore, no longer assigned to a nurse for care. Patients who may be in waiting rooms, who are waiting to be discharged or waiting to receive a prescription are not counted in the ratio as long as a nurse has not been assigned to their care. Only patients assigned to licensed nurses are included in the nurse-to-patient ratios.

3. **Q:** ***Do hospitals have to staff their discharge lounges with licensed personnel?***

   A: Only patients who are assigned to licensed nurses for care are included in the ratios. If the discharge lounge houses patients who are still assigned to a licensed nurse for care, those patients are counted in the ratios. If all the people in the discharge lounge are no longer patients, and they are not assigned to licensed nurses, they do not count in the ratios.

4. **Q:** ***Under the traditional triage model, at what point is the patient included in the ratios? When the patient walks through the ED doors and is awaiting triage? Or when a patient is triaged and sent back to the waiting room? Or when the patient is triaged and then placed in a bed?***

   A: A patient is counted in the nurse-to-patient ratios when the patient is assigned to a licensed nurse for care.

5. **Q:** ***If a patient is triaged by an RN to the ED or Fast Track and does not require further nursing intervention and the "required" nursing assessment elements (e.g., nutritional status, etc.) are documented by the doctor or PA during the medical screening exam, does the patient become included in the ratios?***

   A: If a patient has been triaged by an RN and does not require further nursing intervention, and all assessments and treatments are rendered by a physician or a PA, that patient would not be assigned to a licensed nurse for assessment and/or treatment. Therefore, the patient would not be counted in the ratios because the patient was never part of a licensed nurse's assignment.

6. **Q:** ***A patient receives a rapid medical evaluation (instead of triage) by a physician or PA. Lab and X-ray orders are initiated and the patient is sent back to the waiting room since there are no beds available. At what point is this patient included in the nurse staffing ratios?***

A: The patient is included in the ratios at the point that the patient is assigned to a licensed nurse for care.

7. **Q:** ***A patient receives a rapid medical examination by a physician or PA and triage nurse team. It is determined that this patient is a low-acuity patient and does not require further nursing care. The patient is treated in triage and discharged from triage. Is this patient included in the nurse staffing ratios?***

   A: If the physician or the PA is providing treatment, the patient is not included in the ratios. The patient is not counted in the ratios when being examined by the triage nurse team unless the triage includes assigning the patient to a nurse for care and treatment. As above, the patient is included in the ratios when that patient is assigned to a licensed nurse for care.

8. **Q:** ***A patient receives a rapid medical examination by a physician/PA and triage nurse team. It is determined that this patient is a low acuity patient and does not require further nursing care. The patient is placed in a designated rapid medical evaluation or fast tack where the patient's treatment is completed by a physician/PA with the assistance of an ED tech and is discharged. Is this patient included in the ratios?***

   A: No, since the patient was not assigned to a licensed nurse for care and treatment, the patient is not included in the ratios.

G. <u>Patient Placement</u>

1. **Q:** ***A number of our facilities care for long-term vent patients. These are patients who may require hospitalization for unrelated pulmonary issues. They are stable on their vents; can these patients be cared for on a Med-Surg Unit? Again they are not hospitalized for their pulmonary condition.***

   A: This is outside the scope of these regulations. The patient's condition as assessed by the physician and nurse, and reflected in the PCS, and the patient's level and intensity of care needs, will determine the appropriate placement of patients on the various units. Regardless of the unit placement, of course, the nurse assigned to the patient would have to demonstrate current competence in the care of ventilator-dependent patients.

2. **Q:** ***Several months ago you told us that a mixed unit staffing should be based on Med/Surg of 1:6 and the acuity will drive up the staffing for those "mixed" patients housed on that floor. You site (sic) Peds, but during our conversations we discussed telemetry patients. The example we discussed was a 24 bed Med/Surg floor with capacity for monitoring eight telemetry patients. As long as the telemetry patients constitute less than 50% of the***

unit, you indicated this would be a mixed unit and staffing would be based on Med/Surg with the PCS driving staffing up for this patient population. Since you do not mention this in the Statement of Reasons would you please address this is (sic) your Q and A.

