Clarification Document

Illinois Hospital Nurse Staffing Data Collection Guidelines

For Reports Submitted to the Illinois Department of Public Health

Supplement March, 2012

Illinois Department of Public Health

Division of Patient Safety and Quality

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Introduction

The Hospital Report Card Act (210 ILCS 86) enacted in 2003 is intended to provide consumers information about the quality of health care provided in Illinois hospitals so that they may make informed choices about their health care provider. The Act expressly states, among other issues, that consumers have the right to access nurse staffing information. Hospitals are required to submit their nursing hours per specified clinical service areas quarterly to the Illinois Department of Public Health. Since November, 2009, the information has been made publicly available at www.healthcarereportcard.illinois.gov and is regularly updated.

As incoming data was examined more extensively, it became evident that there was wide variation in nurse staffing data collection methods at reporting hospitals. Over the past year, the Illinois Department of Public Health together with representatives from the Illinois Organization of Nurse Leaders, the Metropolitan Chicago Healthcare Council, the Illinois Hospital Association, and an expert panel of nurse leaders from representative hospitals across the state, collaborated to address this issue. Consultation with Chief Nurse Executives and staff internally collecting the data at hospitals enhanced understanding about what factors may be contributing to the variability. During this process, nationally recognized leaders in nurse staffing quality measurement and data collection were engaged for expert consultation, including the National Quality Forum, the Joint Commission and the National Database of Nursing Quality Indicators (NDNQI), which is a program of the American Nurses Association's National Center for Nursing Quality. The following data collection supplement is a result of those combined efforts and is intended to enhance clarity and produce more consistent and reliable data comparisons, as well as ease operational compliance. This supplement should be used to complement prior data collection guideline documents. The first two sections, one on "Direct Care Nurse Staff Hours" and the second on "Inpatient Days Data Collection" are applicable to all clinical service areas. The last section has specific clarifications for medical/surgical, telemetry, critical care and maternal-child clinical care service areas.

Section I. Overall Guidelines for Reporting Direct Care Nurse Staff Hours

A. Direct Care Nursing Hours - Include:

- Productive hours worked by any licensed or assistive nursing staff who provide direct patient care for **50% or more** of their shift in a clinical service area should be included. The 50% rule applies to employees, as well as agency, per diem, travelers, registry and contracted direct nursing care staff.

- The total shift work hours should be reported, not an estimate of time allotted to direct patient care. Example: If a patient care technician spends 75% of their eight hour shift in direct patient care, and 25% of their time as a unit secretary, report all of their eight hours worked (not just the hours in direct patient care). This rule applies to all nursing personnel, which may include telemetry technicians, sitters, charge nurses, and nurse managers.
- Hours for unlicensed assistive personnel, such as sitters, nursing assistants, patient care technicians that devote 50% or more of their total hours in a shift in direct care activities such as taking vital signs, bathing, feeding, or dressing patients, assisting with transfers, ambulation or toileting (i.e. hands on nursing care) should be included.
- Productive hours worked means the actual work hours. Do not include hours for vacation, holidays, sick leave and any other absences.

B. Direct Care Nursing Hours – Exclude:

- Nursing personnel whose time spent in direct patient care services is **less than 50%** should not be counted. This can include nurse managers, charge nurses, and assistive personnel.
- Unit secretaries, diabetic educators, wound/ostomy care nurses, lactation specialists and other clinical nurse specialists and specialty teams should **NOT** be counted in direct care hours reported.
- Any nursing staff hours where the patient care responsibility is only to spend time observing monitors s**houl**d **NOT** be reported as direct care staff hours, for example in an E-ICU or when telemetry technicians are located in separate rooms from patients.
- Sitters whose primary responsibility is only to spend time observing patients should **NOT** be reported as direct care staff hours.
- Any nursing staff hours where over 50% of time is spent doing administrative work should not be included.
- Licensed nurses who are participating in orientation should **NOT** be included.
- Student nurses fulfilling educational requirements should **NOT** be included.
- Do not "double-count" hours for nursing staff affiliated with special response teams. Hours spent on the Rapid Response teams, Stroke Alert teams, Cardiac Arrest teams, Trauma teams should be included in the productive hours worked of their "home" clinical service area category, e.g. medical-surgical, critical care, pediatrics, etc.

Section II. Inpatient Days Data Collection

Careful attention to the calculation of "inpatient days" is essential in assessing the patient work load of nursing staff. It reflects the demand for nurse staffing. Ultimately, the supply of nursing staff (direct care hours worked) can be analyzed relative to the demand for nursing staff (inpatient days) to help assess nurse staffing levels and needs.

The number of inpatient days captures the sum of the daily census of patients for a given area during the reporting period. The census count includes patients occupying beds for the inpatient clinical service area for which data is reported. A patient day conceptually is 24 hours, beginning with

admission hour. However, in today's inpatient setting many clinical service areas include a mix of short stay patients and inpatients. Short stay patients are not typically classified as inpatients. They may be observation patients, outpatients, or same day surgery patients. They may be treated and cared for on inpatient units, but for less than a full 24 hours. Some hospitals may have dedicated short stay units, but many do not. To accurately assess the complete patient load of nurses, **the census should be adjusted to capture short stay patients** when they receive care on an inpatient unit.

Hospitals use a variety of strategies to determine how to account for the nursing hours associated with the short stay, leading to a wide variation in data reporting. Expert consultation from NDNQI was sought about preferred methodologies for calculating those hours when short stay patients are not cared for in distinct units, but are mixed in patient populations on any unit. Four different patient day reporting options are listed below. Hospitals are encouraged to select the option that will most accurately reflect the total patient work load for their setting and for each clinical service area. Note that these options are in alignment with the National Quality Foundation and the National Database of Nursing Quality Indicators guidelines. Studies of reliability have found all four methods equally reliable when applied appropriately.

