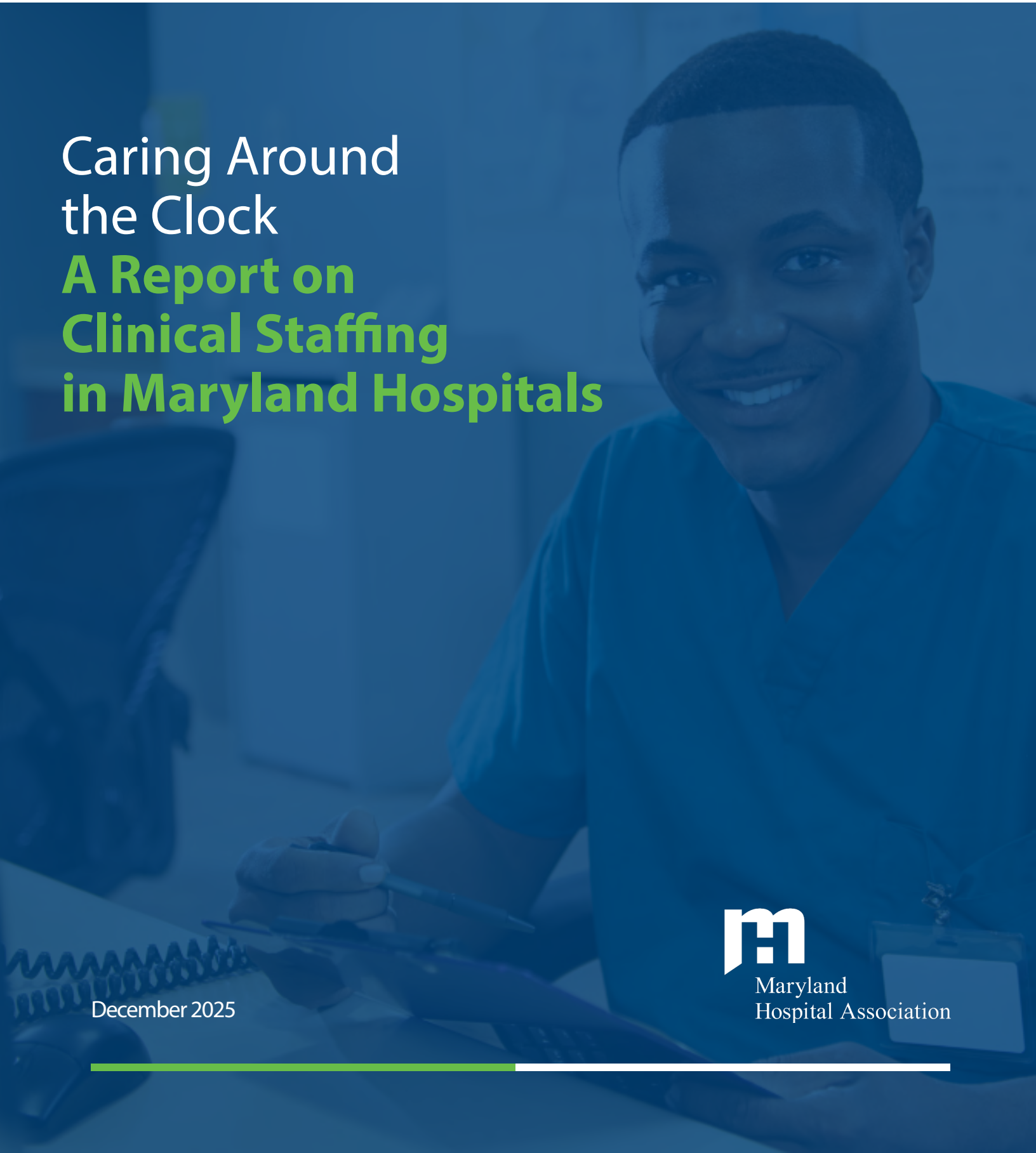

Caring Around the Clock

A Report on Clinical Staffing in Maryland Hospitals

December 2025

Maryland Hospital Association

Maryland
Hospital Association

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Executive Summary

Staffing hospitals safely and effectively every hour of the day is one of health care's greatest challenges. An aging population and rising rates of complex conditions are driving increased demand for hospital care. At the same time, hospitals nationwide continue to face persistent workforce shortages.

Maryland hospitals and health systems have responded with a variety of strategies, giving caregivers a direct role in staffing decisions to align teams with patient needs and, at the same time, making long-term investments in their workforce.

This report offers a behind-the-scenes look at how team-based staffing decisions are made, the requirements that guide them, and the innovative strategies hospitals use to bolster safety, retention, and satisfaction.