A: Units which may include mixed patient populations of diverse diagnoses and diverse age groups who require care appropriate to a medical/surgical unit are addressed at 22 CCR 70217(a)(11). For all the reasons outlined in the Statement of Reasons describing the rationale for 70217 (a)(11), CDHS believes that the acuity of patients in mixed units of acute care hospitals warrants a minimum nurse-to-patient ratio of 1:6. The PCS will continue to coexist with the minimum ratios to require an increase in nurse staffing in response to increased patient acuity and/or the needs of the specific patient population, e.g. telemetry patients. Please note the new regulation at 22 CCR 70217 (a) (14) which states, "Identifying a unit by a name or term other than those used in this subsection does not affect the requirement to staff at the ratios identified for the level or type of care described in this subsection."

3. **Q:** ***What staffing would facilities need to maintain for fetal demise deliveries on a med/surg floor?***

A: All patients on a med/surg unit must receive a minimum nurse staffing ratio of 1:6. The PCS will coexist with the ratio requirements to increase nurse staffing in response to patients' needs. Also, current regulation at 22 CCR 70215 (c) already requires that, "The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with…..staff of other disciplines involved in the care of the patient." These patients may, for example, require coordination of care with psychology service or social service staff, pastoral care staff, discharge planning staff, etc.

H. Outpatient and Inpatient Units

1. **Q:** ***Several units – OB and Oncology – do outpatient procedures on the units. They could be OB checks, stress tests, chemotherapy etc. The patients are not inpatients but outpatients. We consider these patients to be outpatients and therefore, do not fall under these regulations. Is this correct?***

A: If the outpatients are cared for in an outpatient service of the hospital as defined at 22 CCR 70525, they are not covered by these regulations. If, however, the outpatients occupy inpatient beds on inpatient units and are assigned to nurses on those units, then those patients must be counted as part of the nurse's assignment and are included in the ratios. In the case of OB checks, 70217(a)(3) specifies that the nurse-to-patient ratio for antepartum patients who are not in active labor is 1:4. "Stress tests" are done on perinatal units; a different kind of

"stress test" is done on coronary care, telemetry and medical/surgical units. The appropriate ratio for the unit type applies.

Outpatients receiving chemotherapy on an inpatient oncology unit would be counted in the nurse's maximum assignment of 1:5, which is the ratio for specialty care units at 22 CCR 70217(a)(12). If the outpatients are receiving chemotherapy on a medical/surgical unit, they would be counted in the nurse's maximum assignment of 1:6. Where those patients are placed, and the level of staffing they receive, shall be determined by their needs as assessed by their physician or nurse and reflected by the PCS. On each unit, the applicable minimum ratio applies, regardless of whether the nurse has an assignment of inpatients only, mixed outpatients and inpatients, or outpatients only so long as those outpatients occupy inpatient beds in inpatient units.

2. **Q:** ***If a hospital has an ED with an attached "clinic" that patients are referred to for minor issues, but the beds are on the hospital license do these patients fall under the 1:4 requirement. Frequently, these patients are seen by Physician Assistant's or Nurse Practitioner's.***

A: Emergency Room beds are not counted on the license (22 CCR 70419(b)). Is this an outpatient service or part of the Emergency Department? If the hospital has an outpatient "clinic" service on its license, then it is not part of the emergency department and is not covered by the ratios, and the hospital needs to follow the Outpatient Service regulations at 22 CCR 70525-70533. If the clinic is on the license as part of the hospital's emergency department, then the hospital needs to follow all of the Comprehensive Emergency Medical Service (22 CCR 70451-70459), Basic Emergency Medical Service (22 CCR 70411-70419), or Standby Emergency Medical Service (22 CCR 70649-70657) regulations, and the ratios apply for Basic and Comprehensive (22 CCR 70217(a)(8).

