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Oregon Nurse Staffing Advisory Board (NSAB)
Wednesday, November 28, 2018
1:00 PM – 5:00 PM

Meeting Minutes

Co-chairs	Carol Bradley, MSN, RN, CENP; Susan King, MS RN, CEN, FAAN
Roll-call members present:	Carolyn Starnes, ASN, RN; Debbie Robinson, MSN, RN; Jennifer Burrows, RN, BN, BSc, MBA; Virginia Smith, BSN, RN-BC; Uzo Izunagbara, RN; Rob Campbell, CP, ADN, RN; Zennia Ceniza, RN, MA, CCRN, ACNP-BC (on phone).
PHD staff present	Dana Selover, MD, MPH; Anna Davis, JD; Matt Gilman, MPPA; Marisha Childs, JD; Sophia Wilkus; Wendy Edwards, RN; Karyn Thrapp, RN.
Guests present	Jordan Ferris; Diane Waldo; Therese Hooft; Dana Bjarnason; Kathy Kirby; Jolene Fincher; Theresa Brock; Beth Callison; Pat Brown

Agenda Item 1	Call to Order
Co-chair Carol Bradley called the meeting to order. Matt Gilman introduced new PHD Nurse Staffing staff members: Marisha Childs, nurse staffing coordinator and Sophia Wilkus, nurse staffing administrative specialist.	

Agenda Item 2	Approval of prior meeting minutes
Corrections/edits suggested by D. Robinson and S. King. OHA staff will make edits. Motion to approve minutes: J. Burrows Seconded by: D. Robinson All in favor: no opposition	

Agenda Item 3	Travel Policy update
Members are reimbursed at the www.GSA.gov rate. Members should contact HCRQI at least five weeks in advance of travel if air travel is requested.	

Agenda Item 4	Membership & bylaws updates

Calendar for 2019

The NSAB meeting calendar for 2019 would put the November meeting in conflict with a holiday. Members agreed to move November 2019 meeting to the 3rd Wednesday of that month (**November 20, 2019**).

Review Membership Terms

M. Gilman presented the membership dashboard to show member terms and expiration.

Board member T. Gurrad has finished her term. Board co-chair reiterated concerns about NSAB having representation from smaller hospitals.

Discuss co-chair selection

Both current co-chairs terms expire at the same time.

OHA staff discussed ways to create a seamless transition with new co-chairs; Board co-chair recommended staggering the co-chair terms.

Board co-chair suggested sending a letter to the Governor and amending language in the bylaws to create staggered co-chair terms.

Board member asked whether a Board member can be involved with appointment of new members beyond sending a letter to the Governor and the NSAB by-law amendment to indicate the Board's preference for co-chair appointments of prior Board members.

A. Davis confirmed that the Board members can make recommendations to the Governor regarding their preferences for co-chair terms.

Action Item	• OHA will communicate with Governor's Office of Executive appointments for details about how long applications are held and share the Board's preference to have staggered Co-Chair appointments

Agenda Item 5	Status updates

Nurse staffing waivers

A. Davis presented the waiver dashboard. She noted that previous waiver dashboards use terminology of 'small hospitals,' which has now been changed to 'Critical Access Hospitals' at the request of NSAB members.
Board member asked how often waivers need to be updated. A. Davis stated that waivers last for three years and can be renewed.

D. Selover asked Board members to provide feedback on other data points that would be helpful to see in the dashboard.

A. Davis stated that waiver requests have slowed down and asked the Board if they are amenable to receiving this information less frequently.

Board co-chair recommended providing the information in May and again for the year-end meeting in November. If the information in the waiver differs from the usual request (the use of techs) or if there is an uptick in requests, that information should be tracked and provided to the Board via dashboard.

Action Item	• OHA will provide waiver dashboard in May and again at year-end meeting and annually thereafter.

Nurse staffing surveys

A. Davis presented the survey dashboard. OHA is moving into the revisit stage now that there are numerous approved Plans of Correction. She stated that a few facilities are on their fourth or fifth Plan of Correction. All of these facilities have had conference calls regarding Plans of Correction.

Board member asked how many Plans of Correction OHA will allow before imposing civil penalties.

