

# Crisis Continuum Staffing Definitions

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## DISCLAIMER

The information contained in this document does not constitute any official position of the Minnesota Department of Health (MDH). Health care facilities or systems implementing these strategies in crisis situations should assure communication and coordination with their Health Care Coalition (HCC) partners, MDH, and public safety partners to assure the invocation of appropriate legal and regulatory protections as appropriate in accord with state and federal laws. Recommendations within this document may be superseded by incident specific recommendations by MDH.

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## Introduction

During a pervasive or catastrophic public health event that results in medical surge, *each health care facility or health care system will determine the most appropriate steps and actions for their entity* based on their environment, hazards, and resources. This document is designed to help health care facilities appropriately define their level of staffing along the crisis continuum during a pervasive or catastrophic public health event, which may cause overwhelming medical surge. This guidance assumes incident management and incident command practices are implemented and key personnel are familiar with the [Minnesota Crisis Standards of Care Ethical Framework](#) and processes that underlie scarce resource decision-making.

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## Assumptions

**Staffing adjustments assume the following are also being done at the facility level:**

- Participation in the Critical Care Coordination Center (C4) and other load-balancing mechanisms
- Restrictions on electives and outpatient services to redirect nursing staff to inpatient care
- Reduction on chart/screening requirements
- Hiring of contract staff as possible

## STAFFING CRISIS CONTINUUM

- Nurse managers/educators pulled to clinical roles
- OT/Hazard pay and other incentives
- Mandatory shifts
- Use of nursing extenders to support basic patient cares (e.g. nursing assistants, hospital volunteers, etc.)
- Move staff between selected facilities in a system to maximize staff skill utilization (e.g. CRNAs, PACU, other specialty nursing)
- Cancellation of leave / vacation as required
- Augmented use of telemedicine and virtual services to improve use of staff

## Crisis Continuum

The below table represents an example of how staffing may be categorized and should not be interpreted as policy or recommendations of the State or any specific health care system. The safety of nurse to patient ratios may vary depending on the acuity of the patients and require adjustments. Examples provide a consistent level of adaptations and care across facilities.

Category	Conventional	Contingency	Crisis
Staff Used	Usual Staff on Units	“Step Over Staff” with consistent training from other units.  Example: PACU RNs to ICU; nurse educators at bedside	“Step Up Staff” that do not usually care for patients of current acuity.  Example: Intermediate or tele RNs to ICU
Staffing Ratios	Usual RN to Patient ratio	Ratio increase $\leq$ 150% of usual Example: From 1:6 up to 1:9	Ratio increase $>$ 150%
Tiered Staffing	No	No	Yes
COVID-19 Status	Quarantined/positive staff off work	Quarantined staff used for direct patient care for COVID+ patients	COVID+ staff used for direct patient care
Volunteer/ Government providers utilized for direct patient care	No	No	Yes



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