SPECIAL NURSING TASK FORCE

FINAL REPORT

AUGUST 18, 1989

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In May, 1989, AMHI Acting Superintendent, William Thompson, invited nurse representatives from the coalition hospitals to meet with him and discuss two areas of principal concern to the institution regarding nursing. The concerns were: (1) the structure and organization of nursing, and (2) the nurse staffing requirements for patient care. The nurse representatives were presented these problems and asked how they might help AMHI in addressing them.

From that meeting a proposal (Appendix A) was developed for Mr. Thompson which identified specific objectives, a time line and nurses with needed expertise who would participate. The proposal was accepted and the special nursing committees began their work.

In the proposal for addressing the nursing issues, process steps were identified. These have been followed with the exception of the retreat. It is believed that a retreat might still be beneficial to lay the foundation for critical future change.

The first step in the process was for the two committees, the committee coordinator and the nursing leadership of AMHI to meet and discuss the proposed study and to outline how each group might proceed. Specific information elements needed were identified, facilities were toured and current systems were explored through communication with staff. This step was focused on establishing constructive work relationships with the AMHI staff.

The next phase of the review included data gathering for the committees. Similar processes were adopted for both work groups. These included review of relevant literature, focused interviews with members of AMHI nursing staff, and phone consult with a nurse consultant* recommended by the Joint Commission for Accreditation of Health Organizations (JCAHO).

Once the data collection was completed, the committees held work sessions to assimilate these findings and begin to formulate recommendations. It was determined that the preliminary findings and recommendations should be subject to some testing prior to drafting a report. The committee chairmen met with the committee coordinator and verified that their information, while collected through separate means, was consistent and their developing views were complementary. A session was then held with the Consultant for Nursing and the Unit Directors and/or their designee to share the assessment and developing recommendations. Their input and reactions were invited and a positive, constructive exchange ensued.

The committee coordinator and the committees met again for integration of their efforts and the report was drafted for submission to the Superintendent.

*Ms. Sylvia Blount, RN, CEO, Vacaville Prison, California, consultant recommended by the Joint Commission for Accreditation of Health Organizations, who was successful in achieving accreditation of California State Hospitals.

DISCUSSION AND GENERAL FINDINGS

It is important to identify that the recommendations in this report represent only a beginning. The work that needs to be done is long term and developmental in nature, however, a new foundation has to be laid and a framework developed that will support continued enhancement of not only nursing services, but all the institutional factors that influence patient care.

There are general findings of significance that influence this report. First, the absence of a clear care model in most areas of the hospital proves to be a major obstacle for planning. The care model should be the basis for structure and for staffing. Without it, the projections lack the program focus it must have. It has been the committee's conviction that their recommendations would provide sufficient resources to support a clinical care program, however, it is expected that modification to their proposals would naturally flow from a clear therapeutic program in the future. In addressing the care of AMHI patients, decisions need to be made about a number of items: (1) the rationale for clustering of patients, (2) the therapeutic initiatives to be offered, (3) the quality of life aspect of the hospital experience, and (4) the connections between the hospital and other community based mental health services.

Another major concern is the need for the nursing recommendations to be congruent with the institution's plans. The nursing organization and structure must fit the hospital organization so that there will be ease of communication, role clarity and minimal question regarding accountability. Similarly, the staffing plan must be based on assumptions that are consistent with the institution's view.

The final concern is how the recommendations will be translated to the AMHI community and what strategies will be employed to support personnel during a necessarily difficult time.

It has been stressed by the committees throughout their work that their efforts have concentrated on <u>what</u> needed to be done, not <u>who</u> should do it. There has been no attempt to assess the performance of any of AMHI's present staff. The work has been exclusively system analysis and the recommendations represent the committees' best thinking for system improvement.

The reality is that the recommendations, if implemented, have various implications for many of the staff. Because the changes will be so far-reaching, it is imperative that a systematic plan be developed for communication, education and, whenever possible, participation.

The Committee on Nursing Structure and Organization has completed the assessment phase of this project and we have developed a series of recommendations for short- and long-term reorganization and development of nursing services at the Augusta Mental Health Institute. These recommendations are in a developmental phase and may still require further definition and refining; particularly in consultation with the Acting Superintendent and nursing staff members at AMHI.

Definitions and qualifications for each nursing role have been addressed in general terms but this area is one which requires further study by this committee and will also await, in part, reorganization of nursing services. General recommendations in the area of definition of nursing roles are found later in this report.

ASSESSMENT

1. There is no defined nursing service. Nursing services are integrated with a number of other professional services in a decentralized organizational model.

   The decentralized model has failed to support development of standards of nursing care or development of clinical skill or professional accountability in nursing staff.

2. There is no mechanism for development or evaluation of standards of nursing care.

   The lack of defined structure and fragmenting of responsibility has created a situation in which the time and energy of nursing staff are primarily directed to organizational maintenance as opposed to development, delivery and evaluation of nursing services.

3. There is confusion and dissension as to the mission of AMHI as a whole.

   a. This confusion, combined with the lack of clear organizational structure, has resulted in lack of defined programs for the treatment or maintenance of specific patient populations.

   b. The above factors have led to poor definition of criteria for patient placement which further compounds problems in developing standards of nursing care. Many units combine patients with such a variety of needs as to render attempts at planned care approaches almost impossible.

4. There is minimal involvement of medical staff in development or evaluation of either programs of care and treatment or individual treatment plans. This is reflective of the lack of organizational mission and structure defined in prior assessment statements.

   This lack of consistent interaction with medical colleagues significantly hinders efforts to develop nursing care standards and treatment modalities.

5. Definition of authority and accountability for all aspects of nursing service is lacking or absent.

   a. Roles of registered nurses, licensed practical nurses and mental health workers are so blurred as to render a lack of professional accountability for practice.

   b. Functions of each role are fragmented to the point of inefficiency and lack of accountability for the intended outcome of any given function.

   c. This lack of definition and accountability permeates both patient care functions and management functions.

   d. The ratio of mental health workers to registered professional nurses further compounds this problem by forcing the investment of professional nursing responsibility in the mental health worker's role.

6. The role of the patient advocate(s) is not clearly defined or focused on enhancement of patient rights, appropriate contribution to definition of standards of care, or contribution to individual treatment plans and interventions as necessary.

7. There is a lack of support services in general and particularly in evening, night and weekend shifts. This leads to investment of nursing resources in the provision of such support services as housekeeping, dietary and others.

8. The lack of organizational structure and role definition has contributed to an inability to develop an appropriate, effective employee evaluation system.

   a. Lack of a sound evaluation system inhibits development of accountability in individuals.

   b. Lack of an evaluation system which enhances professional growth inhibits retention of professional staff.

9. There is a lack of knowledge and skill in both the areas of nursing care and management functions which seriously inhibits efforts to improve nursing services at AMHI.

   a. Registered professional nursing staff lack up-to-date knowledge and skills in both general and psychiatric nursing.

b. Mental health workers at all levels receive only marginal preparation for responsibilities and much of this through job experience rather than through planned education with evaluation of outcomes.

c. All roles vested with management functions receive little or no preparation or development for this responsibility.

10. The redefinition of both care giving and management roles and functions is rendered especially difficult by the interplay of existing labor union contracts and civil service systems.