Board co-chair explained the reason some facilities are on their fourth or fifth Plans of Correction is a result of the challenge of writing a Plan that adequately addresses the citations. OHA is seeing progress in the Plans of Correction by facilities submitting multiple Plans of Correction. OHA explained that facilities are not typically sending in the same Plan of Correction language repeatedly; there have been improvements in each sequential Plan of Correction submitted by these facilities in particular. For each of the facilities on their fourth or fifth Plan, OHA has reviewed the progress in the Plans of Correction and can show that each time the facility submits a plan there are significantly fewer citations that need additional correction – each of the Plans shows progress by the facility in addressing outstanding issues. Civil penalties have not been a focus yet.

Board member asked OHA staff who is generally on the Plans of Correction conference calls.
A. Davis stated that there are a mix of individuals on the conference calls. In some cases, it is the CNO, but in many cases the call includes staffing committee co-chairs, administrative staff and others who are involved in formulating the Plan of Correction. Some hospitals also include quality improvement staff in the calls.
Board member encouraged members to ensure the right mix of people are on the Plan of Correction conference call to facilitate a productive discussion. It is more productive to have a mix of direct care nurses along with nurse managers that are involved with the staffing committee on the conference call rather than to have a quality control

nurse or quality improvement staff member who is not involved with the staffing committee.

A. Davis reiterated that OHA does not have the authority to require certain facility staff members to be on the conference call; it is up to facilities to determine who is included on the calls. OHA can and will encourage facilities to invite co-chairs and others to participate.

Action Item	• OHA will provide additional guidance recommending members of the nurse staffing committee and the CNO participate on conference calls.

Nurse staffing complaint investigations

Board member asked how or if the complainant is contacted by OHA after making the complaint.

A. Davis explained that the process is aligned with all complaints received. After a complaint is filed, the complainant receives confirmation, and is advised that his/her complaint will be reviewed for possible investigation and advised that there will be forthcoming correspondence at that time. Once a report is drafted, a letter goes to the complainant explaining whether the complaint was substantiated or not; if an investigation is conducted, a copy of the report is provided.

Board member expressed concern about the perception of the timeline from the perspective of the complainant from the time the complaint is made to resolution.

A. Davis explained that because some complaints are combined with survey it is challenging to define an average timeframe for complaint investigation. She acknowledged that the survey team is behind on complaints in general, including nurse staffing complaints, and has prioritized the nurse staffing full surveys in order to try to implement the triennial survey cycle specified in the statute. The slowdown is due to both a staffing shortage and an increase in the surveyor workload in general. There are a few nurse staffing complaints that are in the triage process and OHA will schedule those for investigation once the triage is completed.

Board member suggested prioritizing complaints noting that if all received complaints are substantiated, perhaps that is a signal to what is missing in the regular survey.

Action Item	• OHA staff noted the request to prioritize complaints and will discuss further internally.

Agenda Item 6	Committee Updates

SurveyMonkey committee

M. Gilman reviewed the goal and purpose of the committee, which has not met since the last NSAB meeting.

The new revised survey questionnaires will be in use for the 2019 surveys.

Board member asked about data points collected reflecting the volume of surveys completed.

M. Gilman described the general response rate and how survey results are used.

Action Item	• M. Gilman will email the SurveyMonkey committee to finalize suggestions for implementation in the 2019 surveys.

Survey Tool committee

M. Gilman shared that this committee has not met since the last NSAB meeting. The committee last met over the summer and reviewed survey-tool packet.

Action Item	• M. Gilman and A. Davis will be reconciling comments and recommendations and finalizing changes. Staff will bring this reconciliation to the next Board meeting.

Overtime committee

M. Gilman stated that this committee met in October and one of the items of discussion related to how surveyors categorize overtime. The recommendation resulting from this meeting was that facilities may provide documentation of overtime via paper or electronic records. M. Gilman confirmed that surveyors review paper and electronic records and may request that electronic records be printed so that they can review them with the nurse staffing team when preparing the report.

Board co-chair suggested that mandatory overtime requires a report and needs to be validated by the nurses, but voluntary overtime would not need to be reported and validated.