In summer 2025, the Maryland Hospital Association (MHA) surveyed chief nursing officers (CNOs) at acute and specialty hospitals across the state about their approach to staffing. MHA received responses from 37 hospitals with details about how they strengthen and sustain hospitals' clinical workforce.

The survey showed that hospitals adapt their unique organizational structure, workforce dynamics, and patient care priorities to ensure adequate staffing that meets real-time patients' needs. Maryland CNOs reported using a combination of tools and strategies, including staffing matrices and grids, self-scheduling tools, and clinical team huddles to appropriately account for patient care needs, while allowing staff flexibility and autonomy in scheduling decisions. In addition, hospitals and health systems have embraced shared governance principles to enhance both daily operational decision-making and long-term strategic planning.

These models allow nurses and other health care professionals to engage in the full spectrum of decision-making, through participation in unit-level, department-level, and hospital/system-level committees.

CNOs also identified several ways the state could strengthen the health care workforce including:

- More support for nurse residency and externship programs
- Increased funding for hospitals to recruit, train, and retain health care staff
- Investment in education and training programs
- Improved placement/treatment options for complex behavioral health patients, leading to lower risk of violence against staff

The survey also revealed opportunities for hospitals to continue to build on existing efforts to engage frontline staff and provide transparency in the staffing and scheduling process. (See page 8 for a detailed breakdown of the survey results). To that end, MHA member hospitals have agreed to voluntarily adopt a framework to increase staff engagement.

MHA Clinical Staffing Commitments

Endorsed by Hospitals Across Maryland

Maryland's hospitals are dedicated to delivering the highest quality health care to the community. This cannot happen without supporting the heartbeat of the hospital – the workforce. Following the conclusion of the 2025 legislative session, the Maryland Hospital Association (MHA) convened a work group of hospital representatives to examine how staffing decisions are made, the current regulations that guide these decisions, and ways that hospitals are supporting their workforce. MHA also surveyed chief nursing officers across acute and specialty hospitals to understand their approach to staffing and staff well-being. Using this information, the work group identified opportunities to build on existing efforts to empower staff, elevate their voice in staffing decisions, and improve their well-being. This report and the following Clinical Staffing Commitments are the culmination of these efforts.

MHA member hospitals commit to adopt the following framework to enhance collaboration between frontline clinical staff and hospital leadership, while allowing flexibility for individual hospitals to implement these actions in a manner that is appropriate to their unique culture, organizational structure, and patient population.

MHA member hospitals will:

- Include efforts to continuously improve staff engagement and work-life balance as part of the hospital's annual operating plans.
    - Engage frontline clinical staff in developing staffing plans and policies
    - Create and promote forums for frontline clinical staff to discuss issues and share feedback
    - Establish metrics to ensure accountability and foster a collaborative working environment
- Continue to build and promote programs and supports to prioritize staff well-being and value
- Provide opportunities for career progression, mentorship, and professional development
- Provide a readily available, anonymous system to solicit staff feedback
- Participate in forums hosted by the Maryland Hospital Association to share progress on implementation of these efforts

Hospital Endorsements

Introduction

Maryland is home to more than 60 nonprofit hospitals in almost every one of the state's 24 jurisdictions. Hospitals not only provide life-saving care 24/7/365, but they also are economic engines in their communities, employing more than 168,000 people.[1]

"No single method, model, or assessment tool ... has provided sufficient evidence to be considered optimal in all settings and all situations. Any approach to determining appropriate nurse staffing levels, therefore, must consider all the elements affecting care within the individual practice setting."

- American Nurses Association, 2019 [2]

Hospitals are among the few organizations that face the challenge of maintaining constant operations. They cannot close to celebrate a holiday, when there is severe weather, or if employees call out sick. This requires intentionality and flexibility to maintain operations and to adhere to the accreditation and regulatory standards required to ensure patient safety, quality care, and a supportive work environment.

In 2021, when Maryland hospitals faced the most critical staffing shortage in recent memory due to COVID-19, MHA launched the Task Force on Maryland's Future Health Care Workforce. The Task Force proposed a strategy to build a sustainable health care workforce through:

- Acute care certified nursing assistant training programs
- Apprenticeship opportunities to upskill non-clinical staff
- Community colleges and high school partnerships to grow the workforce pipeline
- International recruitment

Since a peak in 2022, employee vacancy rates have declined.[3] However, staff turnover, an aging workforce, and an increase in patient acuity continue to make daily staffing a challenge. Nurses and nursing support staff make up more than 40% of Maryland's hospitals workforce.[4]

[1] https://mhaonline.org/wp-content/uploads/2025/06/Economic-Impact-2-pager-FINAL.pdf [2] Ibid [3] MHA Workforce Survey – April 2025. NOTE: Q4 2024 data represents 90% Survey Response Rate; 47 of 52 hospitals. [4] MHA Workforce Survey – April 2025. NOTE: Q4 2024 data represents 90% Survey Response Rate; 47 of 52 hospitals.