RECOMMENDATIONS

1. Create a Department of Nursing led by a qualified Director of Nursing (see attached organizational chart).

   a. Creation of a Department of Nursing would impose restructuring of other professional services which currently report through the positions of Unit Directors.

   b. Definition of educational and experience requirements for nursing positions (as defined in attached materials) would support development of clinical management skills.

   c. The primary management role for Nursing needs to be a confidential position which is independent from any union affiliation.

2. Place the Nursing Department in the total organizational structure in a direct relationship to the Superintendent (see attached organizational chart).

   This would enhance the abilities of both the Director of Nursing and the Superintendent in achieving the necessary reforms in patient care and organization at AMHI.

3. Redefine the registered professional nurse role at the unit level to enhance direct care functions and professional accountability.

   Revise ratio of RN to mental health worker as suggested by Staffing Committee.

4. Redefine the mental health worker role to enhance patient care functions and more clearly define responsibility.

   a. Evaluate current Mental Health Worker I, II and III roles in relationship to functions and responsibility with focus on direct patient care.

   b. Evaluate current Mental Health Worker IV, V and VI roles with focus on definition of responsibility in areas of material resource management, security and case management services through a Department of Social Work.

5. Create of three positions, responsible to the Director of Nursing, which would carry responsibility for development and management of psychiatric services, extended care services and management services.

   a. The specific unit of service will need further definition as the organization evolves, but some specifics appear on the attached organizational chart.

   b. These positions would be occupied by RN's qualified as described in the attached materials. The Director of Nursing must appoint to these positions as they are key in supporting and developing nursing services.

6. A plan for definition and placement of patient populations must be created and acted upon promptly.

   a. Criteria for definition and placement of patient populations based on potential treatment modalities and nursing needs of patients will better enable all professional staff to develop and carry out therapeutic programs.

   b. Placement of patient populations in this manner will facilitate maximal use of nursing resources.

7. Structure nursing units with defined patient populations and nursing staff assigned according to patients' nursing needs. Each nursing unit should be managed by a Head Nurse who is a Registered Nurse with appropriate education and experience.

   a. Each Head Nurse should have responsibility for the management of resources and standard of care in a nursing unit.

   b. These responsibilities would include selection of nursing staff, assignment of nursing staff to a work schedule, disciplinary action, budget development and control, staff development and program development in conjunction with other professional disciplines.

8. Staffing patterns for nursing units must be developed and managed at the unit level.

   a. This accountability rests with the Head Nurse and is a critical element of optimal use of resources.

   b. Control of staffing at the unit level increases staff cohesiveness and commitment to patient care, thereby supporting both staff retention and quality patient care.

9. The centralized staffing function should consist primarily of a group of nursing staff, both Registered Nurses and Mental Health Workers, who have been hired to fill vacancies in unit staffing patterns on a shift by shift basis.

   a. This would minimize the reassignment of nursing staff from one unit to another, thereby allowing development of unit-based programs.

b. Nursing staff hired to this "float pool" would be working in this model by choice and, therefore, maintain broader skills and better morale. This should improve "sick calls" and overtime.

c. Consideration should be given to development of a sub group of RN's who maintain high skills in physical assessment and general nursing. These nurses should respond to all calls for assessment of patients with acute physical illness. These nurses should not be based on a unit or assigned psychiatric nursing responsibilities.

10. The function of coordinating the materials and ancillary services needed to support nursing services should be defined and developed in a group of positions assigned to supporting nursing services in this manner.

    a. These positions should report to the Assistant Director of Nursing for Management Services and work collaboratively with Head Nurses to ensure that necessary materials and ancillary services were focused on patient care units.

    b. These positions would assist in budget development for supplies and capital items.

    c. These positions should be available on evenings, nights and weekends as well as week days to support nursing administration in the maintenance of a safe and effective care environment.

    d. Creation of these positions would assist nursing administration in focusing direct care givers on patient care and in maintaining a safe and effective care environment.

11. Ancillary services of all types must be addressed if nursing service is to maintain a safe and therapeutic environment and meet standards of regulatory bodies.

    a. Availability of such services as housekeeping, dietary, maintenance and others on all shifts is essential.

    b. Adequate secretarial/clerical support to nursing services from the unit level on through the Director level is essential if such functions as documentation, education and communication are to be addressed.

12. A concentrated, organized staff development effort must be initiated and supported if above recommendations are to be implemented effectively.

    a. Education in clinical nursing knowledge and skills, directed to specific patient populations, is needed for both nurses and mental health workers.

    b. Management development and education is essential for all positions vested with management responsibilities.

c. Career development tracts for both RN's and Mental Health Workers should be reassessed and redefined as the organization develops over the next two years.

d. Use of clinical nurse specialists to broaden and enhance psychiatric nursing skills is recommended.

e. A temporary position, responsible to the Director of Nursing, responsible for developing and implementing a management development program is recommended. This position should be eliminated in two to three years, once sound management practices supportive of the redefined nursing department were implemented.

f. Current Staff Development positions need study and redefinition.

13. Each Assistant Director of Nursing (three) should be assigned a staff support position on a temporary basis to carry out projects necessary to the reorganization and development of nursing services over the next two to four years.

a. The qualifications of these positions should vary, depending on the needs of that part of the organization assigned to the Assistant Director.

b. The amount of work necessary to create an effective nursing services necessitates such temporary support if progress is to be made.

INITIAL RECOMMENDATIONS ON QUALIFICATIONS FOR NURSING POSITIONS

I. Director, Nursing Services

Responsible for the planning and implementation of nursing services through definition of care standards, definition of resource requirements and administration of nursing personnel.

Reports to the Superintendent and works collaboratively with other administrative and clinical positions to define and support services of AMHI.

Qualifications

1. Licensed as a Registered Professional Nurse in the State of Maine.

2. Master's degree in either Nursing Administration or Psychiatric Nursing.

3. A minimum of ten years' experience in nursing with progressive experience in nursing administration. Recent experience in a psychiatric setting preferred.

4. Demonstrated leadership and interpersonal skills.

5. Demonstrated knowledge of psychiatric services.

II. Assistant Director of Nursing (Three)

Responsible for the planning and implementation of a defined group of nursing services through development of appropriate positions and programs.

Reports to the Director of Nursing and works collaboratively with other administrative and clinical positions to define and develop nursing services within a specific area.

Qualifications

1. Licensed as a Registered Professional Nurse in the State of Maine.

2. Bachelor's Degree in Nursing required, Master's Degree in Nursing strongly preferred.

3. Minimum of seven years of experience in nursing with progressive experience in nursing administration.

4. Experience related to specific area of assignment necessary.

5. Demonstrated leadership and interpersonal skills.

III. Head Nurse

Responsible for the development and implementation of nursing services to a specified patient population. Plans and implements staffing patterns, develops staff to meet patient care needs, plans and implements budget to support defined program and works collaboratively with other disciplines and services to develop standards and programs.

Reports to an Assistant Director of Nursing.

