Nurse Staffing Plan
Norwalk Hospital

The nurse staffing plan at Norwalk Hospital is developed by the Norwalk Hospital Staffing Committee through a comprehensive process that draws on multiple sources of data and input from registered nurses and other hospital staff members. The staffing plan is continuously evaluated throughout the year and formally reviewed and updated bi-annually. The staffing plan reflects budgeted, core staffing levels for patient care units including inpatient services, critical care, and the emergency department. Actual staffing is adjusted on a daily or more frequent basis to meet patient care needs.

Considerations in Staffing Plan Development and Decisions

A broad range of factors are considered in the development of the core staffing plan and ongoing staffing adjustments. Staffing plan development and decisions are carried out with consideration given to patient characteristics, complexity of care needs and acuity, the number of patients for whom care is provided, levels of individual patient as well as unit intensity, the geography/physical layout of the patient care unit, the practice environment/care model, available technology, evaluation of outcomes of nursing care, and level of preparation and experience of those providing care, among others.

In addition to the factors described above, when developing the bi-annual staffing plan, Norwalk Hospital considers historical staffing and patient data, staff input, patient care support services, and any plans for new programs.

1. **Professional Skill Mix For Patient Care Units**
   The professional skill mix for each patient care unit is articulated in this hospital nurse staffing plan and utilizes both the annual budgeted staffing plan and the variable staffing guidelines. The core-staffing plan is adjusted as necessary to meet patient care needs and supported by national benchmarking data, historic hours per patient day and historic average daily census. Staffing levels are adjusted utilizing resources from the centralized float pool, floating unit-based staffs to units with appropriate training, staff working additional shifts and placing staff on call.

   The core staffing plan is adjusted as necessary to meet patient care needs using daily census report and acuity. Each patient care unit is staffed with a combination of qualified registered nurses and patient care technicians except for ICU and NICU. The ICU and NICU utilize an all-RN staffing model. The Emergency Department utilizes registered nurses and patient care technicians apart from one hired licensed practical nurse utilized in Vertical Care.

2. **Use of Temporary and Traveling Staff Nurses**
   Norwalk Hospital utilizes temporary/traveling staff nurses when necessary to ensure adequate levels of staffing to provide safe patient care. Such instances requiring temporary/traveling staff nurses may include the inability to fill budgeted staff registered nurse positions due to shortages and limited availability of nurses with specific types and levels of expertise, as well as the need to fill positions temporarily when staff members are on leave. Temporary and travel staff are used as necessary after other options to fulfill staffing needs have been considered.

3. **Administrative Staffing**
The annual staffing plan is developed to provide adequate direct care staff for forecasted patient care needs exclusive of nursing management and inclusive of appropriate support. Administrative staffing is not part of the core-staffing model and only utilized when other avenues have been exhausted and the employee meets the training and certifications of the specific nursing unit.

4. **Review of the Nurse Staffing Plan**
The staffing plan that reflects core staffing levels is formally established and reviewed biannually; it is evaluated as necessary throughout the year. Review of the factors articulated in the section *Considerations in Staffing Plan Development and Decisions* above is conducted through a combination of collaboration of staff and nurse leadership via the Norwalk Hospital Staffing Committee, Practice Council, Shared Governance Council, Unit-Based Councils and Unit Staff Meetings.

5. **Direct Care Staff Input**
Direct care staff input regarding the staffing plan is solicited via the Norwalk Hospital Staffing Committee, Shared Governance, Coordinating Council, Unit based staff meetings, reviews of both staff surveys and patient satisfaction surveys, direct care staff participation in quality improvement activities, as well as open forums with nursing leadership.

