THE NAVY MEDICAL DEPARTMENT'S WORKLOAD MANAGEMENT SYSTEM FOR NURSING (Patient Classification and Staffing Allocation) SELF-INSTRUCTIONAL WORKBOOK

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20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The Navy Medical Department's Workload Management System for Nursing is a dynamic model for determining staffing requirements based upon patients' direct nursing care needs. This workbook, developed in cooperation with the Army Nurse Corps, has been designed as a self-instructional guide for learning the concepts of and practical applications for the system. Upon completion, users will be able to classify patients, determine staffing requirements based upon the

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system, and describe a methodology for insuring the reliability of the data. Study guide questions and practical exercises have been included to ensure competency based learning.

PREFACE

Any significant research begins with planning the project. This endeavor was certainly no exception. Many years of planning and work have gone into the development of this project from its inception to its implementation. The research on which this autotorial is based was the joint effort of the U.S. Army Nurse Corps and the U.S. Navy Nurse Corps to develop a patient classification system which would not only capture the professional nurse's workload based on the patients' acuity of illness, but which would also give direction for staffing based on direct and indirect nursing care requirements. The Nursing Care Hours Standards Study (Sherrod, Raugh, & Twist) conducted at the Health Care Studies Division of the Academy of Health Sciences produced the mean tasking times on which this work is based. Acting on the recommendations of a consulting firm, Health Management Systems, contracted by the Chief, Army Nurse Corps, efforts were made to create a patient classification system which would meet the needs of both the Navy and the Army Nurse Corps. It was felt that the work already accomplished by the Navy, linked with the time standards and task frequencies determined in the Nursing Care Hour Standards study met the criteria recommended by the HMS Consultants. The linkage of data from both projects resulted in a system titled The Workload Management System for Nursing. The Nursing Research staffs at the Walter Reed Army Medical Center and the Naval School of Health Sciences joined resources and developed a research project designed to test the validity and reliability of the new system. This workbook is the product of the extensive research and evaluation which went into this project.

The first edition of this workbook was written by Major Elizabeth Rimm, ANC, then a research nurse at WRAMC. It was later edited and revised by CDR Karen Rieder, Director, Research Department, NSHS, and the Nursing Education staff at Naval Hospital, Bethesda. This, the third edition, is a culmination of the efforts of CDR Karen Rieder, LTC James Vail, Major Dena Norton, and LCDR Susan Jackson.

This workbook is designed to promote conceptual learning through self-study. It employs the concepts of both patient acuity and staffing methodologies as well as practical exercises to test one's understanding of the concepts presented. It is hoped that this format will serve to encourage the user to continue reviewing the material to ensure that the reliability of the system remains strong and viable.

From the system's inception, through the planning and testing phase, and now to its implementation, there are many officers to whom we owe our thanks and gratitude: CAPT Jo Ann Jennette, NC, USN, who was a driving force in both its conceptual design and development; LTC James D. Vail, Chief, Nursing Research Service, Walter Reed Army Medical Center; Major Dena Norton, ANC, and Major Elizabeth Rimm, ANC, principal investigators for the Army Nurse Corps; CDR Karen Rieder, Director, Research Department, NSHS, Bethesda, principal investigator for the Navy Nurse Corps; and LTC Terry Miesner, ANC, Nurse Methods Analyst, U.S. Army Health Care Studies, Fort Sam Houston. We should certainly thank all the Chief Nurses who participated during the test phase; without their contributions this final product would have been impossible. Last, but certainly not least, we appreciate the efforts of all the nurses who contributed by using the system,by evaluating it, and by giving their honest opinions.

As we move through the eighties and into the nineties, we trust that the contribution made by these Army and Navy Nurse Corps Officers will serve as an example of how major research projects can be accomplished effectively and efficiently through collaboration.

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WORKLOAD MANAGEMENT SYSTEM FOR NURSING

EDUCATIONAL WORKBOOK

Table of Contents

DIRECTIONS TO PARTICIPANTS

A. INTRODUCTION

Nurse staffing has traditionally been based on historical data related to the number of beds occupied in a clinical area. Over the years the nature and volume of nursing workload has been significantly altered by increasingly complex technology, specialization, emphasis on health teaching, personalization of service to patients, and ongoing evaluation of personnel performance and patient care. No longer can staffing be managed on the basis of patient census alone! In fact, Departments of Nursing have been mandated by the Joint Commission on Accreditation of Hospitals to define, implement and maintain a system by which the quantity and quality of available nurse staffing is based on identified requirements for nursing care. To this end the Navy Medical Department has developed a system that enables patients to be categorized according to required nursing care and provides guidelines for effective allocation and utilization of nursing resources. The success of this system depends upon the individuals who work with it; therefore, it becomes paramount for staff members to understand their individual roles.

B. LEARNING OBJECTIVES

1. Define the concept of Patient Classification and its relationship to staffing.

2. Develop skill in classifying patients by nursing care requirements.

3. Determine the recommended staffing requirements for a nursing unit according to specific guidelines.

4. Describe the method used for insuring reliability in Patient Classification.

C. FORMAT FOR PROCEEDING

1. Read the information contained in the first unit of this workbook keeping the objectives of this unit in mind.

2. Answer the study guide questions. Contact your proctor for discussion or clarification of any question(s) that you may have.

3. When ready, take the quiz on that unit. Your proctor will review your answers and provide feedback, if needed.

4. Complete Units I-IV in this manner.

5. Unit V consists of a practicum in which you will classify a typical group of patients and be certified as a patient classifier. Unit VI presents a classification tool specific to psychiatric patients.

UNIT I

INTRODUCTION TO WORKLOAD MANAGEMENT SYSTEM

I. OBJECTIVES

A. Describe how the Workload Management System affects the quality of patient care.

B. List the uses of a Workload Management System.

C. List the characteristics of an effective Workload Management System.

D. Define key terms related to Patient Classification.

II. CONTENT

A. Dynamics of the Workload Management System

1. Patient Classification.
2. Staffing Requirements.
3. Allocation of Staff.
4. Quality of Care.

B. Uses of the Workload Management System

1. Navy-wide
2. Hospital-wide

C. Characteristics of an effective Workload Management System

D. Definitions

1. Workload Management System for Nursing
2. Patient Classification
3. Critical Indicators of Care
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5. Points
6. Category
7. Direct Nursing Care Time
8. Indirect Nursing Care Time
9. Nursing Care Hour Requirements
10. Personnel Requirements
11. Registered Nurses
12. Non-Registered Nurses