3. **Q:** ***In M/C (sic) units where out patient procedures are performed and the staff may care for both inpatients and outpatients at "any one time" how do we apply the ratios since outpatients are not included in these proposed regulations?***

A: We are not familiar with the acronym "M/C units" and assume that you are inquiring about medical/surgical (M/S) units. If the outpatients are cared for in an outpatient service of the hospital as defined at 22 CCR 70525, they are not covered by these regulations. If, however, the outpatients occupy inpatient beds on inpatient units and are assigned to nurses on those units, then those patients must be counted as part of the nurse's assignment and are included in the ratios.

I. Patient Classification Systems (PCS)

1. Q: ***The proposed ratios represent a minimum staffing level and patients with higher acuity, such as an agitated brain injury patient or an impulsive CVA patient is assessed at a higher acuity and therefore requires more nursing hours or a lower ratio than 1:6, possibly 1:4 or 1:3.***

A: That is correct. Current regulations include PCS**,** mandated at 22 CCR 70053.2 and 70217(b) to (q). These regulations require that hospitals have a system to determine nursing care needs based on individual patient care requirements. The PCS will co-exist with the mandated minimum ratios to increase staffing as patient acuity increases.

2. Q: ***The acuity of a unit's patient population varies and depends upon the random mix of patients admitted during a specific period of time. Thus, how will DHS decide which is a specialty unit and which is not?***

A: Please refer to the definition of specialty care units and medical/surgical units included in the regulations at 70217(a)(11) and (12). A medical/surgical unit is defined as " …a unit…in which patients, who require less care than that which is available in intensive care units, step-down units, or specialty care units receive 24 hour inpatient general medical services, post-surgical services, or both general medical and post-surgical services. These units may include mixed patient populations of diverse diagnoses and diverse age groups who require care appropriate to a medical/surgical unit." All units contain patients whose acuity varies, and that does not change the essential character of the unit. All patients must receive care based on an assessment of their need for care. If a patient is on a medical/surgical unit and his/her acuity increases, the PCS must increase staffing, to the specialty care unit level and beyond if necessary, to meet the patient's needs. CDHS is more concerned that hospitals meet the needs of the patients than about the name that the hospital gives to a unit.

3. Q: ***As patients progress through their rehabilitation program, ideally becoming more independent and self-sufficient, their acuity and corresponding nursing hours required to care for them usually decrease. Therefore a newly admitted patient may require a lower nurse-to-patient ratio than a patient near discharge. How will this essential element of rehabilitation be addressed?***

A: This progress of patients toward increasing independence and decreasing acuity as discharge approaches is the ideal for all patients, not just rehabilitation patients. The Patient Classification System (PCS), already required in regulation, will remain in place to augment licensed staff and to dictate the skill mix required to meet each patient's individual needs. The staffing for each unit will be dictated

by the PCS with the minimum licensed nurse-to-patient ratios providing the baseline staffing for each unit, below which staffing shall not fall. Because these ratios are mandated to be the minimum level to protect health and safety, they should be thought of as the ratios that would be in place on the slowest shift when the patients are least acute.

4. **Q:** ***Patient acuity is assessed each shift by a professional nurse and may change from shift to shift. How will the proposed regulations address this issue?***

A: Patient's acuity varies on all units. That does not change the essential character of the unit. All patients must receive the amount of nurse staffing their acuity demands regardless of their placement on a specific unit, as determined by the PCS. The hospitals must have a system for determining the nursing staff needs of the patients.

2. Specific Unit Questions:

A. Post Anesthesia Care Units

1. **Q:** ***For the PACU– A number of facilities have two levels of post anesthesia units. Level One – which is the traditional recovery unit with 1:2 Ratio. What is the staffing ratio for a Level Two Recovery unit? The level 2 cares for outpatients and post-procedural patients.***

A: All patients in a recovery room or Post Anesthesia Care Unit (PACU) are post-procedural. If the level 2 recovery room (PACU) cares for outpatients only, and the PACU is a part of outpatient services and is not part of an inpatient area, the regulations would not apply. These regulations do not address outpatient services provided by acute care hospitals. Regulations governing outpatient services have not changed. They can be found at 22 CCR 70527-70533. The specific requirements for outpatient service staff are at 22 CCR 70529 (c) and (d) that reads: "A registered nurse shall be responsible for the nursing service in the outpatient service. There shall be sufficient nursing and other personnel to provide the scope of services offered."