6.Staffing Plan Reporting by Unit

Department	RN to Patient Ratio (7a-11p)	RN to Patient Ratio (11p-7A)	UAP to Patient Ratio
Oncology/Medicine	1: 4-5 (Standard) 1:6 (Flex with staffing variances) *	1:5-6 (Standard) 1:7 (Flex with staffing variances) *	1: 6-8
Medicine	1: 4-5 (Standard) 1:6 (Flex with staffing variances) *	1:5-6 (Standard) 1:7 (Flex with staffing variances) *	1: 6-8
Surgical/Orthopedic	1: 4-5 (Standard) 1:6 (Flex with staffing variances) *	1:5-6 (Standard) 1:7 (Flex with staffing variances) *	1: 6-8
Neuro/Medicine	1: 4-5 (Standard) 1:6 (Flex with staffing variances) *	1:5-6 (Standard) 1:7 (Flex with staffing variances) *	1: 6-8
Progressive Care	1:3-4 PCU level 1:5-6 (Flex with staffing variances for med surg pts)*	1:3-5 PCU level 1:6 (Flex with staffing variances for med surg pts)*	1: 5-8
ICU	1:1-2	1:1-2	N/A
Maternity	1:3-4 M/B couplets 1 RN in Nursery	1:3-4 M/B couplets 1 RN in Nursery	1:12 M/B couplets
NICU	1:1-2	1:1-2	N/A
Labor & Delivery	1:1-2	1:1-2	1 every shift
Psych	1:4-5	1:4-7	1:5-10, 1 tech for Q15 min environmental checks
Emergency Dept	1:4-6 1:5-7 (Vertical Care)	1:4-6	1:8-10
Operating Room	1:1	1:1	
PACU	1:2	1:2	

Ambi	**1:3-4**	**N/A**	
Gastroenterology	**1:1 procedure** **1:3 recovery**	**N/A**	
Cardiac Cath Lab	**2:1 procedure** **1:2 recovery**	**2:1 procedure** **1:2 recovery**	**N/A**

***See definition for staffing variances in section 7**

The hospital does not currently use LPNs in the acute care areas. There is one LPN assigned to the Emergency Department and works only in the Vertical Care area in a supportive role.

UAPs as defined by the NDNQI definition who are individuals trained to function in an assistive role to nurses in the provision of patient care, as delegated by and under the supervision of the registered nurse. This includes nursing assistants, patient care technician and graduate nurses (unlicensed) who have completed unit orientation. This excludes unit secretaries, clerks, schedulers, monitor techs, therapy assistants, orderlies, transporters, student nurses and patient care sitters who all do not provided typical UAP activities.

(D) Norwalk Hospital utilizes hours per patient day to ensure staffing remains within national benchmarks and census to adjust patient care staffing. In addition, rounding is performed by leadership throughout the day to evaluate patient needs, acuity and receive staff input. Nursing leadership meets daily M-F at 12 noon to assess census and staffing requirements in anticipation for the next 24 hours. The Nursing Staffing Committee is in the process of researching evidenced-based acuity tools and plans to implement and incorporate into future staffing plans.

(E) Supportive personnel utilized to provide safe patient care include but are not limited to: secretaries during the hours of 7a-3p and 3p-11:30pm on the inpatient care units and 24 hours in the emergency room, rapid response team which includes a critical care trained RN, surgical technicians, Cath lab technicians, assistant patient care managers, unit coordinators, mental health associates, nurse educators, quality specialist, physical therapists, occupational therapists, speech therapists, respiratory therapists, patient transportation services, case management, dietary services, environmental services, safety and behavioral attendants (sitters) and student nurse associates (Junior and Senior nursing students who function in an elevated PCT capacity).

7. Differences Between Staffing Plan and Actual Staffing Levels

There have been unanticipated staffing challenges at various times during 2023. As previously reported, there are pockets of staff who became ill and many forms of viral outbreaks in the community that add to workforce staffing challenges. In addition, there are times when preferred providers are unable to accept patients related to their own workforce challenges and staffing issues. There is also continued unanticipated turnover on many units with staff transferring to other departments or leaving for personal reasons. Rarely, med-surg units and the ICU worked 1 RN or PCT less than the staffing plan supports which can be validated by the hospital CNM reports to be less than 80% of the time.

Staffing Variances

- Maintaining a flexible staffing pattern is imperative to the operational needs of the hospital. Highlighted below are instances of balancing patient safety and throughput while still maintaining safe nurse to patient ratios.
- ICU RNs are flexed to 1:3 when required for patients needing a higher level of care. All attempts are made to offload patients up for transfer to a lower level of care and to find supplemental staff. There is ongoing focus on maintaining ICU ratios at 1:1-2 appropriate to patient acuity.
- The Progressive Care RNs flex from a 1:3- 1:5 based on acuity mix of assignment. Med-surg overflow is often placed on this unit and will follow med-surg ratios.
- On medical-surgical units, focus for 2024 is to maintain a 1:4-5 ratio on the day and evening shifts and a 1:5-6 ratio at night (per section 6). In 2023 focus was on achieving a 1:5 ratio on the day and evening shift and 1:6 ratio at night but variances in staffing levels occurred due to surge census and sick calls leading to 1:6 ratios on day and evening shifts and 1:8 ratio at nights shift to support operational integrity.
- The Emergency Department faced staffing challenges with some staff turnover and fluctuations in volume and discharges on the inpatient side. Float pool nurses have been assigned to the ED to assist with patients requiring med-surg level of care and there was ongoing support from ED Nursing leadership stepping into patient assignments when required.

