STAFFING

STRATEGIES FOR SCARCE RESOURCE SITUATIONS

NORTHWEST HEALTHCARE RESPONSE NETWORK

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.	**Contingency Capacity** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources)	**Crisis Capacity** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant and adjustment to standards of care (Hick et al, 2009).

RECOMMENDATIONS	***Strategy***	***Conventional***	***Contingency***	***Crisis***
Staff and Supply Planning 1. Assure facility has process and supporting policies for disaster credentialing and privileging - including degree of supervision required, clinical scope of practice, mentoring and orientation, and verification of credentials. 2. Encourage employee personal preparedness planning (ready.gov, redcross.org). 3. Cache adequate personal protective equipment (PPE) and support supplies. 4. Educate staff on facility disaster response and recommend regularly scheduled HICS training. 5. Educate staff on community, regional and state disaster plans and resources. 6. Develop facility plans addressing staff's family / pets or staff shelter needs (such as daycare and unaccompanied minor needs) as well as transportation plans for staff to get to and from the facility. 7. Include a process of staff identification and verification. Recommend photos and hard-copy files. 8. Create Job Cards for essential services and functions. 9. Pre-identify critical positions and ensure redundant staffing for these. 10. Recommend redundant staff communications and notification plans/procedures.	*Prepare*			
Focus Staff Time on Core Clinical Duties 11. Minimize meetings and relieve administrative responsibilities not related to event. 12. Cohort inpatients per OSHA/Public Health or CDC guidelines.	*Conserve*			
13. Reduce documentation requirements.	*Adapt*			
Using Supplemental Staff 14. Utilize administrative positions (e.g., nurse managers) as patient care extenders. 15. Adjust personnel work schedules (longer but less frequent shifts, etc.) if this will not result in skill / PPE compliance deterioration. 16. Voluntary call-back of staff 17. Increase use of agency, per diem, travelers, float pools, locums staff 18. Retain staff for extended hours (in accordance with labor contract and existing contracts/agreements when applicable) 19. Use family members/lay volunteers to provide basic patient hygiene and feeding – releasing staff for other duties. 20. Postpone and reschedule out-patient non-acute and preventative care appointments to open more acute care out-patient appointments during surge.	*Substitute* *Adapt*			
Focus Staff Expertise on Core Clinical Needs 21. Personnel with specific critical skills (ventilator, burn management) should concentrate on those skills; specify job duties that can be safely performed by other medical professionals. 22. Reduce availability of non-time sensitive laboratory, radiographic, and other studies. 23. Postpone and reschedule elective procedures if it will improve staffing and space needs and does not result in undue patient inconvenience	*Conserve*			
24. Have specialty staff oversee larger numbers of differently specialized staff and patients (for example, medical/surgery nurses working in critical care are overseen by a critical care nurse).	*Substitute* *Conserve*			
Use Alternative Personnel to Minimize Changes to Standards of Care 25. Bring in equally trained staff (burn or critical care nurses, Disaster Medical Assistance Team [DMAT], other health system or Federal sources). 26. Cancel all non-acute/preventative care appointments, surgeries, and procedures (e.g., endoscopies, etc.) and divert staff to emergency duties including in-hospital or assisting public health at external clinics/screening/dispensing sites. 27. Use less trained personnel from outside institution with appropriate mentoring and just-in-time education (e.g., healthcare trainees or other health care workers, Medical Reserve Corps, retirees).	*Adapt*			

28. Implement alternate consultation and care techniques such as telemedicine. 29. Provide just-in-time training for specific skills.				