CHA | California Hospital Association

FAQs

December 20, 2021

FAQs for Hospitals Facing Critical Staffing Shortages

California hospitals are currently experiencing an extreme shortage of health care workers, including nurses. This document answers frequently asked questions for hospitals that cannot meet the state's nurse-to-patient staffing ratio requirements. *Please also see CHA's COVID-19 Surges: FAQs & Resources for California Hospitals.*

1. I don't have enough nurses to meet the nurse-to-patient ratio requirements. Am I automatically in violation of Title 22?

   No. The ratio requirements have two exceptions:

   - The ratio regulation states that "The hospital shall plan for routine fluctuations in patient census. If a healthcare emergency causes a change in the number of patients on a unit, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels. A healthcare emergency is defined for this purpose as an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care." (See Title 22, California Code of Regulations, Section 70217(g).)

     The pandemic has clearly resulted in "unavoidable" occurrences at "unscheduled" intervals. Therefore, this exception likely applies, as long as the hospital can demonstrate that prompt efforts were made to obtain required staffing (even if those efforts were unsuccessful). Hospitals should document their efforts to obtain additional staff, such as contacting on-call staff, offering incentive pay or bonuses for working additional shifts, reassigning staff as appropriate, contacting staffing agencies, etc. Hospitals should also document their efforts to reduce patient load, including transferring/discharging patients as appropriate, postponing non-emergency procedures, diverting ambulances, closing beds or units, etc.

   - The ratio penalty statute states that "A general acute care hospital shall not be subject to an administrative penalty ... if the hospital demonstrates to the satisfaction of [CDPH] all of the following:
     - Any fluctuation in required staffing levels was unpredictable and uncontrollable.
     - Prompt efforts were made to maintain required staffing levels.
     - In making those efforts, the hospital immediately used and subsequently exhausted the hospital's on-call list of nurses and the charge nurse." (See Health and Safety Code Section 1280.3(f)(4)(A).)

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Some hospitals have found that, to provide the best patient care in surge situations, they should not reassign their "charge nurses" to work in ratio — these staff are needed to continually assess the "big picture" and perform important tasks such as evaluating and assigning patients, coordinating care, overseeing and assisting less experienced or very busy nurses, helping to make discharge/transfer decisions, and the like. Note that there is no definition of "charge nurse" in the law, and hospitals are not required by law to have a position called "charge nurse." Hospitals may wish to consider using a different title for nurses with the responsibilities noted above, to the extent consistent with their labor agreements, if any.

2. Do only RNs "count" for purposes of meeting the ratio requirements?

No. Licensed vocational nurses (LVNs) may be counted to meet the ratio requirements. LVNs may constitute up to 50% of the nurses assigned to patient care on any unit, unless RNs are required pursuant to the hospital's patient classification system. However, only RNs can be assigned to the newborn ICU, ED triage, or critical trauma patients. Psychiatric technicians may also be counted in the ratio, but in psychiatric units only.

Hospitals are reminded that nurse administrators, nurse supervisors, nurse managers, and charge nurses may be included in the calculation of the nurse-to-patient ratio if those nurses are providing direct patient care. When engaged in activities other than direct patient care, these nurses may not be included in the calculation of the ratio.

3. Am I required to notify the California Department of Public Health (CDPH) when I am out of ratio?

Not necessarily. There is no specific requirement for hospitals to notify CDPH when they cannot meet the nurse-to-patient ratio requirements. However, CDPH has stated in All Facilities Letter (AFL) 20-46.3 that a hospital experiencing a "sudden spike in staff absenteeism or attrition creating an urgent staffing shortage" must report this as an unusual occurrence to the CDPH district office. CDPH has not provided any clarification about how it defines "sudden spike." In addition, it's important to note that the AFL does not apply when a hospital experiences a surge of patients — it applies only when there is a sudden increase in staff absences.