Qualifications

1. Licensed as a Registered Professional Nurse in the State of Maine.

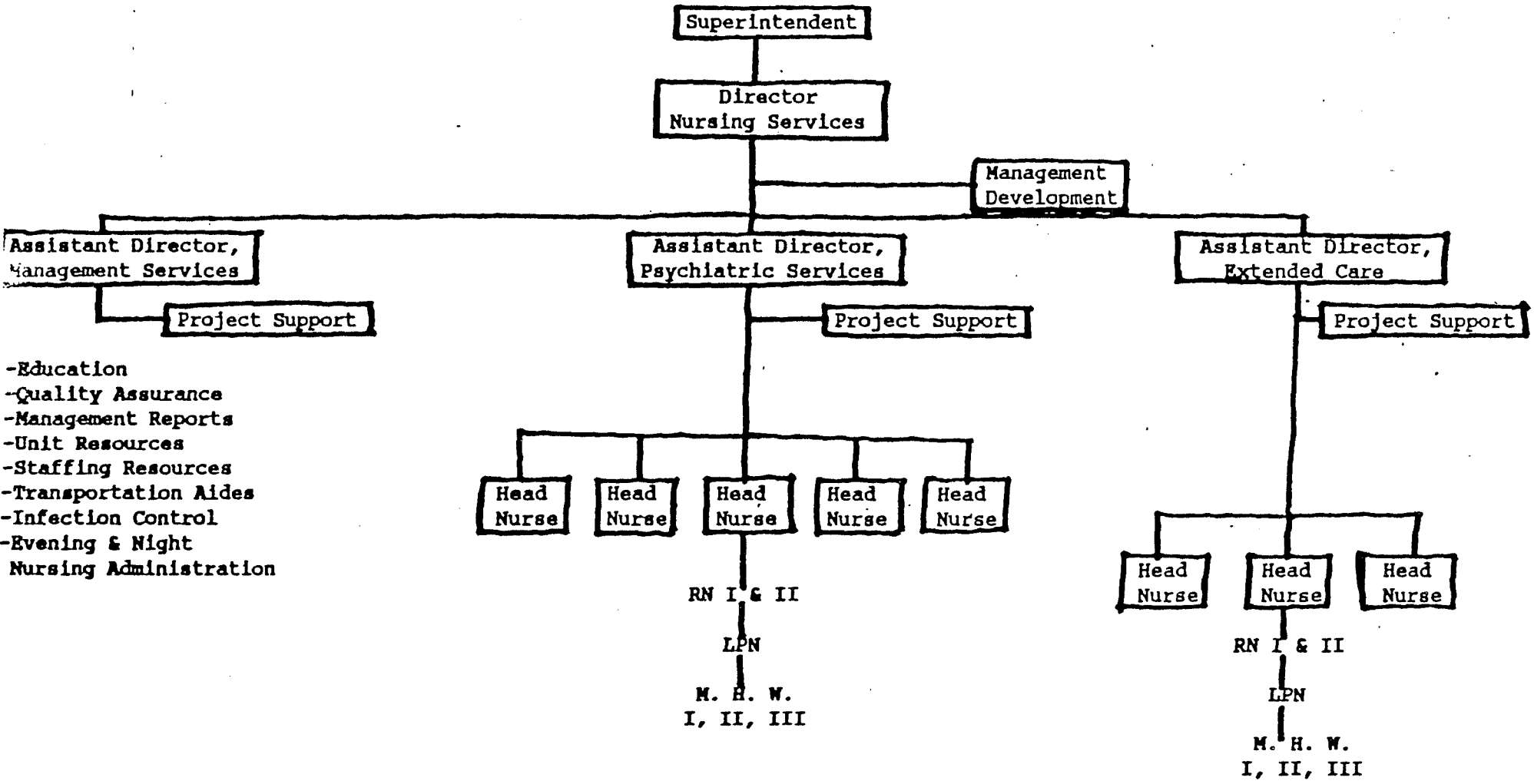
2. Bachelor's Degree in Nursing strongly preferred.

3. Minimum of five years of progressive nursing experience with at least three years in related clinical practice.

4. Progressive management responsibility preferred.

5. Demonstrated leadership and interpersonal skills.

AUGUSTA MENTAL HEALTH INSTITUTE
NURSING SERVICES
TRANSITIONAL ORGANIZATIONAL CHART
2 - 4 YEARS



REPORT ON STAFFING REQUIREMENTS

The Committee to evaluate the staffing requirements for the nursing units at the Augusta Mental Health Institute had three objectives:

I To define the core elements of therapeutic care delivered by the nursing staff for the patient population.

II To recommend a plan for determining the number and skill mix of staff required for nursing care.

III To support these recommendations with a rationale which encompasses principles used to define staffing requirements.

The Committee's assessments and recommendations are outlined according to the above objectives. For the purpose of this report, staffing is the process of determining and providing the acceptable number and mix of nursing personnel to produce a desired level of care to meet the patient's demand for care (Rowland, 1986).

OBJECTIVE I

Define the core elements of therapeutic care delivered by nursing staff for the patient population. The data base included:

I. Interviews with the Consultant for Nursing and Unit Directors.

II Interviews with nursing staff selected at random.

III Unit observations

ASSESSMENT

A. Nursing Care and Practice Model

The therapeutic care provided by the nursing staff appears to be custodial and crisis oriented. The major emphasis of the nursing care is patient safety and defusing escalating behavior in order to prevent an assaultive incident. These are important aspects of psychiatric care for all patients, however, safety and nonviolent crisis intervention are usually approached in the broader context of therapeutic treatment.

The practice model or delivery system utilized to provide patient care seems to be a hybrid of functional and team nursing. This approach has a strong emphasis on tasks and fragments care. Functional and team nursing minimizes continuity of care, blurs the accountability for care and forfeits the evaluation of care outcomes. There is minimal evidence that the Professional Nurse is planning and evaluating care.

Most units do not have a therapeutic treatment program. There is little evidence of large and small group work focused on corrective change that is continuous. This observation also applies to the nursing home units. It is our observation that nursing staff in these units are providing basic physical care to patients. Consequently, the milieu structure is

provided by people, rather than through a therapeutic program. This dependency on staff for structure generates the felt need that more staff is required to do the job. This approach leaves the milieu loose, and the patient population vulnerable to regression.

A therapeutic program provides for patient and staff safety, allows for maintenance of functional status, contains the patient's anxieties, and allows for corrective change. We also noted that the physical environment interferes with the planning and implementation of care; thus increasing the perception that more staff is required to deliver that care. For example, the units are not designed to keep the patient population visible and accessible to staff.

It appears that the Adolescent Treatment Unit has a therapeutic program which provides treatment on an ongoing basis. The milieu is structured and the care delivery system seems to be a modification of primary nursing. The care of the patient appears to be planned and evaluated by a professional team.

B. CONSTANT OBSERVATIONS AND ONE TO ONE INTERVENTION

Nursing interventions such as constant observation and one to one were reviewed because these interventions effect unit staffing on each shift. It is not clear if adequate assessment to initiate and terminate one to one status is conducted by the Professional Nurse. One to one seems to be utilized as an on going intervention rather than an approach reserved for active suicidal ideation and acute care situations.

During the month of June 1989, 8% of the total patient population was placed on one to one status across several units (Table I). This approach to patient care demands a high utilization of staff. We also noted a cluster of patients in the same units who required one to one care over several days. Regression frequently occurs with a lack of structure and therapeutic program.

The procedures for constant observation and one to one lack clarification and distinction about how they differ and when they could be implemented. For example, the supervision procedure for suicide precaution, one to one and constant observation are very similar and describe minimal differentiation.