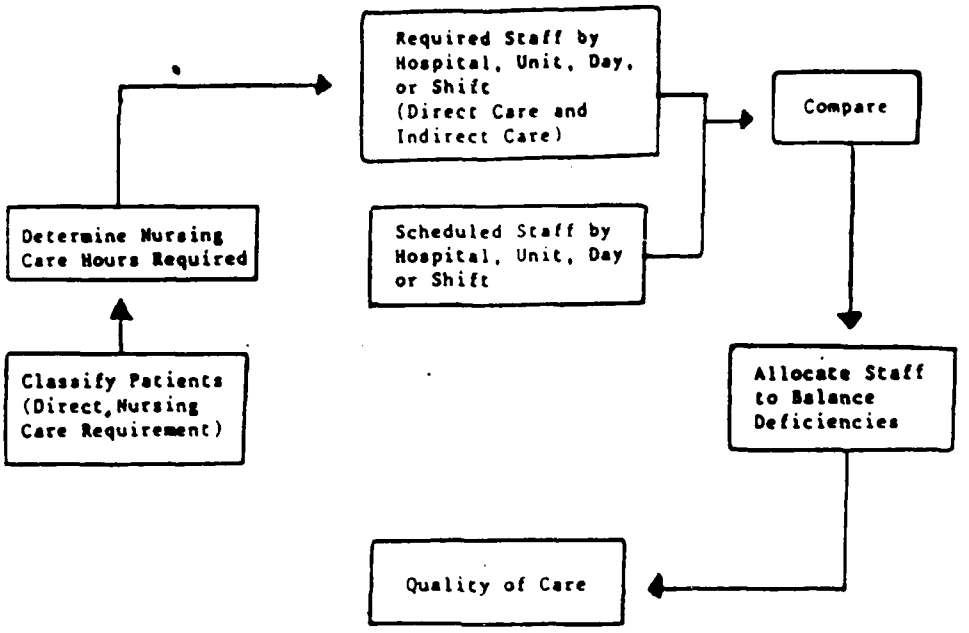
III. STUDY GUIDE QUESTIONS

A. You are orienting a newcomer to the administrative duties of the Charge Nurse and need to explain the Workload Management System. What explanation will you give?

B. The orientee is satisfied with your explanation, but asks for information on critical indicators. Your definition and examples are:

C. Explain how the Workload Management System affects the quality of health care both hospital-wide and Navy-wide.

DYNAMICS OF THE WORKLOAD MANAGEMENT SYSTEM



The flow chart above delineates how the Workload Management System operates. The process begins with the classification of patients into categories of care. The hours of nursing care required and the recommended number and mix of personnel needed to meet these requirements are then calculated based on the number of patients in each category. The actual number and mix of personnel assigned is then compared with the recommended staffing to determine if staffing levels are above, below, or within the recommendations. If staffing levels for the workload to be accomplished differ from recommended levels, staffing can be adjusted to balance the variation. The number and mix of nursing personnel available to provide patient care will significantly impact on the quality of care actually delivered.

In short, the Workload Management System encompasses an integrated process of:

- assessment and classification of patients;
- allocation, assignment and scheduling of nursing personnel; and
- an evaluation or monitoring of care given.

USES OF THE WORKLOAD MANAGEMENT SYSTEM

The data acquired through the use of a Workload Management System is utilized at the hospital level and at command level for planning purposes. Aggregate data from all hospitals is used to establish manpower plans for various categories of nursing personnel and is one of the primary justifications for nursing budgets presented to Congress. The Workload Management System is used to assess deficiencies of nursing personnel among hospitals and to provide a rational guide to correct them.

A variety of benefits might stem from the Workload Management System at the hospital level. The System could be used to:

1. Justify existing assignments or provide information to command levels that can result in changes in existing staffing assignments.

2. Justify requests for additional personnel in various categories.

3. Provide a means for directing admissions to units. (For example, units with heavier workloads could receive the less acute admissions in an effort to balance workloads among units.)

4. Provide a mechanism for quality audits. (Sampling can be done to measure whether care indicated as necessary on the Patient Classification instrument is being given and documented.)

5. Estimate staffing requirements for nursing units based on workload so that adequate personnel are provided to meet patient needs. It is an objective method for assigning float personnel where they will be used most effectively.

6. Qualify the levels of care needed by each patient so that nursing personnel may be assigned appropriately in terms of their expertise.

SYSTEM PERFORMANCE CRITERIA

In order for the Workload Management System to perform effectively, the following criteria were established, and have been supported through research.

Comprehensiveness

The system classifies all inpatients according to levels of required nursing care and determines the amount of nursing time needed to care for these patients. The system applies to all inpatients at all Navy Hospitals and accounts for both direct and indirect care.

Data Output

The system produces a series of daily and monthly reports that are useful both in the operation of the hospital and in the planning and budgeting of resources. The reports are timely and provide information on actual patient days, actual nurse staffing, and nurse workload by patient category, by shift, by ward, and by personnel category.

Data Input

The same definition of patient classes is used throughout the Navy. The definitions are simple to understand, and the procedures for using them speedy and reliable.

Validity

The system measures what it purports to measure. The validity of the patient categories and the times for direct care have been studied for two years in all Naval Hospitals using objective data. The system has also been used and studied extensively in a large number of Army Medical Treatment Facilities. The Pearson Product Moment Correlation between the Patient Classification Critical Indicator instrument and the Nursing Care Hour Standards tool was .81. When adjusted for emotional support the correlation was raised to .89.

Reliability

Unsystematic variation between raters, between hospitals and wards, and overtime can be maintained at a high level. Inter-rater reliability of total scores at six test sites was .84 between staff nurses and the investigator. Inter-rater

reliability between categories was also high. Using the Kappa Statistic, the rating between staff nurses and the investigator was .77.

Implementation

An implementation plan includes the orientation and training of all Registered Nurses and the assignment of officers at each hospital to monitor the ongoing application and reliability of the system.

Usefulness

The system has proven to be a valid management tool for determining patient workload and assigning appropriate staff. It retrospectively documents what has been done for the patient during the current shift and projects the nursing care needed for the following shifts.

DEFINITION OF TERMS

The following definitions provide the groundwork for concepts and information covered in Unit II of this workbook. Be sure that you clearly understand these terms before progressing through this workbook.

Workload Management System for Nursing: a systematic process for determining staffing requirements based upon identified patient care needs. The system includes a patient classification tool and a staffing methodology. The inpatient classification instrument is of factor evaluative design and requires that a registered nurse assess ten factors related to direct patient care and assign a score to each factor. The assessment consists of both retrospective and prospective components; that is, assessment of care required during the day shift is used to predict care requirements for the next 24 hours. The weighted factor scores are summed resulting in the patient being classified into one of six discrete categories. The staffing methodology is used for determining the actual nursing care hour requirements for a specified group of patients and the numbers and mix of personnel recommended to provide quality care. This system incorporates both direct and indirect care time.

Patient Classification: the grouping of patients according to an assessment of their nursing care requirements over a specified period of time.

Critical Indicators: those nursing activities on the patient classification instrument that have the greatest impact on direct care time (see Figure 1).

Factors: a group of critical indicators that cover one specific domain of activities. They include ten areas: vital signs, monitoring, activities of daily living (ADL), feeding, treatments, respiratory therapy, I.V. therapy, teaching, emotional support, and continuous care

Points: the values assigned to each specific critical indicator based upon documented time and motion studies. Each point is equal to 7.5 minutes of direct nursing care time.