Based on MHA's quarterly workforce survey, in Q4 2024, there were 20,244 full time RNs, 17,665 full time LPNs and 7,090 full time nursing support staff working in Maryland hospitals. Estimates suggest that by 2035, an estimated 13,800 additional full-time RNs and 9,200 full-time LPNs will be needed to meet Maryland's needs. Based on the current supply, the RN workforce will only be sufficient to meet about 80% of demand in 2035 and for LPNs that number drops to 44%.[5]

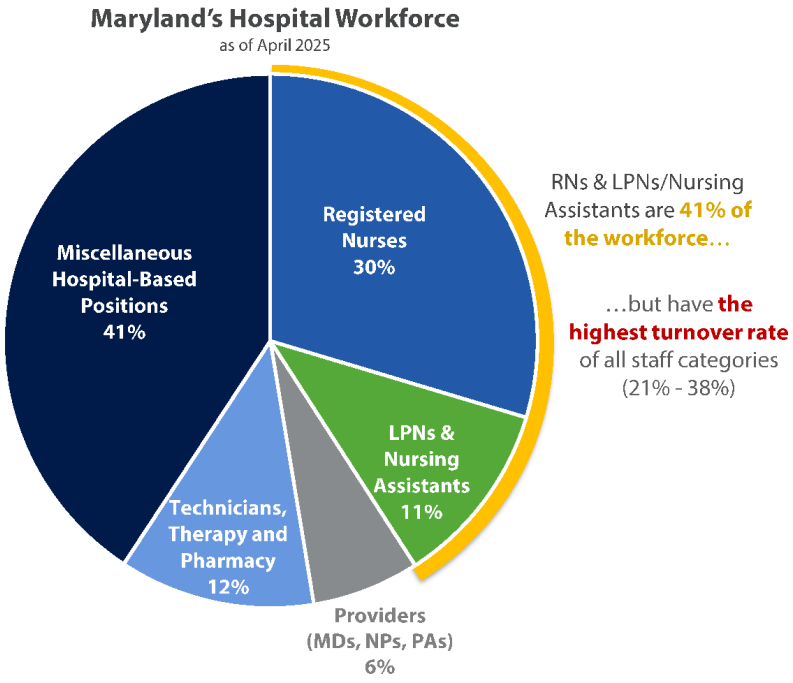
Besides RNs and LPNs, patient care requires support from a broad team of frontline staff including certified nursing assistants (CNAs), patient care technicians (PCTs), respiratory therapists, radiology technologists, laboratory technicians, and other ancillary clinical team members. These frontline staff are critical. At the same time, surgical technicians, respiratory therapists, radiology technicians, pharmacy technicians, and nursing assistive personnel comprise the five positions with the highest vacancies in the state per MHA's latest quarterly workforce survey.

According to the American Nurses Association (ANA), the delivery of nursing care is multifaceted. Determining appropriate nurse staffing is not simply about increasing the number of nurses "beyond what is minimally necessary."[6] Other variables such as patient population needs and staff skills and competencies must be considered. Because non-nursing roles are essential and deeply interconnected with nursing, staffing challenges cannot be solved by adjusting nursing alone.

Even when RN nurse staffing is adequate on paper, a missing respiratory therapist or an absent technician can create bottlenecks that force deviations or inefficient workarounds. Thus, the entire care team must be factored into throughput, safety, and clinical reliability planning. These variables often change throughout a given day depending on the staff, unit, and patient population.

Maryland hospitals are no exception.

Maryland's Hospital Workforce



Top 10 Hospital Occupations by Vacancy Rate as of April 2025	
Surgical Technicians	13.1%
Respiratory Therapist	12.9%
Radiology Technicians	12.4%
Pharmacy Technician	12.2%
Nursing Assistive Personnel	10.5%
Dietitians & Nutritionists	10.3%
Sterile Processing Technician	10.0%
All Other Personnel	9.9%
Housekeeper	9.9%
Registered Nurses	9.9%