The following criteria would trigger a 1:6 ratio on the medical-surgical units including 9W overflow:

- **1) ED holding 5 medical/surgical/PCU holds for more than 4 hours**
- **2) Unplanned absences of 4 or more including ICU, PCU and medical-surgical units**
- **3) 9W in excess of 15 patients triggers a surge and then indicates the need for a 1:6 ratio.**

Managing staffing variances

The following measures are in place to support the nursing units:

- A variety of monetary incentive programs are put in place in real-time and adjusted per unit needs.
- Residency programs in place for both med-surg units and emergency department. Emergency department program is accredited by ANCC. This program (PTAP) continues to be an innovative plan to utilize and sustain new grads in our emergency department.
- Assistant Nurse Managers, Manager, Directors, and Educators have undertaken staff assignments.
- Transferring patients to other Nuvance network hospitals to assist with load balancing.
- Sign-on bonus ongoing to attract experienced nurses for vacant roles.
- Utilization of agency and support staff when necessary.
- International nurses' program ongoing with successful placement of seven international nurses in 2023.
- All available shifts will be posted in the BRG application that staff to the standard ratios.
- Calls and texts to staff will be coordinated through the staffing office, on the direction of the Clinical Nurse Manager.
- In times of flex staffing ratios, communication can disseminate to staff through Patient Care Managers and Clinical Nurse Managers and discussion about efforts to obtain additional staff.
- Continued communication with Staffing Committee regarding long-term staffing challenges including but not limited to current vacancies and leaves of absences.

Norwalk will continue to recruit and hire to support the standard staffing ratios.

8. Additional Information to be Reported.

1. *There were 24 objections raised by staff between 10/1/23- 12/31/23 related to the historic nurse staffing plan (2023) and no refusals to take an assignment related to policy, practice or task assigned. Note: historic disclaimer form utilized by staff while awaiting DPH approved which will be used moving forward. 4 of the objections were submitted by the Patient Care Techs. The committee reviewed each objection related to staff objecting to the number of patients assigned and the action taken by leadership to support the staff and attempt to secure additional staff. Most of the concerns raised were related to having to increase nurse patient ratio beyond what was stated in the prior year's plans with nurses having to take 1-2 additional patient each on the night shift and increased acuity. The committee discussed reasons including ill calls and the need to decompress the ED and admit patients primarily to the medical-surgical units. There will be continued review monthly of the objections by the staffing committee and those received after 12/13 will be reviewed with the committee at the next meeting scheduled for 1/17/24.*

2. ***Provide measures/evidence to support successful implementation of the nurse staffing plan:*** *The following evidenced based articles reflected in the literature support current staffing ratios and data/measures to support successful implementation:*

The following article incorporated a detailed review of 92 articles that examined throughput issues in hospitals. 12 main barriers and 15 root causes were identified regarding which root causes to focus on. It was noted that often lack of staffing is proposed as the only solution to improve patient flow in public debates. This is reflected in many articles by Unions, hospital management, professional organizations and politicians claiming that lack of staffing is the cause of patient flow issues. Research finds the main issue is multifaceted and includes lack of staffing, lack of standards and routines, insufficient operational planning and lack of IT resources all contributing. Even though lack of resources is a relevant factor, the research supports there are other factors that can be more easily addressed to improve capacity.
Ahlin, P., Almstrom, P., & Wanstrom, C. (2022). When patients get stuck: A systematic literature review on throughput barriers in hospital-wide patient processes. Health Policy, 126(2), 87-98. https:fidoi.org/10.1016/j.healthpol.2021.12.002