2. ***Q: For the PACU--What is the CDHS position on staffing of a post anesthetic care unit at night and weekends to be in compliance with Title 22? Is it necessary to have two PACU nurses called in at night and on weekends to care for post-anesthetic patients? Is it sufficient to utilize the OR circulator as the second nurse? In the event the OR circulator is unavailable, is a CNA sufficient as the second person?***

A: 22 CCR 70217(a)(7) requires, "The licensed nurse-to-patient ratio in a Post Anesthesia Care Unit of the anesthesia service shall be 1:2 or fewer at all times,

regardless of the type of anesthesia the patient received." If two nurses are required based on patient acuity as reflected in the PCS, or because there are more than two patients in the unit, two nurses would be required. If there is only one or two patients in the PACU and the PCS does not require additional staffing, only one nurse would be required. If the OR circulating nurse has demonstrated current competence for PACU nursing services to the hospital, and is not needed in the OR, that nurse may care for patients in the PACU. Any nurse with demonstrated current competence for the PACU may care for patients in the PACU. A CNA can never be used as a substitute for a licensed nurse. CNAs can work in an assistant capacity to the licensed nurses in the PACU, as directed by the PCS.

B. Pediatric Units

1. ***Q: For Pediatrics-- What definition of pediatrics are you using for the Pediatrics Unit and for those pediatric patients on the "mixed" medical/surgical floor?***

   A: We are using the definition currently in regulation (Title 22 CCR 70535) for Pediatric Units. It reads, "Pediatric Service Definition: Pediatric service means the observation, diagnosis and treatment (including preventative treatment) of children and their illnesses, injuries, diseases and disorders by appropriate staff, space, equipment and supplies." We are using the definition already in regulation at 22 CCR 70537(d) for pediatric patients in both pediatrics units and mixed units. It reads, "Pediatric Service General Requirements: Patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstances and the reason documented in the patient's medical record."

C. Rehabilitation Units

1. **Q.** ***Will freestanding rehab units fall under these regulations? We understand the department is now considering rehab units that are licensed on the hospital licensure as medical/surgical (units which) (sic) need to meet the 1:6 regulation, but what is the plan for free standing units?***

   A: If the rehabilitation services are a supplemental service on a general acute care hospital license, it makes no difference whether the service is provided in an inpatient unit or a freestanding unit because, from a regulatory viewpoint, they are the same. Rehabilitation services may be specialty care units if they meet the definition included at 70217(a)(12). It is also possible that a rehabilitation unit would be classified as a medical/surgical unit (see 70217(a)(11)) depending on the acuity and care needs of the patients. Freestanding rehabilitation hospitals are licensed as general acute care hospitals, and units within them may be specialty care or medical/surgical care units.

CDHS refined the definition of "specialty care unit" in the regulations to better differentiate between the care required in the ICU/CCU, step-down, specialty care, and medical/surgical units. The minimum safe nurse-to-patient ratio in specialty care units is 1:5 or fewer at all times. The ratio required for medical/surgical units is 1:6 or fewer at all times.

This is clinically appropriate because of patient acuity and the required level of care. The care required in specialty care units results in more nursing hours at the bedside to perform all the tasks accomplished on medical/surgical units plus additional nursing tasks, including the administration, continual monitoring, and patient evaluation of response to medications which can potentially cause life-threatening adverse reactions.