The Title 22 "unusual occurrence" reporting requirement states that reports must be made as soon as reasonably practicable by telephone to CDPH and to the local health officer. The AFL does not specify reporting by telephone, but rather is silent on the method. Given that these Title 22 regulations are dated, it is possible that CDPH will consider an email notification to the CDPH district office and the local health officer to be sufficient. The AFL further clarifies that the report must be made as soon as practical within 24 hours. The hospital must furnish other pertinent information related to the occurrence as requested by the local health officer or CDPH. (See Title 22, California Code of Regulations, Sections 70737 (general acute care hospitals) and 71535 (acute psychiatric hospitals).)

4. Can I get a program flex or a waiver of the nurse-to-patient ratio requirement?

The governor's executive order giving CDPH the authority during the pandemic to waive hospital licensing requirements does not allow CDPH to waive nurse-to-patient ratio requirements unless pre-existing law already gave CDPH this authority (for example, for rural hospitals). However, CDPH does have the ability to approve a program flexibility request (which is different from a waiver) for nurse-to-

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patient ratio requirements in very limited circumstances, such as to allow a hospital to designate a bed(s) in a critical care unit as requiring a lower level of care (an intermediate care, step-down, telemetry, medical-surgical, specialty care, or pediatric services unit). At this time, CDPH has not, to our knowledge, approved many of these program flex requests, if any. However, CDPH is willing to consider (and has approved) requests for program flexibility for hospitals to implement team nursing models. The team nursing models that CDPH will consider do not reduce the overall number of nurses needed, but allow a hospital to team up more experienced nurses with less experienced nurses to jointly care for a group of patients. These models average the number of patients and the number of nurses to meet the numerical ratios, instead of the current requirement to specifically match each patient to an identified nurse. For example, without an approved program flex, a hospital would need two ICU-experienced nurses to care for four ICU patients. However, if a team model program flex is approved, the hospital could assign one ICU-experienced nurse and one non-ICU-experienced nurse to together care for four ICU patients. Although this model does not decrease the total number of nurses needed overall, it allows an experienced or specialized nurse to lead a team to provide the best care for patients.

A hospital seeking to implement a team nursing model must submit a **5000a program flexibility request form** to CDPH. For the most expedient path, CDPH recommends that the hospital submit it directly via email to CentralizedProgramFlex@cdph.ca.gov. The flex request must explain how the hospital proposes to staff the units for which it is requesting a flex. For example, if the hospital plans to team up staff to care for a group of patients, the hospital must indicate the unit(s) that will utilize a team nursing model, the number of staff on each team, their licensure types (RN or LVN), and the number of patients for whom the team will care.

The hospital must also explain, for each unit, the responsibilities/tasks each nurse on the team will perform. For example, let's say an ICU-experienced nurse (who we will call the "primary" nurse) will be teamed with a med/surg-experienced nurse (who we will call the "secondary" nurse) to care for four ICU patients. The hospital might explain that the primary nurse will conduct critical care patient assessment; identify nursing diagnosis' perform ventilator care according to unit guidelines; administer all critical medications; and document the patient assessment, nursing diagnosis, care planning, and patient education. The hospital might state that the secondary nurse will conduct patient assessment based on level of competency in collaboration with the primary nurse; perform tasks assigned by the primary nurse based on level of competency; provide ventilator management only if competent to manage stable/chronic vented patients; administer non-critical medications; and document assessment, care planning, and patient education based on level of competency.

Note that this is just one example of a plan that was approved by CDPH — other plans may also be acceptable. We describe this plan to help hospitals understand the level of detail CDPH is looking for, not to suggest that this way of dividing tasks is required. It is not enough to simply ask for a "team nursing" waiver and not provide any details. Specific information must be provided to CDPH so it can evaluate the details of the proposed staffing model.

CDPH may ask hospitals requesting a program flex to describe the actions they have taken to try to increase staffing. This could include paying overtime or other incentives for staff to accept additional shifts, filling unfilled positions as much as possible, discharging patients as appropriate, rescheduling non-emergent surgeries, diverting ambulance traffic, etc. In addition, CDPH expects hospitals to try to obtain temporary staffing from the hospital's usual vendors, as well as from certain staffing agencies with which

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CDPH and the state of California have worked. The state has reported that **these agencies** have displayed a high standard of responsiveness, deployment speed, and clinical competency of their staff.