C. PATIENT ESCORT AND SUPPORT SERVICES

Presently, many units schedule several patient escorts each day for on campus appointments. These appointments are often lengthy and remove care providers from the units. It was reported that staff are required to escort patients in order to communicate information about the patients. This is an example of poor staff utilization and a more efficient escort and communication system is required.

A variety of non-nursing functions such as cleaning floors and toilets, managing linen, preparing food and clerical activities were reported to be delegated to nursing staff. This is another indication of poor staff utilization and a lack of support from other ancillary departments.

RECOMMENDATIONS

. DEVELOPMENT OF THERAPEUTIC PROGRAMS

Each unit needs to develop a therapeutic program which provides structure to the milieu. A lack of therapeutic structure results in patient regression, acting out and increased need for one to one intervention. The Adolescent Treatment Unit has a structured milieu and care planned by a professional team. We suggest that the Adolescent Unit conduct a program evaluation in an effort to evaluate quality and appropriateness of care provided to this particular population. Once evaluated, this program can be used as a model to develop other therapeutic programs. Development of therapeutic programs could begin immediately.

. DEVELOP A PROFESSIONAL PRACTICE MODEL

Develop a professional practice model which provides for continuity of care and accountability for care outcomes. This approach would require a higher ratio of Professional Nurses to nonprofessional care staff. The Adolescent Unit can serve as a model of modified primary nursing. This approach establishes accountability and continuity in the plan of care with those providing the direct care. Successful implementation of a professional practice model could occur after the transition in leadership and the establishment of a Department of Nursing.

. EVALUATE CONSTANT OBSERVATION AND ONE TO ONE INTERVENTIONS

A review of these procedures with clarification about how and when to implement them is necessary. More specific criteria for implementation is needed to insure uniform application. The emphasis should be on patient assessment conducted by the Professional Nurse. We suggest minimum use of constant observation and utilization of one to one for acute care needs. There is a subgroup of patients who make self-destructive gestures such as wrist scratching, hand and head banging, who regress with one to one intervention. The use of the quiet room, frequent checks and behavioral approaches are more effective with this patient population. Concern about milieu structure is critical and has an impact on the utilization of one to one intervention. We suggest that seclusion with frequent checks be implemented for the patient who is assaultative. The evaluation of these procedures can be immediate.

. A MORE EFFICIENT SYSTEM FOR PATIENT ESCORT AND SUPPORT SERVICES

We suggest that patients who have on campus privileges, use them to their appointments unescorted. We suggest unit appointments for therapy, social work and unit rounds by clinic staff for those patients restricted to the unit. This would allow care providers to remain with the larger group of patients who need care and a better utilization of the assigned staff. This would also provide a better mechanism of communication about the patient needs.

Ancillary support services provided by the appropriate personnel need to be in place and functioning daily. Professionals need to be free of non-nursing functions in order to provide therapeutic care to the atients.

OBJECTIVES II & III

Recommend a plan for determining the number and level of staff needed for nursing care and support these recommendations with a rationale which encompasses principles used to define staffing requirements. The data base included:

I Interviews with the Consultant for Nursing.

II Interviews with Unit Directors and Staffing Coordinator.

III Interviews with a random selection of nursing staff.

IV Review of acuity tool (Appendix A) sick time, overtime, float record (Appendix B), position control report (Appendix C), minimum staffing plan (Appendix D), ICF survey report (Appendix E).

ASSESSMENT

A. STAFFING METHODOLOGY

The present staffing methodology is based upon the capacity census, the usual number of staff expected, with some attention to safety of the patient environment. For example, the total FTE's on duty in June sometimes matched the daily minimum plan, sometimes matched the needs specified by the acuity tool, and some units had no match at all. This indicates a lack of structure and methodology for daily staffing (Table II and III).

The time schedule for each unit is planned by two central staffing coordinators. These coordinators plan and augment daily schedules. A float system is utilized to provide staff coverage to those units with sick calls and additional staffing needs for one to one care. This means that units which have adequate staff coverage for a given shift are at risk to lose a care provider to a unit in need of help. We suspect that this approach to fill staffing needs has created the problem of excessive sick time and overtime usage and contributes to low morale.

During the month of June a total of 9.3 FTE's per day reported out sick. A total 18.5 FTE's per day worked overtime. Also in June a total of 8 FTE's per day were floated to other units (Table II). The float system also creates problems with continuity of care because care providers are "floated" to units where they do not know the patient and have difficulty providing individualized care.

The Psychiatric Patient Classification and Nursing Care Hours report is currently utilized by most units to collect data about patient acuity, census and staff compliments per shift (Appendix A). However, these data were not used to guide staffing decisions. Upon review of the classification data and use of RN's I, II, III, LPN's and MHW's I, II, III

for direct care, we conclude that some units are understaffed such as Stone South Middle and Stone North Upper, while other units are overstaffed such as Stone North Upper, Stone North Middle, Forensic and Forensic Treatment (Table III). Table three also illustrates that the total budget positions are nearly adequate to meet the acuity needs of patients for the capacity census. If actual census surpasses capacity, additional worked hours in overtime might be necessary.

Overall the units are overstaffed for the average census but adequately staffed for capacity census. There is, however, a 10% vacancy in budget positions. This vacancy rate leaves the nursing staff feeling short staffed. These data differ from the Quality Health Report (QHR) and we suggest that the data sources used were different.

A review of the classification data and the staff currently available indicates that current staff to patient ratios meet the standard as applied at Trenton New Jersey State Hospital and McLean Hospital in Belmont, Massachusetts and exceeds the standard at a California State Hospital (Table IV). There are some confounding variables which skew the present staffing plan. Excessive use of one to one intervention along with a high degree of role diffusion makes the present core staffing plan feel inadequate.

The nursing home units could explore a more comprehensive classification system. We suggest that this area develop a classification tool which would capture the actual acuity needs of those patients. The ICF Survey Report represents minimum staffing versus staff needed to meet patient's needs (Appendix E). We note that these units seem under staffed and do require a higher ratio of professional to non professional staff. We also suggest a program evaluation to ascertain the need for Occupational therapy, Physical Therapy and further development of recreational activities.

ROLE DIFFUSION AND ROLE BLURRING

Upon review, we find a budgeted ratio of 1:7 Professional Nurses to Mental Health Workers and Licensed Practical Nurses and an actual ratio of 1:10 due to vacancies (Table V). This appears to be out of balance compared with McLean Hospital and indicates a need for more professional nurses.

There are many staff, professional and non professional, who perform clinical and administrative functions that belong to the purview of a nurse manager. Consequently, this role diffusion has blurred the line of accountability at the unit level and has removed care providers from direct care activities. This blurring of accountability also contributes to inadequate decisions about staffing and inadequate management of sick time and overtime usage. We agree with the Quality Health Report (QHR) which recommends reallocation of professional nurse and Mental Health Worker positions to direct care FTE's.

RECOMMENDATIONS

UNIT BASED SCHEDULING

Facilitate time planning at the unit level because those individuals have the local specific knowledge about the patients and the care they require. This could be implemented immediately and would increase morale and unit accountability.

Explore flexible staff schedules that would meet individual unit needs. This could lead to a more efficient use of staff and enhance recruitment and retention.