Category: the representative grouping of patients according to their nursing care requirements. The WMSN consists of six categories. A category I patient requires minimal care whereas a category VI patient requires intensive care. The categories are as follows:

CATEGORY	POINT RANGE	DIRECT CARE DESCRIPTION
I	0-12	Self Care/Minimal Care
II	13-31	Moderate Care
III	32-63	Acute Care (1 staff to 3 patients)
IV	64-95	Intensive Care (1 staff to 2 patients)
V	96-145	Continuous care (1 staff to 1 patient)
VI	146+	Critical Care (1 staff to 1 patient)

Direct Care Time: the activities that take place in the presence of the patient and/or family (usually at the patient's bedside). These activities are observable, behavioral, and include the following:

1. Placement of equipment at bedside
2. Explanation of procedure to patient
3. Preparation of patient

FIGURE 1

PATIENT CLASSIFICATION CRITICAL INDICATORS

VITAL SIGNS (MANUAL TPR, BP)

(1) Vital signs QID or less
(2) Vital signs q4h or x 6
(4) Vital signs q2h or x 12
(8) Vital signs q1h or x 24
(2) Rectal or axillary temps or apical pulse QID or more
(2) Femoral or pedal pulses or FHT q4h or more
(2) Tilt tests q4h or more
(6) Post-op, post-partum or post-newborn

MONITORING

(2) Intake and output q8h or x 3
(8) Intake and output q2h or x 12
(2) Circulation or fundus checks q2h or x 12
(3) Neuro checks q4h or x 6
(6) Neuro checks q2h or x 12
(2) CVP or ICP (manual) q2h or x 12
(6) Cardiac/apnea/temp/pressure monitors (not additive)
(6) Transcutaneous monitor
(4) A-line or ICP (monitor) or Swan Ganz set-up
(2) A-line or ICP (monitor) reading q2h or x 12
(2) PAP/PA wedge reading q4h or x 6
(4) PAP/PA wedge reading q2h or x 12
(2) Cardiac output TID or x 3

ACTIVITIES OF DAILY LIVING

(6) Infant/toddler care (≤ 5 years)
(2) Self/minimal care (adult or child > 5 years)
(6) Assisted care (> 5 years) - positions self
(14) Complete care (> 5 years) assist with positioning
(32) Total care (> 5 years) - position and skin care q2h
(4) Extra linen change and partial bath 2x per shift
(14) Turning frame (2 staff to turn q2h)
(8) Peds recreation/observation - 0-12 yrs (exclude NBN)

FEEDING

(2) Tube feeding (continuous) - per bag change
(5) Tube feed (bolus) adult/child/neonate q4h or x 6
(6) Adult meals > 5 years (spoon feed x 3)
(10) Child meals ≤ 5 years (spoon feed x 3)
(2) Infant/neonate bottle x 1 feeding
(12) Infant/neonate bottle q4h or x 6
(24) Infant/neonate bottle q2h or x 12

TREATMENTS/PROCEDURES/MEDICATIONS

Simple > 15 and < 30 Minutes Total

(2) Start IV or NG insertion or Foley insertion or EKG
(2) Surgical prep or enemas or ace wraps/elastic stockings
(2) Simple dressing x 2, or tube care x 2 (exclude trach), Foley care x 2
(2) S&A or SpGr or Guiac or spin HCT x 6
(2) Lab studies x 6; ABG stick or blood culture x 3
(2) Medications q3h - q8h (exclude IV) - (up to 12 trips)
(2) Irrigations or instillations x 4 or less
(2) Restraints (2 or 4 point or posey)
(2) Assist to chair or stretcher and return x 3
(2) Assist to walk and return x 1
(2) Infant circumcision or phototherapy
(2) Isolation (gown & glove x 8)
(2) Accompany patient off ward > 15 minutes & < 30 minutes
(2) Other activities requiring > 15 minutes & < 30 minutes

Complex > 30 minutes and < 1 Hour Total

(4) Chest tube insertion or lumbar puncture
(4) Thoracentesis or paracentesis
(4) Complex dressing change (> 30 minutes to complete)
(4) Straight catheterization x 4 or more
(4) Medications q2h or more (exclude IV) (> 12 trips)
(4) Range of motion exercises x 3
(4) Accompany patient off ward > 30 minutes
(4) Other activities requiring > 30 minutes and < 1 hour
(4) Transfer (in-house) - assess & orient
(12) New admission - assess & orient

Special Procedures > 1 Hour < 4 Hours

(8) Each complete hour requiring continuous staff attendance

RESPIRATORY THERAPY

(2) Oxygen therapy or oxyhood
(2) Incentive spirometer or C&DB q4h
(2) IPPB or maximist BID or x 2
(4) IPPB or maximist q8h or x 4
(6) IPPB or maximist q4h or x 6
(8) Croup tent or mist tent
(2) Chest pulmonary therapy BID or x 2
(4) Chest pulmonary therapy q6h or x 4
(6) Chest pulmonary therapy q4h or x 6
(2) Suctioning q4h or x 6
(4) Suctioning q2h or x 12
(4) Tracheostomy care x 3
(10) Ventilator

IV THERAPY

(4) KVO (change bottle BID or less)
(4) Heparin lock or Breviac
(6) Simple (change bottle TID or QID)
(8) Complex (two or more sites or change bottle q4h or multilumen line)
(2) Medication q8h or x 3
(3) Medication q6h or x 4
(4) Medication q4h or x 6
(2) Blood products (each unit)

TEACHING AND EMOTIONAL SUPPORT

(Must be documented)

Teaching

(2) Group teaching
(4) Preoperative teaching
(4) Structured teaching (i.e. diabetic, cardiac, colostomy care, post partum first 24 hrs, newborn care, discharge)

Emotional Support (in excess of 30 minutes q 24 hours.)

(4) Patient/family support (i.e. anxiety, denial, loneliness, etc.)
(4) Modification lifestyle (i.e. new prosthesis, body image, behavior modification, etc.)
(6) Sensory deprivation (i.e. retarded, deaf, blind, language barrier, bilateral eye patches, confused, combative, etc.)
(10) Maximum points for emotional support

CONTINUOUS

(96) Patient requiring 1:1 coverage all shifts (i.e. peritoneal dialysis, combative, etc.)
(148) Patient requiring greater than 1:1 coverage all shifts (i.e. ventilator with multiple vasopressors, IABP, etc.)

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4. Performance of task

5. Removal of equipment from area

6. Recording (if at bedside, i.e., vital signs, I&O, etc.)

7. Assessment/observation

8. Teaching

Indirect Care Time: those activities, conditions and circumstances that necessitate time over and above the direct care critical indicators. To address these factors, indirect care time and unpredicted needs have been incorporated into the system.

1. Indirect Care includes such things as charting, transcribing orders, phone calls, clean-up, etc.

2. Unpredicted Needs refer to unanticipated needs due to changes in patient's condition, admissions, delay and stand-by, care conferences, personal time and staff education.

Nursing Care Hour Requirements: the hours of nursing care time required for each category of patient based upon an assessment of their direct and indirect nursing care requirements. This is operationalized via six pre-calculated patient care hour requirement charts: Medical/Surgical, Pediatric, Critical Care, Psychiatric, Nursery, and OB/GYN.

Personnel Requirements: the number and mix of RNs and non-RNs required to care for the patient workload on a unit. This is operationalized via six charts: Medical/Surgical, Pediatric, Critical Care, Psychiatric, Nursery, and OB/GYN.

RN: a professional Registered Nurse who has satisfactorily completed an orientation program to the hospital.

Non-RN (NRN): personnel other than RNs who have satisfactorily completed an orientation program to the hospital. This includes Corpsmen, LPNs, and medical ward clerks.

UNIT II

PATIENT CLASSIFICATION

I. OBJECTIVES

A. Describe correct use of the Patient Classification Critical Indicators Sheet.

B. Describe special instructions in completing the Patient Classification Worksheet.

C. In a simulated exercise, correctly classify ten patients with 80% accuracy.

II. CONTENT

A. Explanation of the Patient Classification Worksheet with instructions for completing.

B. Special instructions for classifying patients.

C. Practice in classifying patients.

III. STUDY GUIDE QUESTIONS

A. List three forms that are necessary to classify patients accurately.

B. During what time of the day are RNs to classify patients and forward the information to the Patient Care Coordinator?

C. In which category should a patient be classified if he requires 1:1 direct care for greater than four hours?

THE CLASSIFICATION METHODOLOGY

The Classification Methodology for determining direct care time utilizes the Patient Classification Worksheet (Figure 2), the Critical Indicator Sheet, and Guidelines for using Critical Indicators (Appendix A).