Board co-chair shared that at her facility the measuring/monitoring of overtime including the number of hours worked warranting overtime pay, versus picking up an extra shift which, places a nurse over the hours hired to work, but not warranting overtime pay, and similar situations present challenges.

Board member asked if the Overtime Committee could put some structure around how an institution should be reviewing its mandatory overtime – tracking and trending its usage -- that might lessen the burden on the surveyors in evaluating that information.

Board member suggested that the committee could perform an informal survey by reaching out to staffing committees to find out how committees review aggregate overtime/mandatory overtime for the annual staffing plan review.	
Action Item	• Overtime Committee will be reconvened to discuss topics in notes above.

Acuity committee

M. Gilman stated that the acuity committee had to be rescheduled. A Doodle poll will be resent to committee members who did not receive the recent poll.

Board member asked if it will be possible for OHA to do a literature review/search as it relates to acuity prior to the May 2019 meeting and asked if Oregon Nurse Staffing Collaborative (ONSC) will be included in the acuity committee meetings.

D. Selover stated that because of the upcoming legislative session, that may be challenging. In addition; the nurses on the Board are the subject matter experts, and OHA looks to the nurses for this information. The hospitals and nurses are best-situation to determine best practices within their facilities using the resources they have available.

Board co-chair highlighted that the rule does not actually reference an acuity tool, rather the rule discusses acuity being a consideration when a staffing plan is being developed. An important conversation around acuity is to demonstrate that acuity is in fact being considered in the development of a staffing plan.

Action Item	• OHA will update member email addresses and resend Doodle poll to schedule an acuity committee meeting and include ONSC

Agenda Item 7	**Surveyor Q&A**
Q1	**How does the safe patient care definition (OAR 333-510-0002(17)) inform the Plan of Correction determination; is this list comprehensive enough and who decides this?**
A1	The safe patient care definition applies broadly to nurse staffing care provided throughout the hospital not just exclusively to nurse staffing. Credible allegations of actual patient harm to a specific patient or patients, or situations where patient harm is likely to occur due to a specific failure on the part of the hospital or staff are investigated per non-nurse staffing processes. For nurse staffing purposes that definition is used to allow OHA to impose civil monetary penalties (as per, 333-501-0045(2)).
Q2	**How are safe staffing variances determined to be nurse staffing issues (to be investigated by OHA) vs individual RN performance (under the purview**

	of the Oregon State Board of Nursing) as it relates to 'safe patient care' provision?
A2	The hospital is responsible for the provision of all care and services provided by its staff. OHA is responsible for regulation of the hospital. Findings of actual or potential patient harm during a non-nurse staffing survey or complaint investigation will result in citations of deficient practice of the applicable OARs for the hospital, even if those failures are attributed to an individual staff person. If, during the surveys and investigations, we determine there is a potential problem with an individual licensee's practice we generate a formal referral to the licensing board with jurisdiction of that individual's practice.
Q3	**Do hospital Nurse Staffing surveys address unit-level Nurse Staffing Plans for reorganization or leadership restructuring in the facility's Statement of Deficiencies and Plan of Correction?**
A3	As addressed above, the hospital may propose any number of actions in the development of its POC, including re-organization.
Q4	**What unique ethical challenges does a surveyor experience when surveying a given hospital for which one (direct care RN or management role) has worked for in the past?**
A4	This is not a unique ethical challenge specific to Nurse Staffing Surveys (NSS) or Nurse Staffing Complaint (NSC) investigations. State of Oregon policies prevent surveyors from surveying facilities in which they had been employed within the two years prior to employment at OHA. In addition, surveyors in all program types experience occasions when we encounter friends, families, or acquaintances who work as staff in facility types we survey or whose names appear on patient lists in those facilities. Such potential conflicts of interest, if known prior to survey, are discussed with survey manager. If those potential conflicts are discovered during a survey, adjustments in assignments or changes to employee record or patient record selections are made.
Q5	**What barriers do the surveyors face when they are collecting and reviewing the nurse staffing compliance data?**
A5	Periodically hospitals may not provide the requested documents and data as requested on the needs list or in a verbal request, or that information may not be provided in a timely manner. (For example, the list of qualifications and competencies for each Nurse Staffing Member (NSM) type on the unit.) However, generally there are very few barriers to obtaining the requested information.
Q6	**Having reviewed the presence of various forms of acuity systems across the State, are there findings any safety issues associated with these tools?**
A6	Surveyors evaluate the Nurse Staffing Plans (nurse staffing plan) to determine if those include clear processes/systems/methods/tools to evaluate patient acuity and nursing care intensity. It is unclear what kind of "safety issue" is being referred to in the question and further how one would conclude that a