Examine the high utilization of sick time and overtime. Establish clear authorization of sick time and overtime at the unit level and establish policies to effectively manage it.

Improve distribution of staff to all shifts. A fuller staff compliment to evening and night shifts is needed. There is a strong tendency to heavily schedule the day shift and leave the evening and night shifts light. These decisions should be based upon the patient acuity and skill mix of staff required not solely upon staff's desire to work the day shift.

Reallocate of FTE's from units identified as overstaffed to the units identified as understaffed. This could be implemented immediately.

CENTRAL FLOAT POOL

Develop the use of the central float pool. This pool includes individuals who elect to be assigned to nursing units in need of staff. It is well documented in the health care literature that "floating" staff from units impacts morale and is viewed negatively. The central float pool is a more cost effective approach and may help decrease sick time.

Expand the pool to include professional Nurses and Licensed Practical Nurses.

Utilize one Staffing Coordinator to manage the Central Float Pool and assign staff to units in need of help. The nursing home units are self contained and could cover their staffing needs.

PATIENT CLASSIFICATION TOOL

Continue the utilization of the present classification tool and establish content validity and interrater reliability. The use of a classification tool demonstrates movement away from a census focused model of staffing. This is positive because a classification system can better predict the patient's nursing care needs, staffing needs and budgetary parameters.

Acquire consultation to educate and assist staff with a full understanding and application of this tool. The notion that a computer system is required to capture this data is erroneous. The Staffing Coordinator would be an appropriate individual to tabulate

this data. This can be accomplished immediately. Computer support could be pursued after a classification system is in place.

DEVELOP DATA MANAGEMENT SYSTEMS

A more efficient system to collect and interpret pertinent data is needed. Present systems do not handle data diligently and accurately. We suggest a more accurate documentation, filing and trending system to be established. Assistance is also needed for the accurate interpretation and application of this information. These efforts can be accomplished without automation. Computer support should not be pursued until a data management reporting system is in place.

CLARIFY ROLES AND JOB DESCRIPTIONS

Clarification of roles according to professional competency is needed. This would contribute to the better utilization of current staff.

The skill mix should be adjusted to reflect a 1:3 ratio of Professional to Non Professional staff in all units except Alternative Living Program and the nursing home units (Table VI).

We recommend additional staff changes in the following areas:

I. A ratio of 1:6 Professional to Non Professional for Alternative Living Program.

II. Determine the staff ratio for the nursing home units as part of the development of a classification system.

III. Increase RN II positions, MHW II and MHW III positions and decrease MHW I positions to improve skill mix of staff and to ease into the transition period.

IV. Consider reallocation of MHW FTE's to Registered Nurse FTE's based on attrition.

SUMMARY OF RECOMMENDATIONS

STRUCTURE AND ORGANIZATION

1. Create a Department of Nursing led by a qualified Director of Nursing.

2. Place the Nursing Department within the total organizational structure in a direct relationship to the Superintendent.

3. Redefine the Registered Professional Nurse role at the unit level to enhance direct care functions and professional accountability.

4. Redefine the Mental Health Worker role to enhance patient care functions and more clearly define responsibility.

5. Create three positions, responsible to the Director of Nursing, which would carry responsibility for development and management of psychiatric services, extended care services and management services.

6. A plan for definition and placement of patient populations must be created and acted upon promptly.

7. Structure nursing units with defined patient populations and nursing staff assigned according to patients' nursing needs. Each nursing unit should be managed by a Head Nurse who is a Registered Nurse with appropriate education and experience.

8. Staffing patterns for nursing units must be developed and managed at the unit level.

9. The centralized staffing function should consist primarily of a group of nursing staff, both Registered Nurses and Mental Health Workers, who have been hired to fill vacancies in unit staffing patterns on a shift by shift basis.

10. The function of coordinating the materials and ancillary services needed to support nursing services should be defined and developed in a group of positions assigned to supporting nursing services in this manner.

11. Ancillary services of all types must be addressed if nursing service is to maintain a safe and therapeutic environment and meet standards of regulatory bodies.

12. A concentrated, organized staff development effort must be initiated and supported if above recommendations are to be implemented effectively.

13. Each Assistant Director of Nursing (three) should be assigned a staff support position on a temporary basis to carry out projects necessary to the reorganization and development of Nursing Services over the next two to four years.

SUMMARY OF RECOMMENDATIONS

STAFFING

1. Each unit needs to develop a therapeutic program which provides structure to the milieu.

2. Develop a professional practice model which provides for continuity of care and accountability for care outcomes.

3. Evaluate constant observation and one to one interventions.

4. Develop a more efficient system for patient escort and support services.

5. Establish unit based scheduling.

6. Continue the use of the central float pool, staffed with individuals who elect to be assigned to nursing units in need of staff.

7. Continue the utilization of the present classification tool and establish content validity and interrater reliability.

8. Acquire consultation to educate and assist staff with a full understanding and application of this tool.

9. Develop data management systems to collect and interpret pertinent data.

10. Clarify roles and job descriptions.

11. Increase RN II, MHW II and MHW III and decrease MHW I to improve skill mix of staff and to ease into the transition period.

12. Consider reallocation of Mental Health Worker FTE's to Registered Nurse FTE's based on attrition.

TABLE I

Number and Percent of Patients on 1 to 1 Observation PER DAY

On AMHI Psychiatric Units

UNIT	AVERAGE CENSUS	NUMBER OF PATIENTS ON 1:1 OBSERVATION	% OF PATIENTS 1:1 OBSERVATIONS
SNL Admit	18.7	6.0	32%
SSU Adult Tx	44.8	1.4	3%
SSM Young Adult#	44.8	2.7	6%
SNU Pre Discharge	25.4	1.1	4%
SNM Older Adult	46.0	1.0	2%
Adolescent	12.8	3.8	30%
Alternative Living	No data	No data	No data
Forensic	7.1	1.0	14%
Forensic Tx*	23.0	1.0	3%
TOTAL	222.6	18.0	8%

Source: AMHI Patient Acuity Records, June 1989

* Forensic Tx had 10 patients on pass, thus 23 patients on unit.
# Stone South Middle - no data available, estimate made.

TABLE II

AVERAGE PER DAY: FTEs Scheduled vs. FTEs Actual on Duty - AMHI Psychiatric Units

JUNE 1989

UNIT NAME	CAPACITY CENSUS	ACTUAL CENSUS	ACUITY FTEs CAP CEN	FTEs DAILY PLAN	FTEs SCHEDULED PER DAY	FTEs SICK PER DAY	FTEs OVERTIME PER DAY	FTEs FLOATED IN PER DAY	FTEs FLOATED OUT PER DAY	TOTAL FTEs ON DUTY	ACUITY FTEs AVER CEN
SNL Admit	30.0	18.7	31.0	23.0	25.1	1.0	2.8	0.4	0.8	26.1	19.0
SSU Ad. Tx	45.0	‡ 44.8	25.0	17.0	23.2	1.7	1.7	1.3	0.8	23.7	24.5
SSM Y. Ad.	45.0	* 44.8	* 35.0	17.0	30.6	1.2	1.9	1.1	0.6	33.0	* 34.4
SNU Pre Disch	45.0	25.4	29.0	10.0	18.6	1.5	0.6	0.4	2.4	15.7	16.4
SNM Older Ad.	40.0	46.0	27.0	17.0	28.1	1.5	2.4	0.4	2.5	26.9	31.0
Adolescent	20.0	12.8	20.0	17.0	22.4	0.9	3.5	0.6	0.3	25.3	12.5
Altern. Liv.	40.0	no data	12.0	12.0	22.0	0.3	1.3	0.1	0.3	22.8	* 12.0
Forensic	8.0	7.1	9.0	6.0	10.3	0.5	1.4	0.3	0.4	11.1	7.9
Forensic Tx	25.0	‡ 23.0	18.0	12.0	1.9	0.7	2.9	0.6	0.7	21.2	16.6
TOTALS	293.0	222.6	206.0	131.0	199.4	9.3	18.5	5.2	8.0	205.8	174.3

Sources: Sick/Overtime Report, June 1989 for Sick, Overtime, Float-In, Float out
"Position Control Report", June 1989 for Capcity Census
AMHI Patient Acuity Records, June 1989 for average census, acuity plans, FTE scheduled.