In reference to two studies completed, one in Illinois acute care hospitals and the other in Queensland (Australia), evidence strongly supports 30-day mortality and length of stay decreased and would also be a huge cost savings for hospitals with improved ratios by one patient per nurse. Norwalk Hospital will continue to focus on supporting staffing ratios as outlined in the attached plan.
Of note overall adult inpatient mortality ratio for Norwalk Hospital improved dramatically in the past year. FY 2021- 1.0, FY 2022 1.12, and FY 2023- .88. Goal is less than 0.99 with top performers at 0.62. Adult inpatient LOS ratio also reflected improvement from FY 2022 at 1.00 and FY 2023 at 0.91 under target of 0.93 and top decile at 0.81.
Lasater, K. B., Aiken, L. H., Sloane, D., French, R., Martin, B., Alexander, M., &
McHugh, M. D. (2021). Patient outcomes and cost savings associated with Hospital Safe Nurse Staffing Legislation: An observational study. BMJ Open, 11(12). https://doi.org/10.1136/bmjopen-2021-052899
McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C., & Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality,
readmissions, and length of stay: a prospective study in a panel of hospitals. Lancet (London, England), 397(10288), 1905-1913. https://doi.org/10.1016/S0140-6736(21)00768-6

An international study was completed and compared models of care with registered nurses, licensed practical nurses and unlicensed personal. The study demonstrated higher levels of registered nurses positively impacts patient outcomes (i.e., lower odds of mortality) and lower levels negatively (i.e., higher odds of mortality). Norwalk Hospital supports an all-Registered Nurse model.

Musy, S. N., Endrich, O., Leichtle, A. B., Griffiths, P., Nakas, C. T., & Simon, M. (2021). The association between Nurse Staffing and inpatient mortality: A shift-level retrospective longitudinal study. International Journal of Nursing Studies, 103950. https://doi.org/10.1016/j.ijnurstu.2021.103950

The following article's goal was to provide a narrative review regarding the effect of nurse staffing ratios on patient outcomes and to provide an analysis of state-level nurse staffing policy choices and assessment of those policy options.
The review and analysis centered on outcomes related to patients instead of nurses. Despite limited research, assigning lower nurse-to-patient ratios (i.e., 1 nurse: 5 patients vs. 1 nurse :8 patients) is associated with improved outcomes and decreased length of stay. In addition, the following must be considered when looking to improve outcomes, nurse preparation, patient acuity, and nurse autonomy. This article reviewed the current nurse staffing policies in the U.S. There are 3 main types: mandated nurse-to-patient ratios, public reporting of nurse staffing plans, and nurse staffing committees and pros and cons of each were reviewed. There is limited research regarding the impact of both publicly reporting and nurse staffing committee legislation have on measurable patient outcomes. The conclusion was nurses much be involved in evaluation of the nurse staffing policy for the good of patient outcomes and the health of the nursing workforce.
Bartmess, M., Myers, C. R., & Thomas, S. P. (2021). Nurse staffing legislation: Empirical evidence and policy analysis. Nursing Forum, 56(3), 660-675. https://doi.org/10.1111/nuf.12594

The following international study was completed in a variety of critical care units suggesting that there may be an association between a higher level of nurse staffing and improved patient outcomes. The study found a higher level of nurse staffing was associated with a decrease in the risk of in hospital mortality and nurse-sensitive indicators. The study was limited and concluded due to the "heterogeneity" of the study, (units included) there could not be recommendations regarding optimal ratios to improve outcomes. Norwalk Hospital maintains a 1:2 ratio in the critical care unit for greater than 90% of the patients.
Driscoll, A., Grant, M. J., Carroll, D., Dalton, S., Deaton, C., Jones, I., Lehwaldt, D., McKee, G., Munyombwe, T., & Astin, F. (2017). The effect of nurse-to-patient ratios on nurse-sensitive patient outcomes in acute specialist units: A systematic review and meta-analysis. European Journal of Cardiovascular Nursing, 17(1), 6-22. https://doi.org/10.1177/1474515117721561

In reference to the article stating improved nurse-to-patient ratios lead to better patient outcomes and adherence to sepsis bundles, Norwalk Hospital has demonstrated improved inpatient adult sepsis mortality ratios year over year supporting adequate and improving staffing ratios. FY2021=1.12 FY2022= 1.00 FY2023=0.83 Target should be less than 1.00 with top performers at 0.68
Lasater, K. B., Sloane, D. M., McHugh, M. D., Cimiotti, J. P., Riman, K. A., Martin, B., Alexander, M., & Aiken, L. H. (2021). Evaluation of hospital nurse-to-patient staffing ratios and sepsis bundles on patient outcomes. American Journal of Infection Control, 49(7), 868 873. https://doi.org/10.10166.ajic.2020.12.002