	process/system/method/tool would reflect a "safety issue." Surveyors are evaluating a nurse staffing plan to ensure you have a safe system in place rather than looking to see if there is a safety issue with the nurse staffing plan.
Q7	**What suggestions do the surveyors have for NSAB?**
A7	For the facilities: mock surveys are recommended; ensure that the Nurse Staffing Plan is implemented across all nursing units. For the NSAB: None at this time.
Q8	**What is the minimum number of units surveyed at a hospital?**
A8	Per policies described online and in survey tools - 1 to 49 beds: 2 units; 50 to 99 beds: 3 units; 100 to 199 beds: 4 units; 200+ beds: 5 units.
Q9	**Who determines which units are surveyed?**
A9	Per policies described online and in survey tools we use the "modified systematic random sampling" method using the list provided by the hospital of units where nursing services are provided.
Q10	**If a survey is triggered by a complaint is that unit always surveyed?**
A10	During a complaint investigation (not combined with a full survey) only the unit(s) where the non-compliance is alleged is surveyed. If the complaint is combined with a full survey, the unit that is subject to the complaint is subject to the full survey.
Q11	**Clarify how the data from the Survey Monkey is used in assessing the extent to which the facility is complying with the nurse staffing law.**
A11	Information obtained during interviews with staff whether in person or via Survey Monkey is evaluated to determine whether it supports, strengthens, or clarifies findings from other sources such as observations and record or document review. Interview information is not generally the only source on which a deficiency is cited.
Q12	**What are the factors that surveyors need to determine if the staffing plan is based on patient need and other requirements of the law?**
A12	Hospitals must demonstrate compliance with all State and Federal regulatory requirements, not exclusive to nurse staffing. Surveyors evaluate compliance with those regulatory requirements and generate needs lists prior to surveys and complaint investigations based on the requirements being evaluated. In the case of a Nurse Staffing Survey, a comprehensive needs list has been developed that provides for the documents and records surveyors need.
Q13	**If the surveyors accept decisions of the staffing committee as evidence that the requirement of the law related to patient acuity need, unit activity, meals, and breaks, etc., do they interview members of the committee to ensure that such decisions were made based on those same factors?**
A13	Hospital Nurse Staffing Committee member co-chairs are routinely interviewed, and all nurse staffing members are provided opportunity to participate in SurveyMonkey interviews. Throughout the survey process when documentation is not clear, clarifications are requested and those may be provided by various individuals. However, to date, surveyors have not encountered situations that

	would prompt us to be concerned that nurse staffing committee documentation about decision-making had been falsified, altered, or was otherwise called into question. If such an occasion occurred, clarifications would be requested per usual processes, and all findings reviewed with the OHA team when the survey team returned to the office.

Agenda Item 8	NSAB Feedback

Cross-walk documents – review topics/definitions that due to time constraints were not addressed at the last meeting.

D. Selover explained that in July one of the priorities from the Board included acuity and overtime. These documents were prepared so that the NSAB would have information and an opportunity to provide feedback to OHA on priority issues.

Nurse Staffing Units definition

A. Davis addressed which units are covered and which are not using the definition from statute and rule. These definitions have been clarified in the Interpretive Guidance. The definition includes inpatient and outpatient units in both on and off-campus locations. The inclusion of a unit for purposes of representation on the hospital-wide nurse staffing committee and having a nurse staffing plan is based on whether the service is covered by the hospital license and whether nursing staff members in the unit are primarily engaged in providing direct patient care services. OHA has provided this guidance to hospitals and surveyors do the same analysis in a survey or complaint investigation and look to the committee minutes for evidence that the hospital has made this determination.