Formula: Hours per month ÷ 30 = hours per day. Hours per day ÷ 8 = FTEs per day

‡FTU - 10 patients on Pass, thus 23 average census
SSU - 16 patients on Pass for Community placement. Thus 44.8 on unit.

* SSM - no data available, estimate made

ALP

TABLE III
AVAILABLE STAFF, BUDGETED STAFF, STAFF BY ACUITY
REPORTED IN FTE's
AMHI PSYCHIATRIC UNITS

UNIT	CAPACITY CENSUS	STAFF AVAILABLE	BUDGETED POSITIONS	POSITIONS BY ACUITY	DAILY 24 HR MIN. PLAN	DAILY 24 HR BY ACUITY
SNL Admit	30.0	41.1	44.0	42.8	23.0	31.0
SSU Ad. Tx	45.0	39.0	41.0	34.6	17.0	25.0
SSM Y. Ad.	45.0	34.5	38.0	est 48.2 no data	17.0	est 35.0 no data
SNU Pre Di	45.0	33.0	35.0	40.6	10.0	29.0
SNM Older	40.0	34.3	41.0	37.8	17.0	27.0
Adolescent	20.0	23.6	27.0	27.4	17.0	20.0
Altern. Li	40.0	26.0	27.0	used 27.0 no data	12.0	used 12.0 no data
Forensic	8.0	12.0	16.0	12.6	6.0	9.0
Forensic T	25.0	22.5	26.0	25.2	12.0	18.0
TOTALS	293.0	266.0	295.0	296.2	131.0	206.0

*All figures are based on paid hours. 1 FTE = 40 hrs/week or 2080 hrs/yr.

Sources:
Capacity census from "Position Control Report", June 30, 1989
Staff available from "Position Control Report". Only RN, MHW I, II, III and LPN used.
Budgeted positions from "Position Control Report". Only RN, MHW I, II, III and LPN used.
Acuity from June 1989 Acuity Records.
(HPPD x Census) ÷ 8 = FTE/Day. x 1.4 = Budget
Daily Minimum Plan from Staffing Office
Daily Acuity from average HPPD calculated from June 1989 AMHI records.

TABLE IV
RATIO OF STAFF TO PATIENTS*

AMHI PSYCHIATRIC UNITS

UNIT NAME	UNIT TYPE	CAP CENSUS	AMHI STAFF AVAIL			BY ACUITY			CALIFORNIA			TRENTON & McLEAN		
			DAY	EVE	NOC	DAY	EVE	NOC	DAY	EVE	NOC	DAY	EVE	NOC
SNL	Admit	30.0	1-3	1-3	1-5	1-3	1-3	1-6	1-6	1-6	1-12	1-4	1-4	1-7
SSU	Ad. Tx	45.0	1-4	1-4	1-8	1-5	1-5	1-9	1-6	1-6	1-12	1-4	1-4	1-7
SSM	Y. Ad.	45.0	1-5	1-5	1-9	1-3	1-3	1-6	1-6	1-6	1-12	1-4	1-4	1-7
SNU	Pre Disch	40.0	1-4	1-4	1-9	1-4	1-4	1-7	1-8	1-8	1-18	1-4	1-4	1-7
SNM	Older Ad.	40.0	1-4	1-4	1-8	1-4	1-4	1-8	1-6	1-6	1-12	1-4	1-4	1-7
Adolescent		20.0	1-3	1-3	1-6	1-3	1-3	1-5	1-6	1-6	1-12	1-4	1-4	1-7
Altern. Liv.		40.0	1-5	1-5	1-11	NO ACUITY AVAIL			1-8	1-8	1-18	---	---	---
Forensic		8.0	1-3	1-3	1-4	1-3	1-3	1-4	1-8	1-8	1-18	---	---	---
Forensic Tx		25.0	1-4	1-4	1-8	1-4	1-4	1-7	1-8	1-8	1-18	---	---	---
AVERAGE		293.0	1-4	1-4	1-8	1-4	1-4	1-7	1-7	1-7	1-15	1-4	1-4	1-7

*Ratios all based on capacity census.

Formulas: 1. Number of Full time Equivalent Staff Available ÷ 1.4 = Number of staff available daily.
2. No. staff avail x 40% = No. for Days. (40% for Eves) (20% for Nocs) Census ÷ No. = ratio.

California figures reported per telephone consult. Trenton and McLean calculated from materials received: Total Census ÷ No. staff planned = ratio.

TABLE V

Ratio of Professional to Non-Professional Staff*

On AMHI Psychiatric Units

UNIT	BUDGETED POSITIONS	FILLED POSITIONS
SNL Admit	1 RN to 2.4 LPN/MHW	1 RN to 3.3 LPN/MHW
SSU Adult Tx	1 RN to 4.8 LPN/MHW	1 RN to 6.8 LPN/MHW
SSM Young Adult	1 RN to 4.4 LPN/MHW	1 RN to 6.6 LPN/MHW
SNU Pre Discharge	1 RN to 3.4 LPN/MHW	1 RN to 3.7 LPN/MHW
SNM Older Adult	1 RN to 3.1 LPN/MHW	1 RN to 5.2 LPN/MHW
Adolescent	1 RN to 4.4 LPN/MHW	1 RN to 5.5 LPN/MHW
Alternative Living	1 RN to 12.5 LPN/MHW	1 RN to 25.0 LPN/MHW
Forensic	1 RN to 3.0 LPN/MHW	1 RN to 11.0 LPN/MHW
Forensic Tx	1 RN to 7.6 LPN/MHW	1 RN to 21.5 LPN/MHW
AVERAGE	1 RN to 5.1 LPN/MHW	1 RN to 9.8 LPN/MHW

*Only RNs I, II, III, LPNs and MHWs I, II, III used.