In reference to the evidence-based articles related to the Emergency Department, Norwalk Hospital supports staffing ratios that enabled the department to meet the following metrics for Left Without Being Seen = 2.6% and Left Without Being Treated= 1.7% for FY 2023.This data reflects metrics at or just under the top decile as benchmarked with other Emergency Departments across the country. In addition, Left Before Treated Completed has decreased year over year; 2021=4.06%, 2022=2.36%, 2023=1.7%.
Ramsey, Z., Palter, J. S., Hardwick, J., Moskoff, J., Christian, E. L., & Bailitz, J. (2018). Decreased Nursing Staffing Adversely Affects Emergency Department Throughput Metrics. The western journal of emergency medicine, 19(3), 496-500. https://doi.org/10.5811/westjem.2018.1.36327

Recio-Saucedo, A., Pope, C., Dal1'Ora, C., Griffiths, P., Jones, J., Crouch, R., & Drennan, J. (2015). Safe staffing for nursing in emergency departments: Evidence review. Emergency Medicine Journal, 32(11), 888-894. https://doi.org/10.1136/emerrned-2015-204936

3. *The following reflects retention, recruitment, and turnover for the past year for direct care nurses and average years of experience. There are 358 direct care nurses. There have been 81 nurses that have left the organization between 10/1/22-10/31/23 and 134 direct care nurses hired. Average years of experience is 14 years. During the same time frame, there were a total of 177 roles opened, 85% were filled, 22 remain open and vacant, 4 were cancelled and 1 is on hold.*

Unit	Active Nurses	Average years of experience	Number of terms	Turnover rate
Ambulatory surg	4	18	6	120%
Cardiac Cath lab	7	9	3	43%
Delivery Room	28	15	8	29%
Emergency dept	52	7	12	18%
GI	19	19	7	35%
General Medicine	20	14	2	10%
General Surgery	24	8	4	17%
ICU	27	9	6	22%
IR	2	19	1	33%
Maternity	20	20	2	10%
NICU	18	18	2	11%
Float Pool	33	8	9	27%
Oncology- 6E	23	8	3	13%
OR	13	21	2	14%
Ortho/Neuro- 7W	21	12	7	32%
Pre-op testing	3	33	0	0%
Psych Unit	13	12	3	23%
Recovery	13	23	1	7%
Progressive Care	18	10	3	17%

4. *The hospital captures instances of non-compliance four times per 24 hours. Since the last staffing plan was submitted, the hospital has been out of compliance as follows:*
January 71 = 6.4%, February 37 =3.7%, March 31 =2.8%, April 24=2.2%, May 25 =2.2%, June 28= 2.6%, July 21= 1.9%, August 21=1.9%, September 22= 2%, October 41= 3.7%, November 19= 1.8%. Non-compliance was directly related to "ill calls or "surging" beyond budgeted capacity which directly relates to increased ED volumes and admissions. Continued focus remains on recruitment and retention and other bonuses applied when indicated. (Please see details under section labeled "Differences Between Staffing Plan and Actual Staffing Levels"; page 3.

Certification Hospital Nurse Staffing Plan

This hospital nurse staffing plan has been developed by the Norwalk Hospital Staffing Committee through consideration of anticipated patient population care needs, unit geography, technology and support, and

competency/expertise required of staff providing care. It has been reviewed and discussed by the Staffing Committee, Nursing Leadership, Senior Management, Shared Governance and Coordinating Councils and is regularly evaluated; and is appropriate for the provision of patient care as forecasted.