Board member asked whether Ambulatory Surgical Centers (ASC) are under the purview of nurse staffing law.

A. Davis confirmed that the nurse staffing law continues to cover only hospitals as defined by statute.

Board member recalled that back during Rules Advisory Committee for Nurse Staffing, they operated on the assumption that any unit that took a patient assignment would need a staffing plan. Over time, however, this has evolved into considering the type of care a patient is receiving from the nurse on a unit. The board member explained that an important consideration is what happens on a unit when a nurse is on leave or calls out sick. The question of whether a department back-fills its own positions or replaces open shifts with another nurse impacts the determination of whether a nurse staffing plan is necessary.

Board co-chair explained that at her facility, they consider whether a unit's primary service is nursing care, versus if nursing is ancillary on that unit. Nursing care is ancillary if it is supplemental to the primary care – like in a provider-based clinic.

D. Selover acknowledged that until there is a recommendation by the NSAB to make a change as it relates to this definition – of nurse staffing unit, it will remain as it is.

A. Davis explained the importance of a nurse staffing committee documenting in their meeting minutes what they considered when making the determination of whether a unit is a 'nursing unit' and will have a nurse staffing plan.

Action Item	• OHA will add interpretive guidance for hospital units to document in their hospital nurse staffing committee meeting minutes on what basis the Committee determined whether a particular unit needs a nurse staffing plan and to document in the hospital nurse staffing committee meeting minutes how the determination regarding need for nurse staffing plan was made.

Total Diagnoses per Unit

A. Davis stated that the general guidance OHA provides facilities is that a nurse staffing plan does not need to list all diagnoses on a unit, and instead should take into account the most common diagnoses of that patient population. She further stated that there is no specific number of diagnoses for any particular unit and it is up to the hospital nurse staffing committee to determine what number of diagnoses is appropriate for consideration on a particular unit.

Board member added that on a national scale, the discussion in nursing around determining patient acuity and nursing intensity has less to do with diagnoses per se and less the number of diagnoses, but rather divisions of patients on type, including "med/surg., critical care, etc."

Board co-chair agreed that the total diagnoses requirement is a heavily medical lens as opposed to a nursing lens. Further, the board co-chair suggested that while this guideline is reasonable, it doesn't reflect the experience of Board members who have been through a survey.

A. Davis noted that a frequently cited example of failure to meet this criterion is when facilities have listed most common procedures on that unit rather than the total diagnoses.

Board member suggested that often a procedure is more relevant to the nursing intensity for a patient than the actual diagnosis for that patient.

D. Selover asked if either diagnosis or procedure adequately captures nursing intensity given variables and dimensions by which nurses measure patients.

Board co-chair added that nursing interventions literature provides Nursing Intervention Classification (NIC) and Nursing Outcome Classification (NOC) as a

professional lens for measuring acuity or intensity which may be useful for the Board to consult in providing advice to OHA. Board co-chair stated that the hospital nurse staffing committee cannot determine how much nursing staff is needed based on total diagnoses.

Other Board members voiced support for this perspective.

Action Item	• This topic will be added to the agenda for a future meeting and further discussion.

Non-direct care nursing staff member as second nursing staff member

A. Davis stated that the definition of nursing staff member is included in the overtime statute. The same definition is used in the rules. The Interpretative Guidance includes questions related to the use of technicians, medical staff, and others in lieu of a second nursing staff member.

Board co-chair shared an example of a PACU with a single patient waiting to check out and go home for the day where a single nurse is on the unit and an anesthesiologist is on unit. She posited that the presence of a second nursing staff member is about ensuring patient safety and stated that the availability of a higher level of care should suffice as a backup for patient safety.

Board member offered an additional example of an obstetrical setting in which a Certified Nurse Midwife provides a higher level of care for and ensures patient safety. The midwife is not necessarily providing nursing care and does not meet the criteria for a second nursing staff member under the rule.

A Board member raised a concern regarding an anesthesiologist, for example, being counted as the second nursing staff member and possibly being distracted by other tasks or called away for another patient or consult elsewhere and thereby abandoning patient care duties.