Note: Ratio at McLean is 1 RN to 1.1 non professional staff

Sources: AMHI "Position Control Report", June 30, 1989

TABLE VI

IMPROVING RATIO OF PROFESSIONAL TO NON-PROFESSIONAL STAFF ON AMHI PSYCHIATRIC UNITS
(RN I, II, IIIs, LPNs and MHW I, II, IIIs)

UNIT NAME	BUDGETED POSITIONS	BUDGETED STAFFING						SUGGESTED STAFFING						ADJUSTMENTS				
		RN	LPN	MHW I	MHW II	MHW III	TOTAL	RN	LPN	MHW I	MHW II	MHW III	TOTAL	RN	LPN	MHW I	MHW II	MHW III
SNL Admit	1 to 2.4	13	4	9	13	5	44.0	13.0	4.0	9.0	13.0	5.0	44.0	NONE	NONE	NONE	NONE	NONE
SSU Ad, Tx	1 to 4.8	7	4	17	10	3	41.0	9.0	4.0	8.6	10.0	3.0	34.6	+ 2.0	0	- 8.4	0	0
SSM Y. Ad.	1 to 4.4	7	3	16	9	3	38.0	12.0	3.0	12.2	16.0	5.0	48.2	+ 5.0	0	- 3.8	+ 7.0	+2.0
SNU Pre Disch	1 to 3.4	8	1	14	9	3	35.0	10.2	1.0	10.0	14.4	5.0	40.6	+ 2.2	0	- 4.0	+ 5.4	+2.0
SNM Older Ad.	1 to 3.1	10	4	16	8	3	41.0	9.6	4.0	9.0	12.2	3.0	37.8	- 0.5	0	- 7.0	+ 4.2	0
Adolescent	1 to 4.4	5	2	11	6	3	27.0	7.0	2.0	7.0	8.4	3.0	27.4	+ 2.0	0	- 4.0	+ 2.4	0
Altern. Liv.	1 to 12.5	2	0	12	9	4	27.0	4.0	0.0	8.0	11.0	4.0	27.0	+ 2.0	0	- 4.0	+ 2.0	0
Forensic	1 to 3.0	4	0	7	4	1	16.0	4.0	0.0	2.6	5.0	1.0	12.6	0	0	- 4.4	+ 1.0	0
Forensic Tx	1 to 7.6	3	2	10	9	2	26.0	6.2	2.0	6.0	9.0	2.0	25.2	+ 3.3	0	- 4.0	0	0
Float Pool	0 to 28.0	0	0	28	0	0	28.0	7.0	0.0	10.0	11.0	0.0	28.0	+ 7.0	0	-18.0	+11.00	0
TOTAL	1 TO 7.0	59	20	140	77	27	323.0	82.0	20.0	82.4	110.0	31.0	325.4	+23.0	0	-57.6	+33.0	+4.0

Rationale:

1. Aim for a ratio of 1 RN to 3 non-professional nursing staff, except for ALP.
   Aim for a ratio fo 1 RN to 6 for ALP.
2. Increase RN II positions only for now
3. Reduce MHW I positions. Increase MHW II and III positions to minimize impact of changes on staff
4. Ratio of MHW I to MHW II positions is suggested as 1 to 1.2 - 1.5
5. Adjustments based on ratios and on patient acuity data for total FTEs.
6. Formula: Total FTEs ÷ 4 = No. RNs.
   Total FTEs minus RNs, LPNs, MHW IIIs = No. MHW Is and IIs.

APPENDIX E

DEPARTMENT OF HUMAN SERVICES - BUREAU OF MEDICAL SERVICES

DIVISION OF LICENSING AND CERTIFICATION

INTERMIDIATE CARE FACILITIES SURVEY REPORT FORM INFORMATION

Name of Facility: NH. Unit A. MHI Town Augusta Date: 6/1/89
Lower Greenlaw

he following items are to be completed by the appropriate person in the facility and returned o the surveyor by the afternoon of the first day of survey.

. Total number of patients on day of survey: 135

. Nursing Activities:

A. Number of completely bedfast patients: 0

B. Number of strictly bed/chair residents: 13

C. Number of residents requiring full assistance with eating: 9

D. Number of residents requiring partial assistance with eating: 7

E. Number of residents normally eating in dining room: 14

F. Number of residents with indwelling catheters: 0

G. Number of incontinent residents (bowel/bladder): _____

Number of residents in bowel retraining program: 29 Bladder: 29
24
53

I. Number of residents with decubiti: 1

J. Number of residents receiving special skin care: 26
(Ointments, dressings, lamp treatments, etc.)

K. Number of residents on intake and output measurements: 0

L. Number of residents in restraints: 15

Geriatric Chairs 12
Posey belts (buckled or tied) 2
Posey Belts (locked) 0
Other (describe) Vest 6, Diaper 5, Laprobe 3

M. Number of non-ambulatory on second floor and/or above: N/A

Dietary:

A. Number of therapeutic diets: 23 Mechanical Diets: 12

B. Number of tube feedings: 0

Name and position of person responsible for completing this information:

Sandra Mottified Title: LPN

level 1 0
level 2 7
level 3 28

AMHI PSYCHIATRIC UNITS - MINIMUM STAFFING PLAN

The following are the guidelines for coverage for safety:
The #'s include licensed coverage. Add 1 MHW for COR or 1-1
(ADM & ADOL include COR count)

Admis SNL	Adult SSU	Young Adult SSM	Pre disch SNU	Older Adult SNM	ADOL	ALP	High Security FOR	SSL FTU
5 if census ↓ 15 7 if census ↓ 25 8 ↑ 25	6 7↑ 55	6	4 M-F (including meds & RN	6 7↑ 55	6	4 M-F	2 Add 1 if Census Over 8	4
as above	6 7↑ 55	6	3	6 7↑ 55	6	4 M-F	2 Add 1 if Census Over 8	4
6 if census ↓ 25 7↑ 25	5	5	3	5	5	4	2	4

minimum core staffing
adds: 1 for each 1:1
1 for appts
1 for sick calls

Appendix C - Continued (5 of 5)

Ward	Positions	Budgeted FTE's	Actual FTE's
Greenlaw Lower	Unit Director	0.25	0.25
	RN III	1.0	1.0
	RN II	1.0	0.0
	LPN	6.0	3.0
	MHW II	9.0	no data
	MHW I	24.0	no data
	Totals	41.25	
	Vacancies = ?		
Greenlaw Middle	Unit Director	0.25	0.25
	RN III	3.0	3.0
	RN II	1.6	0.6
	LPN	4.0	3.0
	MHW II	9.0	no data
	MHW I	23.0	no data
	Totals	40.85	
	Vacancies = ?		

Ward	Positions	Budgeted FTE's	Actual FTE's
Forensic	Unit Director	0.2	0.2
	RN III	1.0	0.0
	RN II	3.0	1.0
	MHW VI	0.5	0.5
	MHW V	0.5	0.5
	MHW III	1.0	1.0
	MHW II	4.0	3.0
	MHW I	7.0	7.0
	Totals	17.2	13.2
	Vacancies = 23%		
Forensic Treatment	Unit Director	0.2	0.2
	RN III	3.0	1.0
	LPN	2.0	2.0
	MHW VI	0.5	0.5
	MHW V	0.5	0.5
	MHW IV	2.0	2.0
	MHW III	2.0	2.0
	MHW II	9.0	8.5
	MHW I	10.0	9.0
	Ward Clerk	1.0	1.0
	Totals	30.2	26.7
	Vacancies = 12%		
Clinics	Unit Director	0.25	0.25
	RN III	1.0	1.0
	RN II	3.0	2.0
	RN I	1.0	0.0
	LPN	2.0	1.0
	Totals	7.25	4.25
	Vacancies = 41%		
Senior Rehab	Unit Director	0.25	0.25
	RN III	3.0	3.0
	RN II	4.0	3.0
	LPN	5.0	4.0
	MHW II	8.0	no data
	MHW I	17.0	no data
	Totals	37.25	
	Vacancies = ?		