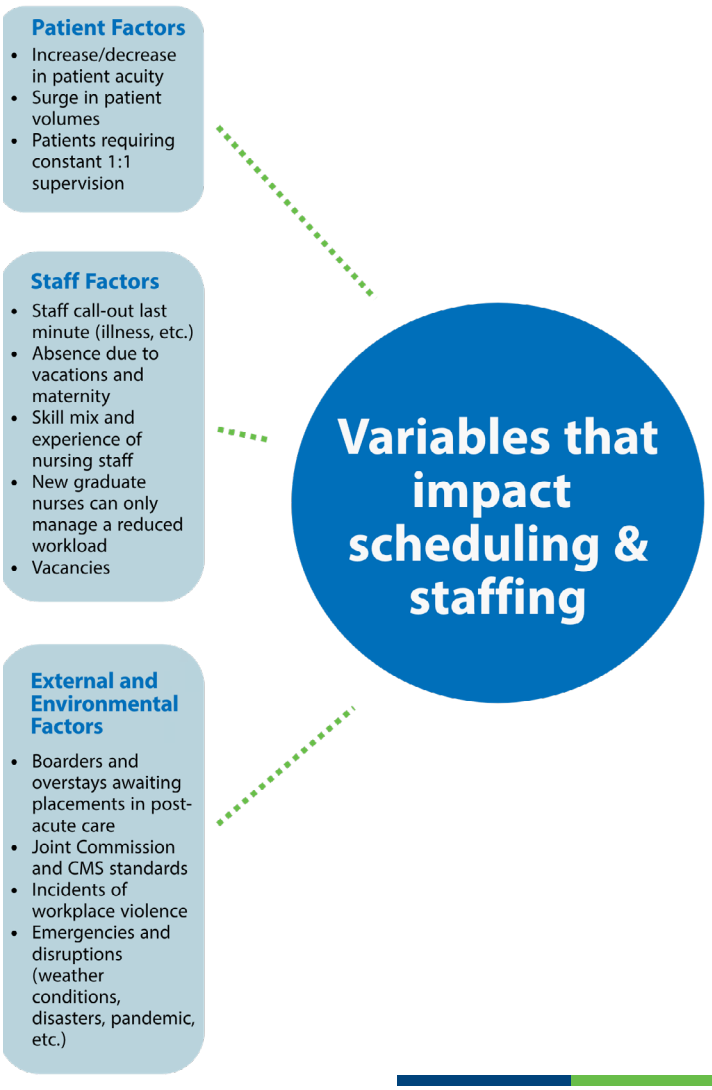
[5] GlobalData - Nurse Workforce Study [6] ANA's Principles for Nurse Staffing, Third Edition

How Hospital Staffing Works

Staffing decisions start with a baseline ratio – a goal for the number of patients a single registered nurse will care for during a shift. These ratios are based on a variety of inputs such as clinical guidelines from national professional bodies for specific units. For example, the American Association of Critical Care Nurses and the Academy of Medical Surgical Nurses produce guidelines, which recommend patient to nurse ratios.[7] [8] However, while these best practices and guidelines are the ideal, scheduling in hospitals is typically based on anticipated census, historical utilization trends, and known leaves or vacancies – striving to align available staff as closely as possible with expected patient volumes. Yet, even the most well-designed plans can diverge from reality. Unanticipated admissions, higher-than-expected acuity, last-minute callouts, or surges in patient volumes can all alter the staffing plans. As a result, actual staffing levels at the unit level may differ significantly from what was planned, requiring dynamic adjustments throughout the day to ensure safe coverage.

For example, the goal might be a 5:1 ratio of patients to a registered nurse on a medical surgical unit. From there, staffing fluctuates throughout the day. Adjustments are made to add or remove a patient from the nurse's ratio based on acuity, the skill of the nurse, the number of admissions and discharges, and what support services – like patient care techs, certified nursing assistants, sitters, or patient observers – are available for each unit.

There is communication among the chief nursing officer, charge nurse, and nursing managers several times a day (prior to each shift starting) to review vacancies, call outs, patient acuity, and new graduate nurses or nurses on orientation who may be supporting fewer patients as they learn. The team must continuously assess patient acuity, care complexity, and staff competencies to redistribute assignments and resources as safely and efficiently as possible. This process is repeated to also project staff schedules throughout the week and on the weekends. This often also means making difficult tradeoffs – balancing the need to maintain quality care and staff well-being against fiscal and operational constraints. Nurse leaders may need to redeploy staff across units, authorize overtime, or rely on float pools and agency nurses to fill critical gaps.[9]



[7] AACN Standards for Appropriate Staffing in Adult Critical Care - AACN
[8] Recommendations for Safe, Effective Medical-Surgical Nurse Staffing
[9] Ibid.

Key Factors Driving Clinical Staffing Decisions in Hospitals

Regulatory & Accreditation Standards for Clinical Staffing Decisions

Hospitals must meet state and federal regulations and maintain accreditation through a Maryland Department of Health-approved organization, such as the Joint Commission, which accredits all the state hospitals.[10] These standards guide staffing and patient care decisions.

With the dedicated teams and managers, these oversight bodies ensure Maryland hospitals uphold the highest standards of patient care, workforce safety, and 24/7 operational readiness.

