**PROGRAM FLEX REQUEST – MODEL TEAM NURSING TEMPLATE**

GENERAL

Facility:
District:
Facility Number:
Facility Type: GACH
License ID:
Phone Number:
County Name:
Address:

**Applicant Details**Name:
Email:

Program Flexibility Application

*Please do not include any patient identifying or personnel information in your application. The information in your application is considered public information and may be disclosed as part of a public records act request.*

**Contact Details**Applicant Contact Number:
Duration of the Request:
Requested Start Date:
Requested End Date:

Note: Typically program flexes are approved for 90 days.

Specify Type of Request

[x]  Requesting an urgent response within 24 hours to help address facility capacity concerns during a disease outbreak, patient evacuations during a natural or human-caused disaster, or another similar situation that cannot wait for a response during normal business hours.

Justification of the request

[x]  A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome- type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency

Nursing Service Staff, T22 DIVS CHI ART 3 70217(a)

Specify Area of Flex

[x]  Staffing

Request Description

There is a current shortage of pediatric nurses. The hospital has made the following efforts to obtain additional staff. Current requests for temporary staff RNs submitted to XXXX contract agency, and four other staffing agencies with little to no success. Additionally, XXXXX is actively recruiting for current open positions without success.

Despite all efforts to fill staffing needs, the hospital continues to face challenges in these unprecedented times.

Exhausting Available Alternatives

The provider must exhaust available alternatives before requesting increased patient accommodations. Check all that apply, none or N/A:

[x]  Transferring patients to other beds or discharge as appropriate

Adequate Staff, Equipment and Space

The provider must make arrangements for adequate staﬃng, equipment and space for increased patient accommodations Check all that apply, none or N/A

[x]  N/A

ALTERNATIVE CONCEPT

Describe the proposed alternate method for meeting the intent of the regulation. Include the alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects. Include a description of the provisions for safe and adequate care so that the proposed alternative does not compromise patient care.

The facility proposes a Team Nursing Model for Pediatrics( PEDs) and (PICU) Pediatric Intensive Care Unit with outlined roles and responsibilities. See attached documents.

**Please provide examples of multiple models that can be adjusted based on the needs of the patients, for example, paramedics, respiratory therapists, LVNs?**

Additional Information

Provide any additional information as desired.

The facility is submitting this urgent request for section 70217 (alll of Title 22 California Code of Regulations) due to demands from the surge of RSV pediatric patients.

During these extraordinary times, we are executing unprecedented measures to ensure we can provide safe, high quality patient care.

Current Peds and PICU census:

***Please attach any supporting documentation for the request. More than one document may be uploaded here. Should include items such as org chart, roles and responsibilities of each type of staff.***

I agree to submit this application and certify under penalty of perjury that my answers are correct and complete to the best of my knowledge. I also certify that

* I understand the questions and statements on this application.
* I understand the penalties for giving false information.
* I understand that this acknowledgment has the same legal effect and can be enforced in the same way as a written signature.
* I am authorized to submit this application on behalf of the licensee.
* This application does not include any patient identifying or personnel information.

This Information provided on this form is mandatory and is necessary for program flex approval. It will be used to determine whether to approve the request for a program flex or waiver as appropriate.

The information in your application is considered public information and may be disclosed as part of a public records act request.

* I acknowledge and agree to the above Terms of Acceptance