Finally, CDPH has stated that it requires hospitals requesting program flexibility related to the nurse-to-patient ratio law to request staffing from their Medical Health Operational Area Coordinator (MHOAC). The state continues to contract directly with staffing agencies and may be able to provide your hospital with staff. These would be provided through a Memorandum of Understanding, under which the state provides the staff and the hospital reimburses the state for the cost of the staff.

The hospital must do this even if the MHOAC has already responded to the hospital that it has no staffing to deploy. CDPH wants the request entered into the Salesforce system, which is a tool used by CDPH to provide a line of sight into all resource requests from MHOACs, including hospital staffing needs statewide. Some MHOACs do not realize that CDPH has adopted this requirement — your hospital may need to educate them in this regard.

As a reminder, a hospital that utilizes a team nursing model for three consecutive days is required by the State Public Health Officer Order of Aug. 16, 2021 to immediately notify all of the following in writing:

- The Medical and Health Operational Area Coordinator (MHOAC)
- The local public health officer
- The CDPH district office. Although the CDPH Centralized Program Flexibility Unit is supposed to notify the district office of approved team nursing flexes, the hospital should make this notification also.

CDPH has stated that it is not currently willing to approve program flexibility requests or waivers for the numerical nurse-to-patient staffing ratios. CHA continues to advocate for greater flexibility for hospitals to utilize their staffing as needed to provide the best care possible for patients during the pandemic.

5. Can student nurses or unlicensed persons provide care for patients?

Yes. The Board of Registered Nursing (BRN) affirmed that during a pandemic, state law allows nursing services to be provided by unlicensed persons, including student nurses. In addition, the BRN developed a chart showing the types of services a student nurse is likely able to competently provide depending on the coursework completed by the student nurse. The BRN also:

- Modified certain requirements for clinical training sites and for nursing students related to the number of hours needed of direct patient care experience (expires Dec. 31, 2021)
- Modified certain nursing preceptorship requirements and restrictions on nursing student clinical training (expires Dec. 31, 2021)

The flexibilities in the two waivers set to expire on Dec. 31 have been replaced by the language included in Assembly Bill 2288 (Stats. 2020, Ch. 282).

Although student nurses and unlicensed persons may provide care for patients, they may not be counted as nurses for purposes of meeting the nurse-to-patient ratio requirement.

6. Can I request nurses or other staff from the state?

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Yes, the state may be able to provide your hospital with staff through the state's contracts with staffing agencies. However, the hospital would need to reimburse the state for the costs of staff. A hospital that needs staff should take the steps outlined in AFL 20-46.3.

The Biden administration announced on Dec. 2 that it will deploy 20+ Department of Defense medical response teams to support clinical staffing at strained hospitals. CHA is advocating for some of these personnel to be sent to California hospitals.

7. Can staff work if they are suspected or confirmed to have COVID-19?

Yes. CDPH guidance in AFL 21-08.5 specifies that during critical staffing shortages, as a last resort, hospitals may consider allowing health care personnel (HCP) with **suspected or confirmed** SARS-CoV-2 infection to work if they are well enough and willing to work, even if they have not met all return to work criteria.

This recommendation is consistent with the Centers for Disease Control and Prevention Guidance on Mitigating Staffing Shortages, which identifies that such a strategy might be considered when, despite efforts to mitigate, staffing shortages persist.

The section "Return to Work for Hospital HCP diagnosed with COVID-19" in the AFL also notes:

- Considerations for determining which suspected or confirmed health care personnel should work.
- Positive HCP may not care for patients who have not tested positive for COVID-19 until at least 10 days from the date of their positive test.
- If hospital HCP are allowed to work before meeting all criteria, they should be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) and hospitals should consider prioritizing their duties as described in the AFL.
- Positive HCP must maintain separation from other HCP as much as possible (for example, use a separate breakroom and restroom) and wear a N95 respirator for source control at all times while in the facility.
- Health care facilities should inform patients and HCP when the facility is operating under critical staffing shortages, that changes in practice should be expected, and that — if HCP with suspected or confirmed SARS-CoV-2 infection are allowed to work — actions will be taken to protect patients and HCP from exposure. (Note that CDPH says that hospitals "should" do this, not that they "must" do this.)

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