Patient Day Options

1. **Midnight Census** - The census is counted at midnight, the first minute of the day. The daily midnight census should be summed for each day in the given reporting period. This method is adequate for units with ***all*** inpatients. It is not accurate, and thus not recommended, for units with both inpatients and short stay patients.
2. **Midnight Census Plus Patient Days from Actual Hours of Short Stay Patients** – This method combines use of the midnight census for inpatients with calculation of short stay patient "days". The total daily hours for short stay patients should be summed separately for the reporting period quarter, and then divided by 24. This number should then be added to the midnight census summary for a total inpatient day calculation.
3. **Inpatient Days from Actual Hours** – This method utilizes accounting systems that track the actual time spent in the hospital by each patient, whether inpatient or short stay patient. It is the most accurate method available. For a given reporting period, sum actual hours for all patients, whether in-patient or short stay, and divide by 24.
4. **Inpatient Days from Multiple Census Reports** – This method uses collection of censuses multiple times per day (for example every 4 or 8 hours). It is also shown to be very accurate, as in Method 3. The sum of each of the <u>average</u> daily censuses should be calculated for the given reporting period.

Hospitals should ideally use one method and use it consistently, unless there is a change in infrastructure and accounting systems that allows improvement in data capture similar to Methods 3 and 4. The best method for each clinical area reported should be utilized.

Section III. Clinical Service Areas

Hospital Report Card Act (210 ILCS 86)

Inclusions and Exclusions for Reporting

Information highlighted below provides clarification of inclusion and exclusion criteria for four clinical service areas - medical-surgical, telemetry, critical care and maternal-child care. Please note that the submission of peri-operative nurse staffing data to the Illinois Department of Public Health was suspended until further notice effective 6/8/11.

Medical – Surgical

The clinical service areas where patients require less care than that which is available in intensive care units and have available 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 age groups, as well as short-stay patients*.

CLINICAL SERVICE AREA	YES – INCLUDE IN MED-SURG REPORTING	NO – DO NOT INCLUDE IN MED-SURG REPORTING
MEDICAL-SURGICAL	All distinct intermediate care or step-down patient care units need to be reported, e.g. all non-critical care.	Any med-surgical or intermediate care patient housed in Critical Care should be included in Critical Care reporting.
	Any "mixed" medical-surgical patient care units that also care for other patient populations should be reported as medical-surgical units and hours, e.g. pediatrics, behavioral health, telemetry, gyne and/or rehab patients.	Any distinct, physically separated Behavioral Health, Pediatric, or Telemetry unit needs to be reported in their respective clinical service areas.
	All short stay patients that may be cared for on medical-surgical units should be reported, including observation patients, outpatients, or same day surgery patients.	The following units are not required and should not be reported under the medical-surgical clinical service area: o Distinct observations units/hours o Distinct outpatient units/hours o Other areas and names: Clinical Decision Units, Pre/Post Procedural Care Units, Rule out Chest Pain Centers

***Note: "Short-stay patients" are those patients not typically classified as inpatients and may be observation patients, outpatients, or same day surgery patients.**

Telemetry

The clinical service areas organized, operated and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals.

CLINICAL SERVICE AREA	YES – INCLUDE IN TELEMETRY REPORTING	NO – DO NOT INCLUDE IN TELEMETRY REPORTING
Telemetry	Any patients being cared for in a distinct telemetry service area are to be counted within the Telemetry grouping.	Any telemetry patients being cared for on a medical-surgical unit should be reported under medical-surgical *(see medical-surgical guidelines above).*

Critical Care

Critical care clinical service areas are areas organized, operated, and maintained to provide for monitoring and caring for patients with severe or potentially severe physiologic instability requiring technical support and often requiring artificial life support. Intensive nursing and medical care of critically ill patients is provided.

CLINICAL SERVICE AREA	YES – INCLUDE IN CRITICAL CARE REPORTING	NO – DO NOT INCLUDE IN CRITICAL CARE REPORTING
CRITICAL CARE	Any patients being cared for in a critical care service area – as long as they are cared for in the critical care area, are to be counted within the critical care grouping, e.g. intermediate patients, observation patients or other short stay patients, overflow patients, behavioral health patients.	Any distinct intermediate or step-down patient care units need to be reported under medical-surgical *(see medical-surgical guidelines above).*
	Any patient cared for in a universal bed in a critical care unit.	
		NICU units and nursing hours are required to be reported under Maternal-Child services.

Maternal - Child Care

Maternal – Child clinical service areas are designed, equipped, organized and operated in accordance with the requirements of the Hospital Licensing Act relating to the medical surgical care of a patient prior to and during the act of giving birth to either a living child or a dead fetus and the continuing care of both patient and newborn infant. Intensive care newborn nursery services are included in maternal-child clinical service areas.

CLINICAL SERVICE AREA	YES – INCLUDE IN MATERNAL CHILD REPORTING	NO – DO NOT INCLUDE IN MATERNAL CHILD REPORTING
MATERNAL-CHILD	The following areas should be included in maternal-child reporting, including any gynecology patients cared for in these areas: ante partum, labor and delivery, postpartum, mother/baby units, NICU, newborn nurseries. All short stay patients that are cared for on maternal-child units should be reported, including observation patients, outpatients, or same day surgery patients.	Any gynecology patients cared for in medical-surgical or critical care areas are reported under those respective service areas.
	All high-risk mothers cared for in these units are counted in maternal child. Patients' care related to trials of labor should be counted.	Any high risk mother or gynecology patient housed on a medical-surgical unit should be counted in medical-surgical clinical service area reporting.