Certification Hospital Nurse Staffing Committee

In accordance with Public Act 08-79 (Senate Bill No. 1067), An Act Concerning hospital staffing, and the amendments in 2015 and 2023, the Norwalk Hospital Staffing Committee has implemented the following to meet the statutory requirements:

1) *The committee is comprised of at least 50% +1 collective bargaining unit appointed direct patient care registered nurses employed at Norwalk Hospital and <50% non-direct care registered nurses. These nurses are selected to provide a broad-based representation of care across hospital services. The hospital ensures that the direct care nurses are provided coverage to attend the monthly staffing committee meetings and that the time spent in meetings is included in the employee's regularly scheduled work week if in agreement with the employee.*
2) *Terms of service in the Norwalk Hospital Staffing Committee are as follows; membership =1 year and co-chairs will serve 2 years (selected by committee). The Committee voted to meet monthly to discuss and review staffing issues/plan with the provision for additional meetings ad-hoc if necessary. The meetings will be held in person, but remote access can be arranged if needed.*
3) *Please refer to the table below for composition of Nurse Staffing Committee*

Title – area employed	***Direct Care Members***	***Non-Direct Care Members***
***Co-Chair**-Critical Care-Patient Care Manager*		*Nicole Vitti*
***Co-Chair**-Surgical Care Unit- Staff RN*	*Laurel Rourke*	
Staff RN- Emergency Dept.	*(alt)*	
Staff RN, Emergency Dept.	*Morgan Ely*	
Staff RN, Neuro-Medicine	*Monika Weigel-Vortmann*	
Staff RN, Neuro-Medicine	*Karin Paragua (alt)*	
Staff RN, Surgical	*Tatiana Smith*	
Staff RN, Surgical	*Sabrina Palmieri (alt)*	
Staff RN, Medicine	*Choralie Paurice*	
Staff RN, Progressive Care	*Roc Keller*	
Staff RN, ICU	*Amy Cook*	
Staff RN, ICU	*Jillian Hirschauer (alt)*	
Staff RN, PACU	*Kristin Mabesa*	
Staff RN, Ambi	*Nerissa Tedero*	
Staff RN, Ambi	*Denise DiFulvo (alt)*	
Staff RN, Operating Room	*Kathleen Roberts*	
Staff RN, GI	*Jennifer Pagliaro*	
Staff RN, Cath Lab	*Melanie Emerson*	
Staff RN, Labor & Delivery	*Jennifer Worsfold*	
Staff RN, Labor & Delivery	*Elizabeth Seyer (alt)*	
Staff RN, Maternity	*Nicole Bunting*	
Staff RN, NICU	*Kathy Kernstock*	
Staff RN, NICU	*Denise Nelson (alt)*	
Chief Nursing Officer		*Leslie Lincoln*
Patient Care Director- Inpatient		*Alison Varcoe*

Patient Care Director – Emergency Dept		*Jose Santos*
Patient Care Director-Maternal Child		*Maureen Revel*
Patient Care Manager-Maternal Child		*Allie Moreira*
Patient Care Manager- PACU/AMBI		*Barbara Spielman*
Cardiology Clinical Ops. Director		*Anne Bartolone*
Patient Care Manager-Medicine		*Kim Muro*
Patient Care Manager- Surgical		*Cathy Lambert*
Patient Care Manager-Emergency Dept.		*Erin Chandanathil*
Patient Care Manager- Neuro-Medicine		*Stacey Santos*
Clinical Nurse Manager		*Maria Baldi*
Nursing Educator		*April Storck*
Nursing Professional Practice Manager		*Connie Cozens*
Patient Care Director – Surgical Serv.		*Patricia Carson*

The nurse staffing plan is developed through consideration of anticipated community needs, historic data and census, unit geography, evidenced-based literature, competency/expertise required by staff providing care and input from the Norwalk Hospital Staffing Committee. The membership for the staff nurses is selected by the Union (CHCA) and volunteers for representation for the nursing leaders who are committee members. Concerns regarding the staffing plan can be submitted to the committee in person during committee meetings, sent to either committee chairs via e-mail or phone or raised and communicated to the committee during unit-based staff meetings, unit councils, shared governance meetings, and leadership rounds. The concerns will be added to the monthly agenda during schedule staffing meetings. Follow up of concerns will be brought back to units by committee members and documented in monthly committee minutes.

The final approved Nurse Staffing Plan will be posted on patient care areas as of January 1, 2024, and available to the public.
The Norwalk Hospital Staffing Committee certifies and attests that Norwalk Hospital, and this committee are meeting the statutory requirements as outlined in Public Act 08-79 (Senate Bill No. 1067).

Leslie Lincoln, RN, DNP, NEA-BC, CNL, Chief Nursing Officer, Norwalk Hospital, Nuvance Health

Updated 12/29/2023.