Notably, The Joint Commission launched National Performance Goals which go into effect Jan. 1, 2026. These goals are described as "requirements that rise above regulation into salient, measurable topics with clearly defined goals."[11] The staffing goal requires hospitals to "be staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care."[12] Hospital leaders are tasked with ensuring there are qualified ancillary staff to meet the needs of the patient population served. The hospital is also required to evaluate staffing during performance improvement activities and report on the adequacy of staffing when undesirable outcomes are identified.

Table 1. An overview of the clinical staffing standards enforced by major state and federal regulatory and accrediting bodies

Agency/Body	Role & Oversight	Staffing Related Standards	Enforcement
Maryland Office of Health Care Quality (OHCQ)	Licenses and regulates hospitals; inspects facilities; investigates complaints	Ensures compliance with quality and safety requirements; can review patient care, supervision, environment, and safety	Inspections, complaint investigations, corrective actions
The Joint Commission	Independent accreditor approved by the Centers for Medicare & Medicaid Services (CMS) and the Maryland Department of Health (MDH); accredits all Maryland hospitals	Requires hospital-wide nursing care plans based on patient needs and nurse competency; emphasizes collaboration, flexibility, and workforce well-being Requires hospitals to meet National Performance Goals. Staffing added as a new goal effective Jan. 1, 2026	Unannounced site visits every 3 years; high standards must be met for accreditation
Centers for Medicare & Medicaid Services (CMS) – Conditions of Participation (CoPs)	Federal agency; hospitals must comply to receive Medicare/Medicaid reimbursement	Requires nursing director to determine staffing levels; mandates 24/7 RN supervision; allows alternative outpatient staffing plans with approval. Patient safety (§482.13) and emergency preparedness (§482.15) standards apply	Regular unannounced surveys and audits; penalties for non-compliance

[10] https://dsd.maryland.gov/regulations/Pages/10.07.01.07.aspx
[11] National Performance Goals | Joint Commission
[12] Hospital National Performance Goals (NPGs)

Hospital Practices & Committees

While accreditation and regulatory standards require hospital leaders – particularly CNOs or directors of nursing – to create and maintain staffing plans that balance patient needs, safety requirements, and budgetary realities, hospitals recognize that safe and effective staffing can only be achieved through teamwork. To capture on-the-ground realities, Maryland hospitals use shared governance principles to bring nurses and other frontline staff into the decision-making process through a combination of daily huddles, standing committees, and broader organizational structures.

Shared governance is a collaborative leadership model that empowers nurses and frontline health care staff to actively participate in the decision-making process, shaping policies, clinical practices, and patient care initiatives.[13] By fostering interdisciplinary collaboration and accountability, shared governance ensures that nurses have a strong voice in leadership, quality improvement efforts, and workforce-related decisions.[14] Hospitals utilizing this model report significant benefits, including improved patient safety, higher staff retention, reduced burnout rates, greater job satisfaction, enhanced interdisciplinary communication, and stronger adherence to evidence-based practices.[15,16]

Table 2. An overview of staffing committees currently in place in Maryland hospitals

Shared Governance Structure	Who Participates	Focus	Implementation*
Huddles (daily/multiple times per day)	Nursing leaders always; often nursing staff and sometimes nursing support staff, ancillary staff, physicians, security personnel [17]	Real-time staffing ratios, patient safety, throughput, shift coverage	100% of hospitals use huddles
Unit-level Committees	Nursing leaders, and nursing staff always; often nursing support staff	Compliance with staffing grids, productivity standards, retention, workflow improvements	67% of hospitals have unit-level committees
Department-level Committees	Hospital leaders always; often nursing staff	Training needs, staffing equity, external resource needs	50% of hospitals have department-level committees
Hospital/System-level Committees	Hospital leadership and nursing leaders	Strategic planning, workforce metrics, quality review, union agreements	53% of hospitals have hospital/system-level committees

*Percentages based on the number of hospitals that responded to the survey
Note: Hospital leaders refers to CNOs, COOs, CEOs, and other executives; Nursing leaders include nurse managers, nurse supervisors, charge nurses; nursing staff refers to RNs and LPNs; nursing support staff includes CNAs and patient care techs; ancillary staff refers to respiratory therapists, radiology techs, social workers, etc.

> Shared governance is a collaborative leadership model that empowers nurses and frontline health care staff to actively participate in the decision-making process.