CDHS did not set a specific minimum numerical licensed nurse-to-patient ratio for rehabilitation units because the patient cohorts and patient acuity in rehabilitation units varies so greatly from hospital to hospital and unit to unit. The patients' diagnoses in these units can range from an acute traumatic brain injury to extended recovery from an uncomplicated hip surgery. Those rehabilitation units that meet the definition of "specialty care unit" should be staffed at that level, and those rehabilitation units that meet the definition of "medical/surgical care unit" should be staffed at that level. Please see the proposed regulations at 70217(a)(11) and (12).

2. ***Q: For Rehab--Will you be adding discussion on rehab units to your Statement of Reasons? You did not mention rehab facilities at all during this process and now we understand you are including as Medical/Surgical patients we would also like to see this addressed in the Statement of Reason (sic).***

A: There is an extensive discussion on rehabilitation units in addenda II and IV that are part of the Final Statement of Reasons. Those documents are available on the Department's website at www.dhs.ca.gov (click on "Regulations"). CDHS did not include rehabilitation patients as Med/ Surg patients. CDHS did not set a specific minimum numerical licensed nurse-to-patient ratio for rehabilitation units because the patient cohorts and patient acuity in rehabilitation units varies so greatly from hospital to hospital and unit to unit. The patients' diagnoses in these units can range from an acute traumatic brain injury to extended recovery from an uncomplicated hip surgery. Those rehabilitation units that meet the definition of "specialty care unit" should be staffed at that level, and those rehabilitation units that meet the definition of "medical/surgical care unit" should be staffed at that level. Please see the proposed regulations at 70217(a)(11) and (12).

D. Emergency Departments

1. ***Q. Several hospitals express concern over EMTALA violations – given the rural facilities need to transfer patients to larger Medical Centers for care but if the Medical Center is closed because of lack of staffing what is the Rural site to do?***

   A: The rural hospitals must have a policy and procedure already in place for how they handle situations when they cannot transfer. These regulations will not change those policies.

2. ***Q: How will the ratio regulations affect Standby Emergency Rooms?***

   A: The regulations governing standby emergency medical services in current regulation at 22 CCR 70649 through 70657 have not changed. The staffing requirements are at 22 CCR 70653(c) and (d). Those requirements are, "A registered nurse shall be immediately available within the hospital at all times to provide emergency nursing care. There shall be sufficient other personnel to support the services offered." These new regulations address staffing only for emergency medical services classified as comprehensive or basic in general acute care hospitals.

E. Neonatal Intensive Care Units/Nurseries

1. ***Q. The regulations clearly define staffing in the NICU but other nurseries (sic). What staffing ratios apply to these areas?***

   A: Current regulation [Title 22 CCR 70549(e)(2)] requires that a ratio of one licensed nurse to eight or fewer infants shall be maintained for normal infants.

F. Chemical Dependency Recovery Units

1. ***Q. Our unit is a 28 bed Chemical Dependency Recovery Unit (D/P) under the "Bed Classifications/Services" in a General Acute Care Hospital. Our unit does not appear to be under the heading of any of those listed. We also employ full-time Certified Alcohol/Drug Counselors as part of our staffing, which is not mentioned in the statute either. How am I supposed to staff?***

   A: Current regulation at 22 CCR 70006 for General Acute Care Hospitals (GACH's) defines the Acute Care Psychiatric Bed Classification as, "beds designated for acute psychiatric, developmentally disabled, or drug abuse patients receiving 24-hour medical care." Therefore, if your unit is a service on the GACH license, it would be considered a psychiatric service unit, and the licensed nurse-to-patient ratio of 1:6 required at 70217(a)(13) applies. These proposed ratios apply to licensed nurses and licensed psychiatric technicians only. Employing professionals from other disciplines (social services, psychology, music therapy, recreational therapy, teaching, etc.) in order to create the psychotherapeutic milieu will be reflected by the PCS, which will remain in

place to enrich staffing above the minimum in response to patient acuity and patient care needs. These proposed regulations do not limit the use of professionals from other disciplines, and that includes Certified Alcohol/Drug Counselors. Because these ratios are mandated to be the minimum level to protect patient health and safety, they should be thought of as the ratios that would be in place on the slowest shift when the patients are least acute.