The Patient Classification Worksheet has spaces across the top for patient names. Under each patient name space are columnar boxes which correspond to a vertical list of the critical indicators on the left side of the page. At the bottom left of the worksheet is a series of blocks for noting the total scores and categories for each patient listed and assessed. At the bottom right of the page is a space for totalling the number of patients in each category.

The Critical Indicator Sheet lists the direct nursing care activities determined to be critical indicators of direct nursing care time. Under each of the ten critical indicator groups is the list of activities that pertain to that group. The numbers in parentheses to the left of each specific critical indicator represent the point score assigned to that activity.

The Guidelines for Using Critical Indicators is the interpretive text for the definition of each critical indicator and its application during the assessment of patients. This guide also contains answers to questions about special situations that may arise when classifying patients.

PROCEDURE FOR USING THE CLASSIFICATION WORKSHEET

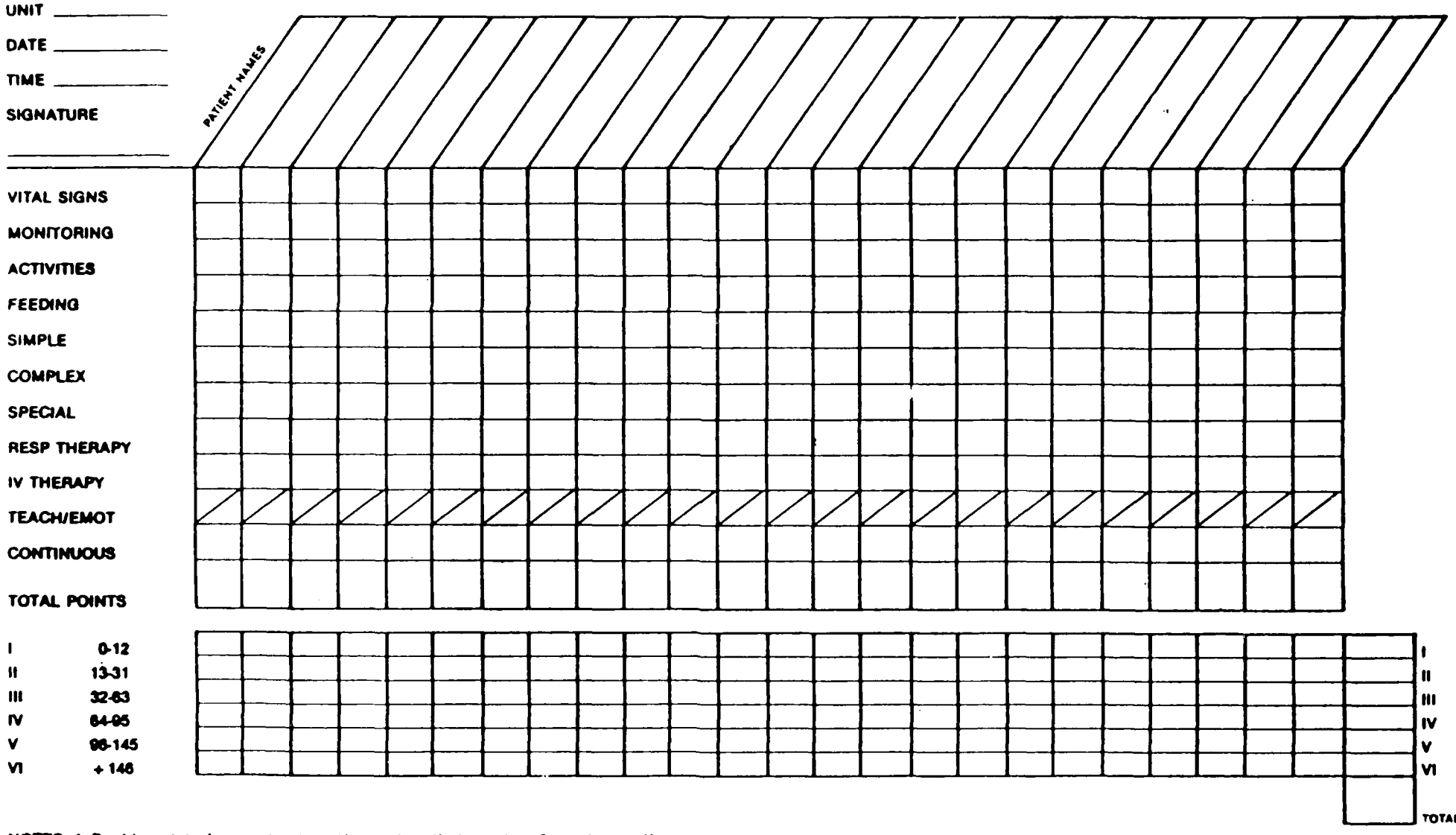
INSTRUCTIONS:

Use the "Patient Classification Worksheet" (see illustration, Figure 2) to classify patients. This is a single page form which may be used to classify up to twenty-four patients. This form will be used for the manual classification of patients and should not be modified in any way. The "point values" in the left column correspond to the amount of time assigned to each activity and alterations in any of these values will void the system. Should you have questions about any of the "critical indicators" and their point values (Figure 1), please direct those questions to the person responsible for monitoring the classification system in your facility. It is imperative that the point values are not altered!

WORKLOAD MANAGEMENT

PATIENT CLASSIFICATION WORKSHEET

FIGURE 2



NOTES: 1. Double points for any treatment/procedure that requires 2 nursing staff members.

2. Adjust points to accomodate frequency, i.e., IPPB q2h = 12 points.

WORKLOAD MANAGEMENT

PATIENT CLASSIFICATION WORKSHEET

FIGURE 2 - EXAMPLE

UNIT 6E

DATE 20 JUN 85

TIME 1230

SIGNATURE Martha Jones LCDR

TX/PRO/RX	PATIENT NAMES	John A.	Philip G	Mary P.	Bev S.	Luke V.	Mark S.	Michele N.	Ben F.	John B.	Dorothy L.
	VITAL SIGNS	1	1	2	4	4	8	6	2	8	1
	MONITORING	6	0	2	8	8	32	10	2	38	0
	ACTIVITIES	2	2	8	6	6	32	40	14	32	6
	FEEDING	0	0	0	0	0	0	6	0	0	0
	SIMPLE	2	4	10	4	2	16	8	8	18	4
	COMPLEX	0	12	0	0	0	0	0	0	4	0
	SPECIAL	0	0	0	0	0	0	0	0	0	0
	RESP THERAPY	4	4	6	4	4	16	4	16	16	10
	IV THERAPY	0	0	0	0	4	14	8	4	14	0
	TEACH/EMOT	0/0	4/0	0/0	0/0	0/0	0/4	0/6	0/0	0/0	4/0
	CONTINUOUS	0	0	0	0	0	0	0	0	0	0
	TOTAL POINTS	15	27	28	26	28	122	88	46	130	25

I	0-12																										—
II	13-31	X	X	X	X	X					X																6
III	32-63		•						X																		1
IV	64-95							X																			1
V	96-145						X			X																	2
VI	+ 146																										0
																											10

TOTAL

NOTES: 1. Double points for any treatment/procedure that requires 2 nursing staff members.