Ward	Positions	Budgeted FTE's	Actual FTE's
SNM (Older Adult)	Unit Director	0.4	0.4
	RN III	4.0	4.0
	RN II	5.0	0.0
	RN I	1.0	1.0
	LPN	4.0	2.2
	MHW VI	1.0	1.0
	MHW IV	2.0	2.0
	MHW III	16.0	16.0
	MHW II	8.0	7.0
	MHW I	16.0	16.0
	Ward Clerk	1.0	1.0
	Totals	58.4	50.6
	Vacancies = 13%		
Adolescent	Unit Director	1.0	1.0
	RN III	2.0	2.0
	RN II	3.0	1.6
	LPN	2.0	2.0
	MHW IV	1.0	1.0
	MHW III	3.0	3.0
	MHW II	6.0	6.0
	MHW I	11.0	9.0
	Totals	29.0	25.6
	Vacancies = 12%		
Alternative Living Program	Unit Director	0.3	0.3
	RN III	1.0	0.0
	RN II	1.0	1.0
	MHW V	1.0	1.0
	MHW III	4.0	4.0
	MHW II	9.0	9.0
	MHW I	12.0	12.0
	Totals	28.3	27.3
	Vacancies = 3%		

Ward	Positions	Budgeted FTE's	Actual FTE's
SSU (Adult Treatment)	Unit Director	0.2	0.2
	RN III	3.0	3.0
	RN II	4.0	2.0
	LPN	4.0	4.0
	MHW VI	0.5	0.5
	MHW IV	2.0	2.0
	MHW III	3.0	3.0
	MHW II	10.0	10.0
	MHW I	17.0	17.0
	Ward Clerk	1.0	1.0
	Totals	44.7	42.7
	Vacancies = 4%		
SSM Young Adult	Unit Director	0.2	0.2
	RN III	4.0	4.0
	RN II	3.0	0.5
	LPN	3.0	3.0
	MHW VI	0.5	0.5
	MHW IV	1.0	1.0
	MHW III	3.0	3.0
	MHW II	9.0	9.0
	MHW I	16.0	15.0
	Ward Clerk	1.0	1.0
	Totals	40.7	37.2
	Vacancies = 8%		
SNU (Pre Discharge)	Unit Director	0.3	0.3
	RN III	3.0	3.0
	RN II	4.0	3.0
	RN I	1.0	1.0
	LPN	1.0	1.0
	MHW VI	1.0	1.0
	MHW IV	2.0	2.0
	MHW III	3.0	3.0
	MHW II	9.0	9.0
	MHW I	14.0	14.0
	Ward Clerk	1.0	1.0
	Totals	39.3	38.3
	Vacancies = 2%		

APPENDIX C
AMHI Position Control Report*
In Full-Time Equivalents (FTE's)

Ward	Positions	Budgeted FTE's	Actual FTE's
Nursing Office	RN IV	5.0	2.0
	RN II	1.0	1.0
	Infection Control	1.8	1.8
	Medication Instructor	0.3	0.3
	Staff Development	1.0	1.0
	Pt. Care Coordinator	1.0	1.0
	Staffing Coordinator	2.0	2.0 (1 Psych; 1 Nsg. Home)
	Coordinator for Nursing	1.0	1.0
	Patient Funds	1.0	1.0
	MHW V	1.0	1.0
	Totals	15.1	12.1
	Vacancies = 20%		
Float Pool	RN III	0.4	0.4
	RN I	1.0	1.0
	MHW (? level)	27.0	25.0
	Totals	28.4	26.4
	Vacancies = 7%		
SNL	Unit Director	0.2	0.2
	Clinical Nsg. Specialist	1.0	1.0
	RN IV	1.0	1.0
	RN III	6.0	5.5
	RN II	7.0	4.6
	LPN	4.0	3.0
	MHW V	1.0	1.0
	MHW III	5.0	5.0
	MHW II	13.0	13.0
	MHW I	1.0	1.0
	Ward Clerk	1.0	1.0
	Totals	48.2	44.3
	Vacancies = 8%		

*From materials prepared by AMHI staff, June 30, 1989. (One FTE = 40 hrs/week)

UNIT NAME	SICK TIME HRS	OVERT HOURS	HOURS	HOURS
SNL Admit	251	664	112	200
SSU Ad. Tx	409	400	320	192
SSM Y. Ad.	296.5	456	256	144
SNU Pre Disch	355	152	112	568
SNM Older Ad.	348	568	112	596
Adolescent	222	848.25	152	64
Altern. Liv.	64	320	24	72
Forensic	112	336	80	96
Forensic Tx	176	688	144	168.25
Float Pool	80	160	0	0
N.S.	16	0	0	0
TOTAL Hrs/Mo.	2329	4592.25	1312	2100.50
TOTAL Hrs/Day	77.63	153.08	43.73	70.02

Formula: $\frac{\text{Total Hours/Mo}}{\text{30 Days}}$ = Total Hrs/Day

FIGURE 1

Psychiatric Patient Classification and Nursing Care Hours Report

Page ___ of ___ Unit _____ Date _____
Signature _____ Time _____

	7-3	3-11	11-7
Census			
RN			
LVN			
NL			
Nsg. Hrs.			
Total Nsg. Hrs.			

Comments: _____

Bed	Name
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

Level 1 (7-12)
Level 2 (13-18)
Level 3 (19-24)
Level 4 (25+)

Do Not Use This Space

Total Hours Required: _____

Nursing Care Activities	Acuity	Bed 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
I. THERAPEUTIC INTERACTION 1 to 1	4																
New Admission	3																
Frequent	2																
Routine	1																
II. MEDICATIONS I.V. fluid, and/or medication	4																
Meds reluctantly/ PRN meds/side effects	3																
New medication	2																
Routine medication	1																
No medications	0																
III. PHYSICAL PROBLEMS Bed care or isolation	4																
Secondary physical problems, moderate extra care	3																
Secondary physical problems, minimal extra care	2																
Routine care	1																
IV. DIET/NUTRITION Hand or tube feeding	4																
Urge, supervise dining 1:1	3																
Supervised group dining	2																
Routine supervised dining	1																
V. HYGIENE Complete care	4																
Direct assistance	3																
Needs urging, supervision	2																
Self-care	1																
VI. ACTIVITIES/ PRIVILEGES Restricted to unit	3																
Staff attended pass	2																
Unattended pass	1																
VII. RISK Suicidal (level 3), elopement, or assaultive, high	4																
Suicidal (level 2), elopement, or assaultive, moderate	3																
Suicidal (level 1), elopement, or assaultive, minimal	2																
No overt risk	1																
VIII. TEACHING/ PLANNING Requires 1:1 with patient/family	4																
Discharge	3																
Requires group teaching	2																
Routine	1																
IX. OTHER Seclusion or restraints	4																
ECT	3																
Accompanied campus appointments	3																
Extra lab tests	2																
Accompanied to school	2																
Care Plan update	1																
		Total Points															
		Acuity Level															
		Bed	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16