2. ***Q: Would having the beds licensed as a Chemical Dependency Recovery Hospital exempt the beds from these ratio requirements?***

A: These ratio requirements regulate only general acute care hospitals licensed pursuant to subdivision (a) of HSC section 1250. Since CDRHs are licensed pursuant to HSC section 1250.3, they are not affected by the ratio requirements.

However, per HSC 1250.3 subsections (c) and (d), whenever chemical dependency recovery services are being provided in a General Acute Care Hospital (GACH), in an Acute Psychiatric Hospital (APH), or in a freestanding building owned or leased by the GACH or APH and on the same premises or adjacent premises within a 15-mile radius and under the administrative control of the GACH or APH, those services must be provided as a supplemental service and in a distinct part. So, a chemical dependency recovery service provided by a GACH must be a supplemental service provided in a distinct part of the facility or a freestanding building and is subject to the ratio in these regulations of one nurse to six patients.

A chemical dependency recovery hospital is a separate category of health facility licensure established by HSC 1250.3 with licensing standards established in 22 CCR. Nothing would preclude an entity that holds a GACH or APH license from making a completely separate application for licensure as a CDRH, so long as those chemical dependency recovery services were not being provided by, nor under the administrative control of, the GACH or APH. The applicant would have to meet all requirements to operate a CDRH.

G. Psychiatric/Behavioral Health Units/Facilities

1. ***Q. Is a psychiatric facility exempt from the ratios? I have dual licensure for acute care and psychiatric facility. Does federal certification exempt the facility from the ratios?***

A: These regulations apply to all General Acute Care Hospitals licensed at HSC 1250 (a). They include a ratio regulation for psychiatric services within a general acute care hospital, at 22 CCR 70217(a) (13). The regulations do not apply to facilities licensed as Acute Psychiatric Hospitals (APHs) at HSC 1250 (b). Ratios regulating licensed nurse staffing in APHs are under development at CDHS. Federal certification does not exempt a facility from these regulations. All

hospitals are required to maintain continuous compliance with all licensing requirements per 22 CCR 70129(a).

3. Other:

A. SNFs and HBPDs

1. **Q:** ***When can we anticipate see (sic) the proposed ratios for SNFs and HBDPs?***

   A: The regulations that will set minimum levels of licensed nurses in skilled nursing facilities and hospital-based distinct part units are currently under development at CDHS. When they will be ready for public comment is yet to be determined. Those regulations are not a part of this rulemaking package.

B. CNAs

1. **Q:** ***Can an employer in their attempt to meet the nurse-to-patient ratios that are to be implemented in January 2004, fire all the CNAs, without hiring additional RNs or LVNs, and then place that additional workload on the RNs? This was done at my facility. I have heard from some union personnel that it's illegal to assign an unlicensed person assignments (sic) or work load to a licensed person. Could you please clarify this?***

   A: The licensed to non-licensed staff skill mix is determined by patient care needs according to the facility's PCS and the individual hospital's staffing policies. These regulations do not address the minimum number of non-licensed staff per patient; these regulations address only licensed nurse-to-patient ratios, as mandated by statute (HSC 1276.4). This new law (HSC 1276.4) did not give CDHS a mandate to include unlicensed assistive personnel, or any other types of professional staff beyond licensed nurses, in the ratio regulations. HSC 1276.4 (b) states, "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…" These proposed regulations, then, set the minimum numerical licensed nurse-to-patient ratio in order to protect the health and safety of patients in California's general acute care hospitals. The minimum standard is just that, a minimum, and patients' health and safety must be protected at all times by competent caregivers.

   Whether an unlicensed person's assignment can be assigned to a licensed person may be a contract issue, but it is not a regulatory issue. There is nothing that is within the scope of practice of a CNA that is outside the scope of practice of an RN or an LVN, so assigning CNA duties to a licensed nurse would not

violate these regulations, nor would it violate the scope of practice provisions of the Business and Professions Code.