2. Adjust points to accomodate frequency, i.e., IPPB q2h - 12 points.

Follow the steps listed below for completing the Patient Classification Worksheet:

1. Fill in the unit, the date, and the time. More than one Registered Nurse may use a single Patient Classification Worksheet. In this event each nurse should place his/her initials in the "signature" area at the top of the worksheet. This is necessary for accountability.

2. Write the names of all patients on the lines at the top of the worksheet. This may be done by the ward clerk, or may be completed by someone on the night shift for use by the day shift staff. Use as many forms as necessary.

3. Select the critical indicators in each section that are appropriate for each patient. Two or more activities in a single line may apply. If so, total the numbers to get a score for those activities. If you take a rectal temp (2 points), plus apical pulse (2 points) plus vital signs QID, this is a total of 5 points. Record the sum (5 points) in the box next to vital signs.

4. Proceed through each group of critical indicators recording the points in the appropriate boxes.

5. Total the points for each patient and record the sum in the space at the bottom of the column.

6. Determine each patient's category by matching the total points with the appropriate point ranges. Place a check mark in the box to identify the category.

7. Count the number of checks to determine the number of patients in each category. The total number of categories may not equal your ward census. This will be the case when you are caring for outpatients on the ward, and you list them on the Patient Classification Worksheet for the purpose of documenting the workload.

PATIENT CLASSIFICATION INSTRUCTIONS

1. Patients must be classified by a Registered Nurse on the AM shift. The classification worksheet may be initiated at any time but must be reviewed and updated between 1200 hours and 1400 hours to ensure that it accurately describes the patient's acuity level.

2 The patient's classification category should reflect the level of nursing care each patient requires at that point in time based on current physician orders, nursing orders, and the nursing care plan.

3. Patients discharged prior to 1400 hours are not to be included.

4. Units may elect to classify each shift if the workload routinely fluctuates significantly from one shift to the next.

5. Anticipate the direct care requirements of patients who have gone to surgery and are expected to return from the RR or ICU after 1400 hours and classify them on the Patient Classification Worksheet.

6. Units routinely (i.e., at least 3 days per week) providing outpatient care on AM and PM shifts may write "outpatient" instead of the patient's name and assign points for treatments/procedures in the same manner as for inpatients. Add the total points for all of the outpatients and divide by 12 to determine the number of Category I's to be counted. Outpatient care totalling less than 12 points is not to be counted.

7. Units monitoring telemetry patients physically located on another unit who do not have a constant cardiac monitor watch incorporated into their staffing, can allot six points for each telemetry patient monitored. The ward on which the patient is located counts six points for a "cardiac monitor".

8. Critical Care Units that provide post-op care after the recovery room closes may write "recovery patient" instead of the patient's name and assign points for treatment/procedures in the same manner as for other patients. Add the total points for all the RR patients, divide by 12 to determine the number of Category I's to be counted. These patients do not receive transfer (in-house) points. Recovery patients totalling less than 12 points are not to be counted.

9. The logistics of classifying patients in the Recovery Room and Labor and Delivery will be provided at a future date.

10. The Patient Classification Critical Indicators List (Figure 1) is to be used by all specialty services except: Psychiatry, Labor & Delivery, and the Recovery Room.

11. There is a separate Patient Classification Form for Psychiatry. Should there be a medical/surgical patient admitted to the psychiatric unit you may use both classification sheets to capture the workload. This also applies to a psychiatric patient admitted to a Medical/Surgical Unit.

CRITICAL INDICATOR INSTRUCTIONS

VITAL SIGNS (MANUAL TPR, BP)

1. "Vital Signs QID or LESS" is the only critical indicator with a one point value.

2. "Vital Signs q 4 h or x 6" in a 24 hour period is equal to 2 points. "Vital Signs q 2 h or x 12" is twice as often, therefore equal to twice as many points--4 points; and "Vital Signs q 1 h or x 24" is equal to 8 points. Vital signs taken every 30 minutes x 24 hrs. would be valued at 16 points.

3. If rectal temperatures are taken at least QID, add 2 points. No matter how much more frequently they are taken (i.e., q 4 h) you still will only count 2 points. This is why the critical indicator reads "QID or MORE".

4. If rectal temperatures AND apical pulses both are taken QID or more frequently, add 2 points for each activity to total 4 points.

5. Femoral OR pedal pulses OR fetal heart tones must be taken q 4 h before you count the 2 points, but once again, since the critical indicator states "q 4 h or more" you would not get additional points if they were done more frequently.

6. Femoral pulses OR pedal pulses OR fetal heart tones OR tilt tests will count 2 points each if done q 4 h or more frequently. If you had a patient with pedal pulses q 4 h AND fetal heart tones q 4 h, you would count 4 points total.

7. Post-operative, post-partum or post-newborn vital signs include vital signs taken after surgery, after delivery (mother) and the first 24 hours of the newborn's life. It also includes vital signs taken after any other special procedure(s) which would require "post-op" monitoring, i.e., post-arteriogram with vital signs q 15 minutes x 4, q 1 h x 4, then q 4 h.

MONITORING

1. Increase point allowance for increased frequency.

2. Intake and output includes time to measure all forms of I & O, including diaper weights. Patients on just intake or just output will not receive points.

3. Circulation or fundus checks must be done at least q 2 h before they count. Circulation checks include checking for movement and sensation.

4. Neuro checks include checking pupils, mental alertness, orientation, sensory discrimination, and motor and sensory testing.

5. Manual measurement of central venous pressure or intracranial pressure means you use a manometer, not a Swan Ganz or electronic ICP machine.

6. If the patient is on one or more monitors (cardiac/apnea/-temperature/pressure monitor), a total of 6 points is counted. Not 6 points for a cardiac monitor plus 6 points for an apnea monitor, but a total of 6 points for both.

7. A-line OR ICP monitor OR Swan Ganz set up is the point value for actually setting up the equipment at the bedside and assisting with the insertion procedure.

8. A-line OR ICP monitor readings performed q 2 h or X 12 equals 2 points. If done every hour it equals 4 points. Readings must be recorded to count.

9. Pulmonary artery pressure and wedge pressure readings also must be recorded to count.

10. Cardiac output points recorded must involve nursing personnel time. If the physician performs the test without assistance, it does not count.

ACTIVITIES OF DAILY LIVING (ADL)

1. Count activities of daily living for all patients even if the family provides this care since the nursing staff is still responsible for giving instructions and monitoring the care provided. The family member cannot be held accountable for the care.

2. Infant or toddler care (less than or equal to 5 years of age) includes neonates and premature infants.

3. Well baby nurseries with rooming-in should allot 6 points for infant/toddler care to account for nursing staff time required to assess and oversee the child.

4. Infant or toddler care includes time to give a complete bath or tub bath, AM care, PM care, washing face and hands routinely and PRN, diaper changes or assisting child to the bathroom, changing clothes and linens, ambulatory weight or infant weight, serving the meal tray and routine nursing assessments.

5. Self/minimal care (adult or child greater than 5 years) include time for administration of non-intravenous medications BID or LESS, providing equipment for a self-bath, serving the meal tray, making an unoccupied bed and routine nursing assessments.

6. Assisted care (adult or child greater than 5 years) includes time for administration of non-intravenous medications BID or LESS, assisting with bathing back and legs or assisting with a shower or tub bath, AM care, PM care, serving the meal tray with some preparation of the food, ambulatory weight, making an unoccupied bed, routine nursing assessment and answering patient questions.

7. Complete care (adult or child greater than 5 years) includes time for administration of non-intravenous medications BID or LESS, a complete bed bath, AM and PM care, weighing the patient, giving the bedpan and/or urinal, making an occupied bed, serving the meal tray with preparation required, assisting with positioning and repositioning the patient, answering the patient's questions, and routine nursing assessments.