[13] Creative Health Care Management. "Shared Governance: What It Is and What It Is Not." Creative Health Care Management, March 11, 2020. https://chcm.com/shared-governance-what-it-is-and-what-it-is-not/. [14] Bradley University. "Shared Governance in Nursing." Bradley University Online, accessed March 11, 2025. https://onlinedegrees.bradley.edu/blog/shared-governance-in-nursing. [15] Kutney-Lee, Ann, Hayley Germack, Linda Hatfield, Sharon Kelly, Patricia Maguire, Andrew Dierkes, Mary Del Guidice, and Linda H. Aiken. 2016. "Nurse Engagement in Shared Governance and Patient and Nurse Outcomes." JONA the Journal of Nursing Administration 46 (11): 605–12. https://doi.org/10.1097/nna.0000000000000412. [16] Nantz, Sarah. 2015. "How to Increase Unit-based Shared Governance Participation and Empowerment." 1. American Nurse Today. Vol. 10–10. https://www.myamericannurse.com/wp-content/uploads/2015/01/ant1-Magnet-Highlights_Shared-Gov.pdf. [17] https://www.ihi.org/sites/default/files/SafetyToolkit_Huddles.pdf

To gain further insights into how and to what extent hospitals employ shared governance principles, MHA surveyed CNOs in summer 2025 on their approach to staffing.

MHA received responses from 37 acute and specialty hospitals, which revealed that Maryland hospitals have embraced the idea of shared governance to enhance both daily operational decision-making and long-term strategic planning.

This approach allows nurses and other health care professionals to engage in a full spectrum of decision-making, from everyday staffing considerations to larger-scale initiatives such as reviewing patient safety policies, clinical practice improvements, and professional development opportunities.

While all hospitals align with the fundamental principles of shared governance, each institution tailors its model to fit its unique organizational structure, workforce dynamics, and patient care priorities.

Accreditation Standards Reinforcing Shared Governance

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association that recognizes hospitals for nursing excellence through Magnet Status, which acknowledges superior nursing practices and patient outcomes, and the Pathway to Excellence program, which recognizes supportive and healthy practice environments that meet certain standards. According to the American Nurses Association, staff satisfaction is an underpinning for the Magnet Recognition Program because it addresses variables that attract (like a magnet) and retain quality nursing staff.[18]

Both these designations involve a rigorous approval process that requires hospitals to meet the highest standards of practice and patient care. Magnet designation mandates policies and procedures that permit and encourage nurses to confidentially express their concerns about their professional practice environment without retribution, as well as the collection of nurse-sensitive quality indicators at the unit level to support research and quality improvement initiatives. Similarly, hospitals seeking recognition through the Pathway to Excellence program must implement shared decision-making practices, prioritize staff and patient safety and wellbeing, and provide professional development opportunities.

In Maryland nearly 30% of acute care hospitals hold a Magnet designation, which is significantly higher than the national average of 10% of all hospitals.[19,20] Four hospitals have the Pathways to Excellence designation. Ten hospitals are planning to pursue Magnet or Pathways in the next two years.

Research shows that hospitals achieving Magnet and Pathway recognition experience: [21,22]

- Lower nurse dissatisfaction and nurse burnout
- Higher job satisfaction among nurses
- Lower registered nurse (RN) turnover
- Greater productivity and teamwork
- Improved patient satisfaction

Magnet Hospitals

- Frederick Health
- Luminis Health Anne Arundel Medical Center
- MedStar Franklin Square Medical Center
- MedStar Harbor Hospital
- MedStar Montgomery Medical Center
- MedStar St Mary's Hospitals
- Mercy Medical Center
- National Institutes of Health Clinical Center (not an acute care hospital)
- Suburban Hospital - Johns Hopkins Medicine,
- The Johns Hopkins Hospital
- University of Maryland Shore Regional Health
- University of Maryland Medical Center

Pathway to Excellence

- Adventist Healthcare White Oak Medical Center
- Luminis Health Doctors Community Medical Center
- MedStar Southern Maryland Hospital Center
- University of Maryland Baltimore Washington Medical Center

[18] ANA's Principles for Nurse Staffing, Third Edition [19] The American Hospital Association's metric 'Total Number of All U.S. Hospitals' as denominator. [20] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_acute_care_fy26_licensedbeds.pdf

[21] American Nurses Credentialing Center. 2020. "About Pathway." ANA. 2020. https://www.nursingworld.org/organizational-programs/pathway/overview/ [22] American Nurses Credentialing Center. 2023. "Why Become Magnet?" ANA. 2023. https://www.nursingworld.org/organizational-programs/magnet/about-magnet/why-become-magnet/

Hospitals Turn Staff Feedback into Action

Hospitals not only gather feedback from staff. They act on it.

Hospitals collaborate with staff and gather input through annual surveys, regular one-on-one employee meetings, townhall meetings, executive rounding both during business hours and non-traditional hours, complaint/grievance hotlines, email and electronic submission options for complaints and ideas, and stay interviews.

The following examples illustrate how frontline voices have directly shaped policies and practices, resulting in safer care and stronger workforce support .