C. Nurse Availability

1. Q: ***I am all for safer ratios, but our problem is not enough nurses for our units. Maybe DHS can check out hospitals that cannot attract nurses due to lack of funds, etc., and have to rely on travel nurses to fill the demand, and figure out ways to hire and retain our staff?***

A: For all of the reasons outlined in the Final Statement of Reasons, CDHS believes that the ratio regulations as adopted for each unit are the minimum numbers of licensed nurses necessary to protect the health and safety of patients in California's acute care hospitals. It would be inappropriate for CDHS to comment on the strategies used by individual providers to comply with these regulations. The methods used to comply with regulations, whether they include the use of registry nurses, traveling nurses, increased recruitment, or other methods, are the purview of the individual hospital's governing body. It is also possible that improving staffing in hospitals may create a work environment that enhances nurses' job satisfaction and facilitates recruitment and retention efforts. Addressing this issue, however, is outside the scope of these regulations.

D. Rural Hospitals

1. Q: ***Did the Legislature make special provisions for rural general acute care hospitals to meet the nurse-to-patient staffing ratios?***

A: Health and Safety Code Section 1276.4(g) allows CDHS to grant waivers from the staffing ratio requirements to rural hospitals, as defined in Title 22, Section 70059.1, on two conditions. Requests must include adequate documentation that explains how the hospital will provide the appropriate care for the acuity level of the patients in the affected units. Requests may be granted by CDHS so long as the "health, safety and well-being of patients affected" by the waiver are "not jeopardized" and the waiver is "needed for increased operational efficiency."

Similar to program flexibility requests, waiver requests should be submitted to the local CDHS district office. Within 7 days of receipt of a waiver request, the district office will contact the hospital to obtain any additional information from the hospital needed to fully consider the request. Final decisions on granting waiver requests will be provided by the district office in writing to the hospital after review by a subject matter specialist.

2. Q: ***The regulations allow Nurse Administrators, Charge Nurses and Supervising Nurses to be counted in the ratio only when providing nursing services,***

such as when covering for other licensed nurses at break and meal times, but do these same limitations apply to rural hospitals who already have difficulty retaining qualified nurses?

A: Section 70217(l) of the regulations allows rural hospitals, as defined in Health and Safety Code Section 1250(a), to request program flexibility for allowing nurse administrators to meet the ratios, even if not providing direct patient care, so that supervision of nursing care is provided on a 24-hour basis.

3. Q. ***Many of our rural facilities have swing beds. When these beds are designated to provide care to post acute patients – those patients usually found in hospital based distinct part units- it is our understanding they are exempt from ratios. What is the number of patients a nurse can care for if caring for both DP and Medical Surgical patients?***

A: If the hospital is licensed pursuant to HSC 1250(a), then the ratio regulations apply to that hospital and to all units within that hospital. If there is a hospital unit that contains acute medical/surgical patients as well as patients in swing beds, and a nurse's assignment consists of both acute care hospital patients as well as skilled nursing level of care patients, then the maximum number of patients that nurse shall care for is six. Permitting otherwise would violate the intent of the statute, which is to limit the number of patients a nurse can care for when delivering care in an acute care setting. The PCS is activated to ensure that the nurse is caring only for the number of patients whose needs he/she can safely meet. If, however, a nurse is caring for skilled nursing level of care patients only, the acute care staffing ratio regulations do not apply.

4. Q: ***What flexibility do the regulations allow for staffing units with mixed patient populations, which are likely to be found in rural hospitals?***

A: Units that may include mixed patient populations of diverse diagnoses and diverse age groups who require care appropriate to a medical/surgical unit are addressed at Section 70217(a)(11). The acuity of patients in mixed units of acute care hospitals warrants a minimum nurse-to-patient ratio of one nurse to six patients, which is the ratio for medical/surgical units. The Patient Classification System will continue to coexist with the minimum ratios to require an increase in nurse staffing in response to increased patient acuity and/or the needs of the specific patient population, e.g., pediatric patients.