8. Total care (adult or child greater than 5 years) includes administration of non-intravenous medications BID or LESS, complete bath, AM and PM care, skin care q 2 h, oral hygiene q 4 h, making an occupied bed, turning the patient q 2 h, giving a bedpan and/or urinal, a bed scales weight, answering patient questions, and routine nursing assessments.

9. Any time a patient requires an extra linen change and partial bath twice per shift for any reason, i.e., vomiting, incontinence, diaphoresis--this is worth 4 additional points.

10. The critical indicator "turning frame" includes time for 2 people to turn the patient q 2 hours.

11. Pediatric recreation and observation (less than or equal to 12 years) excludes nursery babies. This includes time spent in supervising recreational activities, answering patient's questions and crying, visiting with the child, holding the infant, and generally keeping an eye on the child. You may assign only 8 points for recreation/observation.

    NOTE: This critical indicator is not to be given automatically to any child less than 12 years old. Example: A mother (or family member) rooming in with the child may provide recreational activities and/or supervisory activities without staff involvement.

FEEDING

1. Parenteral nutrition (parenteral hyperalimentation) is to be treated as an IV line.

2. Bolus tube feeding or intermittent tube feeding q 4 h or X 6 is equal to 5 points. This includes nasogastric bolus tube feedings as well as gastrostomy bolus tube feedings.

3. Continuous tube feedings or enteral hyperalimentation includes continuous feedings through nasogastric tubes, oral gastric tubes, oral-jejunostomy tubes, and gastrostomy tubes. Count 2 points for each time the bottle/bag of feeding is changed or filled.

4. Count adult or child meals only if the patient must be spoon fed each feeding. Otherwise time to serve and prepare the tray is included under activities of daily living.

5. Well baby nurseries with rooming-in should allot 2 points for each infant feeding given by nursery personnel.

6. Infant/neonate bottle q 4 h or X 6 = 12 points.
   Infant/neonate bottle q 3 h or X 8 = 16 points.
   Infant/neonate bottle q 2 h or X 12 = 24 points.

TREATMENTS/PROCEDURES/MEDICATIONS--SIMPLE

1. Double the points for treatments/procedures/medications that require two nursing staff members. For example, if two people are required to get a patient out of bed and for the return to bed, grant 4 points; if three people are needed, grant 6 points, etc. This is not to be used for training time such as the orientor-orientee situation or for critical indicators in any other section.

2. Count 2 points for <u>each</u> of the following activities: starting IV, inserting a foley, inserting an NG, nursing personnel doing an EKG, performing a surgical prep, or giving an enema.

3. Elastic stockings or ace wraps count 2 points. This includes time to remove and replace them every shift.

4. Simple dressing change. Count 2 points for each BID dressing change.

5. Tube care includes time to change dressings around drainage tubes, i.e., chest tubes, penrose drains, gastrostomy tubes, etc. two times in 24 hours. The indicator does not include trach care (see respiratory therapy). Foley care is allotted 2 points for care BID.

6. Simple tests done on the nursing unit, such as sugar & acetone, guaiac, spin hematocrit, specific gravity or bilirubin test--count 2 points only if done for a total of 6 times, i.e., S & A TID would not count, but that S & A TID combined with a specific gravity TID would count.

7. Lab studies X6 include only those specimens obtained by nursing personnel on the unit and sent to the laboratory for processing. This may be any combination of the following to total 6 activities per 24 hours: venipuncture-blood sample, sputum specimen, urine specimen, or blood samples obtained from intravascular lines (e.g., ABG from A-lines). Each venipuncture counts as a lab study, NOT how many blood tubes are filled.

8. Arterial blood gases X 3 is for samples drawn by arterial punctures ONLY.

9. Medication administration up to 12 trips (excluding intravenous medications) includes all kinds of medication delivery: topical, oral, sublingual, subcutaneous, intramuscular, suppositories, eye drops, ear drops, or nose drops. Count the number of trips you have to make into the patient's room. Two points are allocated for 3 to 12 trips. BID or LESS are included with activities of daily living. PRN medications count only if the patient is actually receiving them.

10. Irrigations or instillations X 4 or less include all types of tube irrigations or instillations.

11. Restraints include time to apply the restraints and conduct periodic circulation checks.

12. Assist to chair or stretcher, or bedside commode counts 2 points when it is done three times in a 24 hour period. This includes just the transfer; it does not include assisting with ambulation. Points may be doubled if two staff members are required to perform the task.

13. Assist to walk and return to bed counts 2 points each time a patient is assisted by one staff member. Points may be doubled if two staff members are required.

14. Accompanying a patient off the ward less than 30 minutes but more than 15 minutes for any reason will be worth 2 points.

15. Other direct care activities requiring more than 15 minutes but less than 30 minutes equals 2 points. These activities must be listed on the patient care plan or activity sheet.

TREATMENTS/PROCEDURES/MEDICATIONS--COMPLEX

1. Count 4 points for assisting with a chest tube insertion, lumbar puncture, thoracentesis or paracentesis.

2. Count 4 points for each dressing change that takes greater than 30 minutes to complete.

3. Count straight catherizations, if done 4 times or more in a 24 hour period as 4 points.

4. Count 4 points if greater than 12 trips were made into a patient's room to administer non-intravenous medications. NOTE: PRN medications count only if the patient is receiving them.

5. Range of motion, active or passive, if done by the nursing staff TID--counts 4 points.

6. Accompanying a patient off the unit for greater than 30 minutes but less than one hour for any reason is equal to 4 points.

7. Points may be given for any other direct care activities that require greater than 30 minutes but less than one hour that are not found on the critical indicator list. These activities must be listed on the patient care plan or patient activity sheets.

8. Count 4 points for each patient transferred to the unit from another unit in the hospital. This includes time for assessment and orientation.

9. Count 12 points for newly admitted patients. This includes time for the complete history and assessment, orientation to the unit, and instructions to the patient and/or family.

TREATMENTS/PROCEDURES/MEDICATIONS--SPECIAL PROCEDURES

1. Assignment of one member of the nursing care team to one patient for direct nursing care for up to 4 hours for whatever the reason counts as 8 points for each hour of care required. If the requirement is for a staff member to provide 1:1 direct care for greater than four hours, do not use this critical indicator--use the continuous care indicator.

2. This is the indicator to be used during cardiac arrests. Count 8 points for each nursing staff member involved for each hour of time. Example: One RN, one paraprofessional involved in a cardiac arrest lasting one hour would count as 2 people X 8 points per hour = 16 points.

RESPIRATORY THERAPY

1. Count 2 points for oxygen therapy regardless of how the oxygen is administered, i.e., by prongs, mask, nasal cannula, collar, face tent, or oxyhood. If oxygen is administered by nasal prongs and a face mask, both are still worth only 2 points.

2. Count 2 points for incentive spirometer q 4 h. Count 2 points for C&DB patients. If you do both, count 4 points. If the patient requires incentive spirometer less than q 4 h or does the treatment himself, do not count any points.

3. IPPB or maximist (nebulizer) must be administered by nursing personnel to count.

4. Suctioning includes oral, tracheostomy, naso-tracheal or endotracheal.

INTRAVENOUS THERAPY

1. Parenteral hyperalimentation is treated as an IV infusion. Use the appropriate IV indicator according to how frequently the bottle is changed.