Expanded Weekend Huddles

Staff asked for more support and communication. The hospital expanded its weekday Operations and Safety Huddles to weekends and added weekend leadership rounding.

Improved Safety Feedback

Staff said follow-up on safety events was not consistent.
The hospital created a daily safety/risk huddle for leaders to ensure timely feedback.

Resource Nurse for Off-Hours

Staff requested a resource nurse on night shifts and weekends to cover services not available during those times. The hospital earmarked FTEs for this position, which is now posted.

ICU Role Conversion

ICU staff asked to convert a day secretary role into tech positions. Leadership approved the conversion based on staff justification.

Revised Charge Nurse Model

Bedside teams asked that charge nurses be included in patient assignments. Leadership modified the care model accordingly, with positive results.

Streamlined ED to Med-Surg Transfers

Med-Surg nurses raised concerns about delays in moving ED admissions. The hospital revised handoff processes and expanded the transport pool, improving workflow.

Violence Prevention and Support

Staff raised concerns about workplace violence and injuries. The hospital responded with updated procedures, added support in high-risk areas, and new safety tools, leading to lower turnover and staff feeling more supported.

Improved Communication Tools

Staff wanted broader communication across teams. Leadership launched an all-employee Teams channel and texting platform to improve outreach.

Innovative Staffing Solutions

Hospitals report finding it significantly harder to identify and attract staff that will want to work through holidays, nights, or weekends. Despite nursing leaders' best efforts at forecasting and preparing for staff shortages during these times, additional circumstances (such as an unusual surge in patient volumes, staff calling in sick, etc.) may further complicate staffing during these periods. During such times, almost all hospitals rely on options such as float pools (where nurses are part of the schedule but not to a particular unit, so they can "float" to where they are needed), part-time, or short-term contractual nurses, and remote or virtual nursing options to meet coverage needs.

All 37 hospitals that completed the survey reported using self-scheduling tools (see page 8). These online systems give nurses the autonomy to choose their own work shifts and days off within established organizational parameters and staffing needs. This promotes flexibility, gives nurses more control over their schedule, and helps reduce burnout.

Additionally, most hospital respondents reported using acuity-based or geography-based scheduling tools to ensure staffing plans match nurse workloads to patient care needs rather than just patient volumes. These tools assess each patient's condition, the staff's workload and location, and the nursing care required, enabling managers to create fair and equitable staff assignments that ensure patient safety, optimize workflows, and improve overall care quality.

Similarly, tools such as "precision staffing" use a documentation driven weight-based algorithmic approach to create a workload score. The score allows staff to see equity in their group assignments and encourages teamwork by allocating resources based on identified care needs.

Innovative Staffing Solutions

- Staff float pools
- Part-time or short-term contractual nurses
- Remote and virtual nursing options
- Acuity, geography or patient-based scheduling tools
- Precision staffing models
- Options in shift length
- Workforce management tools
- Workload balancing tools
- Care centric modeling
- Stress injury tools