Board member expressed agreement that this could be a slippery slope as providers may be called away. The Board member expressed support for having two nursing staff members present unless there is a waiver approved for that unit.

Board member suggested that a department may write in their nurse staffing plan that if there is a single patient left on the unit before closing, that the second-nursing staff member position will be satisfied by a provider of a higher level of care and that provider may not leave the unit.

Board co-chair stated that the risk doesn't seem to be much different from a CNA acting as a second nursing staff member who may be pulled away to attend to other tasks and suggested that regardless of the provider type acting as second nursing staff member, there must be a commitment to the staffing plan created for the unit.

Board member pointed out the language in the Interpretative Guidance indicating that "during the time that an advanced practice RN is working as a nursing staff member, the advance practice nurse: …should not perform services that require advance practice licensure," on page 2 of the Crosswalk document.

Board co-chair responded with the example of an Advance Practice Registered Nurse (APRN) acting as a second nursing staff member on a Neonatal Intensive Care Unit (NICU) unit where a patient is crashing and asked if the APRN would not be allowed to practice as an APRN and would not be able to intubate the patient in this situation.

Board member suggested that this situation would put the APRN's license at risk.

Board co-chair stated that this may not have been written exactly as intended and suggested that the intention of the writing is to indicate that the APRN or other advanced practice nurse should still practice to the full extent of his or her license but should be attentive to the patient or unit needs.

Board co-chair added that there should be the ability and flexibility to recognize the role of other people besides CNAs as second nursing staff members, like the recognition given to technicians.

D. Selover suggested that whomever is being utilized as the second nursing staff member needs to be officially stated in the nurse staffing plan, whether that is an APRN, CNA, or an anesthesiologist, and that the nurse staffing plan must further detail how the unit ensures and maintains documentation that the provider did not leave the unit during their time acting as the second nursing staff member.

Board member related that there have been situations where technicians have asked to leave while they are acting as the second nursing staff member underlining the need for a culture change of commitment to the nurse staffing plan and patient safety.

Action Item	• This topic will be added to agenda for a future meeting and further discussion

Agenda Item 9	Emerging Issues in Nurse Staffing

Increasing use of advanced practice nurses

Board co-chair asked whether OHA would refer a complaint regarding an individual nurse manager who clearly and intentionally elected to violate the nurse staffing plan to the Board of Nursing. The board co-chair stated that this is related to an individual nurse's performance as a licensee and the Nurse Practice Act requires licensees to comply with all relevant laws. She indicated that there was some confusion at a recent Board of Nursing meeting as to whether the Board of Nursing would deal with staffing issues.

A. Davis responded that there have been conversations with the State Board of Nursing regarding how and when OHA makes referrals, and further that this situation has not come up to date. Referrals to the Board of Nursing have been related to other violations of the Nurse Practice Act. The violation described would likely have significant evidence of intent and would be reported to the Board of Nursing. She stated that violations of nurse staffing plans by specific individuals are not a frequent basis for complaints, more often, complaints regarding the implementation of a nurse staffing plan relate to actions by managers or management as a group. For example, there have been violations in which a unit runs a pilot of a new nurse staffing plan without approval of the plan by the nurse staffing committee.

Board co-chair stated that the example is nuanced and restated her concern regarding single bad actors violating nurse staffing plans. She confirmed that the OHA would refer these violations by individuals to the Board of Nursing.

Board co-chair stated that in the case of a violation by an individual nurse manager, it would be reasonable to expect that the unit staff would inform the individual nurse manager's supervisor in accordance with the chain of command at the hospital. If the nurse manager's supervisors do not take appropriate action, it would then be a compliance issue for the hospital.

Agenda Item 10	Public Comment

The following members of the public provided feedback on their perspectives on the Nurse Staffing Law requirements. The NSAB appreciated this candid input. In addition, the Board invited Jordan Ferris of the ONA to present on ONA survey findings at the next Board meeting.

- Jordan Ferris NPC, ONA
- Kathy Kirby RN, Grande Ronde Hospital
- Jolene Fincher, RON, Grande Ronde Hospital
- Theresa Brock VPN, Good Shepherd
- Pat Brown RN

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