2 Heparin locks or Broviac catheters include time to administer a heparin flush q 4 h and perform daily dressing care and tubing changes.

3. KVO IVs are IV lines with a single insertion site that require IV bottle/bag changes BID or LESS in a 24 hour period. This includes time to adjust the flow rate q 1 h and perform daily dressing care and tubing changes. Should a single IV site have 2 bottles infusing, count the frequency of the bottle changes to determine the appropriate indicator.

4. Simple IV's are IV lines with a single insertion site that require a bottle/bag change TID or QID. This includes time to adjust the flow rate q 1 h and perform daily dressing care and tubing changes.

5. The complex IV category is selected for patients with two or more insertion sites, or a single multilumen line, or a single line that requires bottle/bag changes q 4 hours or more frequently. Time is also included to adjust the flow rates q 1 h and perform daily dressing care and tubing changes.

6. IV medications include IV push medications and IV piggyback medications. Each IV medication counts separately. EXAMPLE: Keflin q 6 h and Gentamycin q 6 hours equals 3 points each for a total of 6 points.

7. Blood products are worth 2 points for each unit of RBCs, packed cells or a 6 pack of platelets administered. This includes time to check the blood at the bedside, take pre and post vital signs, hang and regulate the infusion rate, and check the patient frequently during administration.

TEACHING

1. Time allowance for routine assessment, observations and teaching has been incorporated in points for each individual critical indicator. Points for teaching should be given only for structured instruction as outlined in the definitions. These classes must be documented in the patient care plan and nurse's notes.

2. For group teaching, give 2 points to each patient per hour of group instruction.

EMOTIONAL SUPPORT

1. Time allowance for assessment, observation and interaction has been incorporated into the points for each individual critical indicator. Count emotional support only when special problems of the patient warrant emotional support in excess of 30 minutes in 24 hours. This MUST be documented in the patient care plan and the nurse's notes.

2. Maximum point allowance for emotional support is 10.

3. Points in this group are additive. EXAMPLE: You may add 4 + 4 = 8. But you may not exceed the 10 point maximum allowance.

CONTINUOUS

1. The continuous section is to be used to classify patients requiring 1:1 or greater than 1:1 care.

2. If this section is selected DO NOT use any of the additional critical indicators.

3. See Guidelines in Appendix A for a more complete explanation.

PRACTICAL EXERCISE

Using the Patient Classification Worksheet, Critical Indicator Sheet, and the Guidelines for Interpreting the Meaning of the Critical Indicators (Appendix A), classify the patients whose data are found on the following pages.

1. Mr. C is a 73-year old admitted with a diagnosis of congestive heart failure. Use the following information to classify this patient.

Vital Signs	q4h
Monitoring	I&O q8 hrs
ADL	Assisted care (positions self)
Feeding	No assistance needed
Tx/Procedures/Meds	S&A's q4h Medications po qid Needs assistance in and out of bed q shift
Respiratory Therapy	Oxygen 2L by nasal cannula
IV Therapy	None
Teaching/Emotional	Routine only
Continuous	No

2. Baby D is a five-day old term infant with a diagnosis of R/O sepsis. Use the following information to classify this patient.

Vital Signs	q4h with axillary temps and apical pulses
Monitoring	Cardiac monitor I&O q 8 hr
ADL	Infant care Peds observation
Feeding	Similac 4-5 oz. q 3-4 hr
Tx/Procedures/Meds	SpGr's q4h
Respiratory Therapy	None
IV Therapy	IV D5W at 10 cc/hr
Teaching/Emotional	Parents require special teaching on infant care Parents require extra emotional support Encourage maternal/infant contact
Continuous	No

3. Miss E is a 14-year old who is one month S/P VSD repair. She has never awakened postoperatively. Use the following information to classify this patient.

Vital Signs	q4h Rectal temps and apical pulses
Monitoring	I&O q8h Neuro checks q4h
Feeding	Vivonex tube feeding per N/G at 75 cc/hr, bag changed q8hr
ADL	Total care, turn q2hr, and skin care q2hr
Tx/Procedures/Meds	Meds qid per n-g tube Straight cath q4-6hrs ROM at least tid
Respiratory Therapy	Oxygen 30% by T-piece Tracheostomy Suction q2h
IV Therapy	D5NS at KVO rate
Teaching/Emotional	Parents require extensive support
Continuous	No

SPECIAL INSTRUCTIONS: Data for classifying patients is derived from the Patient Profile. To make this a more realistic learning experience, you are being directed at this point to the following pages where information for classifying two additional patients can be found.

PATIENT PROFILE

NAVMED 6500/12 (6-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO		✓	Temp			Dentures
	Bathroom Privileges		✓	Shower		Regular	5/1	✓	Pulse	TID		Speech impediment
	Up in chair			Tub				✓	Resp			Language barrier
	Ambulate			Needs assistance				✓	B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
✓	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other		✓	Self	5/1	FEEDING	DATE		FLUIDS			Hearing defect
				Needs assistance		✓ Self			Forced to			Other
				Special		Needs assistance			Restricted to			
						Gavage			I & O			

DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
5/1		Telemetry monitor					
5/1		May go to Chow hall					

ADDRESSOGRAPH

Mr. A, 23 years old was admitted on 01 MAY 84. This is his 15th hospital day.

DIAGNOSIS

Pericarditis

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

FINDINGS:

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

ALLERGIES:

NKA

DATE ORD	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
5/1		Pen V K 50mg po, QID	06-12-18-24				

ADDRESSOGRAPH

Mr. a. Pericarditis

GPO 1983-405-616/7001 5-1

PATIENT PROFILE

NAVMED 6000/12 (5-80) S/N 0105-LP-206-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
✓	Bedrest	5/1	✓	Bed bath	5/1	NPO	5/1	✓	Temp	rectal qid		Dementia
	Bathroom Privileges			Shower				✓	Pulse	q1h		Speech impediment
	Up in chair			Tub				✓	Resp			Language barrier
	Ambulate			Needs assistance				✓	B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance							✓	Neuro ✓	q1h		Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing aid(s)
			✓	Needs assistance	5/1	Self			Forced to			Other
				Special		Needs assistance			Restricted to			
						Gavage			I & O	q1h		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
5/1		Cardiac Monitor					
5/1		PAP/PA wedge q2h					
5/1		CVP q2h					
5/1		Arterial line gases	q4h				
5/1		N/G tube to low gomco					
5/1		Foley care	BID				
5/1		Chest tube to water					
		seal drainage					
5/1		S & A's q4h					
5/1		Ted hose					
5/1		ROM exercises to legs	TID				
5/1		Turn q2h - skin care	q2h				
		(incontinent of stool)					
5/1		MA-1 at 60% FIO_2					
5/1		Family needs frequent					
		contact and support					
		from nursing staff					
				5/1		IV D_5W at 100cc/h	
				5/1		IV D_5W at KVO rate	
				5/1		Hyperalimentation	
						at 125 cc/h	

ADDRESSOGRAPH

Mr. B, is comatose at this time. This is his second hospital day.