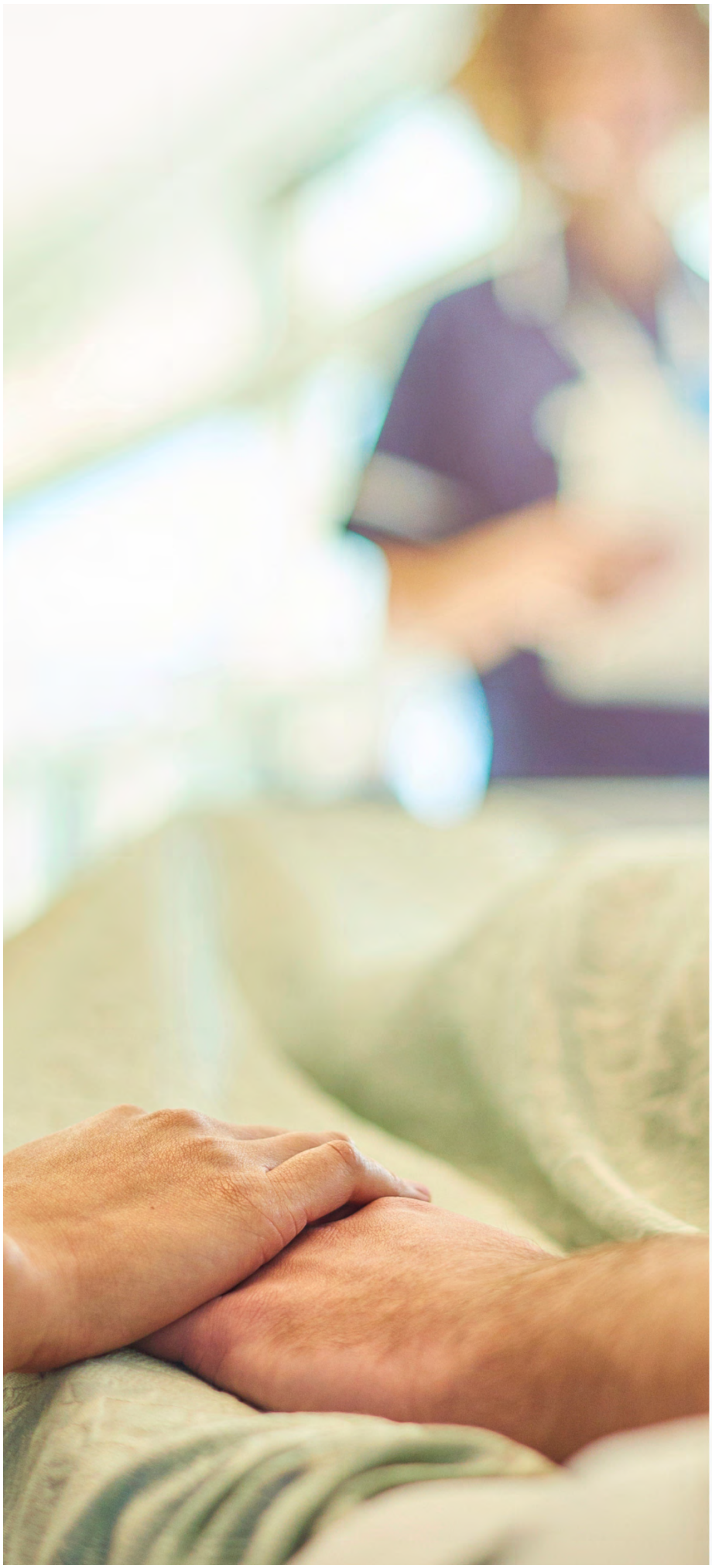
Conclusion

Maryland hospitals uphold the highest standards of care by meeting rigorous state and federal requirements and ensuring staff voices are heard. They make staffing decisions through a shared governance structure which strengthens patient care, improves staff retention, and empowers frontline caregivers.

Hospitals are reinforcing this work by adopting fieldwide commitments to enhance clinical staffing, transparency in how decisions are made, and staff engagement.

State partnership is essential, particularly to expand nurse residency and externship programs, recruit and retain staff, improve behavioral health placements to reduce workplace violence, and invest in education and training pipelines.

Together, Maryland can strengthen its hospital workforce, safeguard access to care, and continue to provide access to high-quality care 24/7/365.



Glossary

Ancillary Staff:

Refers to professionals who support patient care but are not part of the nursing staff, such as respiratory therapists, radiology technologists, laboratory and pharmacy personnel, physical and occupational therapists, social workers, and security officers.

Callout:

When a scheduled employee is unable to report to work due to illness, emergency, or other reasons. Multiple callouts can trigger staffing shortages and require real-time adjustments.

Census:

The total number of patients admitted or assigned to a unit at a given time. Census data drive staffing adjustments throughout the day.

Charge Nurse:

A RN who provides clinical oversight during a shift, coordinates assignments among nursing staff, and serves as the point of contact for the unit during that shift. The charge nurse may still provide direct patient care but also handles staffing coordination.

Chief Nursing Officer:

The CNO oversees nursing practice and policy, staffing models, clinical quality, and patient safety.

Float/Floating:

The practice of temporarily reassigning a nurse or other staff member from one unit to another to address short-term staffing gaps.

Huddle:

A brief (typically <10 minutes) stand-up meeting among staff and leaders at the start of a shift to review staffing assignments, patient updates, and safety issues.

Nurse Manager:

Responsible for daily operations of a specific nursing unit. Manages scheduling, supervises charge nurses and frontline staff, monitors quality and safety metrics, and addresses staffing gaps or callouts.

Nursing Staff:

Includes RNs who are responsible for the type and quality of all nursing care that patients receive, as well as LPNs who work under the supervision of RNs or physicians.

Nursing Support Staff:

A broad category that includes CNAs or equivalent unlicensed staff who assist RNs in providing patient care-related services as assigned by and under the supervision of the RN.

Scheduling:

Balanced forecasting of resource needs based on clinical guidelines, historical trends, anticipated patient volumes, scheduled procedures, etc.

Staffing:

Real time resource allocation of clinical staff to meet a patient's needs while ensuring quality standards are upheld and federal and state laws and regulations are satisfied

Staffing Grid/Matrix:

A planning tool used to determine the number and mix of staff needed per shift or per patient census. Grids typically account for patient acuity, unit type, and regulatory requirements.

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