DIAGNOSIS

Pulmonary Embolism
S/P Cardiac Arrest

AGE	HEIGHT	WEIGHT
50yr		

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

FINDINGS:

	DATE ON	DATE OFF
BI		
VSI		
RELIGIOUS RITES		

ALLERGIES

NKA

DATE ORD	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
5/1		Nafcillin 1 Gm IVPB q4h	06-12-18-24				
5/1		Gentamycin 60 mg IVPB q8h	07-15-23				

ADDRESSOGRAPH

Mr. B, Pulmonary Embolism

U.S. Government Printing Office 1982—000-810/7501 3-1

ANSWERS TO PRACTICAL EXERCISE

UNIT ANSWERS

WORKLOAD MANAGEMENT

PATIENT CLASSIFICATION WORKSHEET

PRACTICAL EXERCISE (STUDY GUIDE)

UNIT 5E

DATE 20 JUN 84

TIME 1200

SIGNATURE

TX/PRO/RX	PATIENT NAMES	Mr. C.	Baby D	Miss E	Mr. A	Mr. B
	VITAL SIGNS	2	6	6	1	10
	MONITORING	2	8	5	6	40
	ACTIVITIES	6	14	32	2	32
	FEEDING	0	12	6	0	0
	SIMPLE	6	2	2	2	10
	COMPLEX	0	0	8	0	4
	SPECIAL	0	0	0	0	0
	RESP THERAPY	2	0	10	0	10
	IV THERAPY	0	4	4	0	14
	TEACH/EMOT	0/0	4/4	0/4	0/0	0/4
	CONTINUOUS	0	0	0	0	0
	TOTAL POINTS	18	54	77	11	124

I	0-12				X		1
II	13-31	X					1
III	32-63		X				1
IV	64-95			X			1
V	96-145					X	1
VI	+ 146						

5

NOTES: 1. Double points for any treatment/procedure that requires 2 nursing staff members.

STAFFING METHODOLOGY

UNIT III

I. OBJECTIVES

A. Utilize the Nursing Care Hour Requirements Charts to determine nursing hours needed on different nursing units.

B. Utilize the Personnel Requirements Charts to determine provider mix for different nursing units.

C. Utilize the Daily Summary Sheet to determine differences between recommended and actual staffing distribution.

D. Utilize the Monthly Staffing Summary Graph to identify trends in workload and staffing distribution.

II. CONTENT

A. Explanation of the Nursing Care Hour Requirements Chart

B. Explanation of the Personnel Requirements Chart

C. Explanation of the Daily Summary Sheet
(procedure for use)

D. Explanation of the Monthly Staffing Graphs
(procedure for use)

III. STUDY GUIDE QUESTIONS

A. There are various Nursing Care Hour Requirements Charts to select from in this system. Briefly state how they differ.

B. There are several Personnel Requirements Charts in this system. Briefly state how to use them.

C. What information will the Monthly Staffing Graph convey to Patient Care Coordinators and Directors of Nursing Services?

D. In what way can this information be used to determine personnel management strategies?

STAFFING METHODOLOGY

This section of the WMSN addresses the conversion of the data gathered from the patient classification process into numbers of staff recommended by the WMSN to perform the nursing workload.

Nursing workload performed in the inpatient area is comprised of two major components. It is important to understand the difference between these components when determining staff requirements for a ward. The first component of nursing workload includes both the direct and indirect care given to the patient. The second major component includes those duties which are necessary to manage the ward.

The amount of patient care given varies according to the number and category of patients. This workload is primarily performed by direct care providers and includes RN and NRN staff. Ward management and administration, however, is a fixed component of nursing workload and must be performed regardless of the number and category of patients. Ward management includes the overall administration, supervision, and evaluation of ward staff, the management of patient care, orientation of new staff, on-the-job teaching, scheduling, and management of resources. This component is primarily performed by the Charge Nurse (CN) and Senior Corpsperson (SC). These two staff members (either designated or relief) also provide support and act as a resource to the direct care providers.

The staffing methodology portion of the WMSN is usually completed by the Patient Classification Coordinator or a Nursing Assignment Coordinator. After the ward staff has completed the patient classification process, the Coordinator for each clinical area receives the Patient Classification Worksheet and reviews it for accuracy. The Summary from this worksheet provides the working basis for determining staffing requirements.

Daily Summary Sheet

The classification data and the recommended number and mix of personnel are recorded on the Daily Summary Sheet along with the number and mix of personnel actually scheduled to work. The difference in actual versus recommended staffing and adjustments made are also recorded on this sheet. The total number of staff required is calculated using the Nursing Care Hour Requirements and Personnel Requirements Charts.

Nursing Care Hour Requirements Charts

To determine hours of care for a unit, six pre-calculated Nursing Care Hour Requirements Charts have been developed based on type of unit (i.e., Medical/Surgical, Psychiatric, OB/GYN, Pediatric, Nursery, and Critical Care). Each of these charts has a title at the top indicating the specialty unit for which it is to be used. A sample of these

charts is represented in Figure 3. To use the chart, first, count the number of patients in each category. For example, if you have 5 Category I patients, find the number 5 in the "Patients" column and read across to the "Category I" column, where you will see the number 8. This means 8 nursing care hours are required to care for five Category I patients. Repeat the procedure for the patients in each category and add the hours for each category to get the total nursing care hours required for 24 hours. For assessing the nursing care hours of patients assigned to a Light Care Unit or a multi-service ward (i.e., combination of Medical-Surgical, Pediatrics, and GYN patients) use the Medical-Surgical Chart.

The direct care times for each patient are identified using the Critical Indicator classification tool. For indirect care, a percentage of staff time based on studies completed by Kelly (1980) and Misener (1983) has been added to the hours identified for each category of care. Therefore, the nursing care hours in these specialty charts provide adequate time for total patient care. The complete set of charts can be found in Appendix C. The time required to perform ward management and administration has been excluded from the Nursing Care Hours Requirements charts. Administrative time is a constant and is accounted for by an administrative "additive" to the recommended staff for the AM Shift Monday through Friday, excluding holidays.

Personnel Requirements Charts

To determine provider mix required (i.e., RN, paraprofessional), one of the Personnel Requirements Charts is used. These charts are also titled by type of unit (i.e., Medical/Surgical, Psychiatric, etc.) and have been designed to distribute staff considering workload fluctuations between shifts. A sample of these charts is presented in Figure 4. The first column at the left of the page titled "Total Hours" represents the total number of hours you calculated from the Nursing Care Hour Requirements Chart. For example, Unit 2 has a staffing requirement of 212 hours of care. Go to the "Total Hours" column, where you will find the number range that includes your hour requirement. In the case of 212 hours the number range is 209-216.

Read across to the next column, "Total 24 Hour Staff," to determine that you need 27 nursing personnel (direct care providers) to staff for the next 24 hours. Continue to read across to determine that you will need 4 RNs and 6 paraprofessionals on evenings, 2 RNs and 4 paraprofessionals on nights and 4 RNs and 7 paraprofessionals on days. The personnel requirement charts do not include the CN or SC on the AM Shift. The complete set of charts can be found in Appendix D.

Note: See special chart for Light Care units.

FIGURE 3

MEDICAL-SURGICAL

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	2	5	11	18	27	45
2	3	10	21	36	54	91
3	5	15	32	53	81	136
4	6	20	43	71	108	182
5	8	25	54	89	135	227
6	10	29	64	107	161	272
7	11	34	75	125	188	318
8	13	39	86	142	215	363
9	14	44	96	160	242	409
10	16	49	107	178	269	454
11	18	54	118	196	296	499
12	19	59	128	214	323	545
13	21	64	139	231	350	590
14	22	69	150	249	377	636
15	24	74	161	267	404	681
16	26	78	171	285	430	726
17	27	83	182	303	457	772
18	29	88	193	320	484	817
19	30	93	203	338	511	863
20	32	98	214	356	538	908
21	34	103	225	374	565	953
22	35	108	235	392	592	999
23	37	113	246	409	619	1044
24	38	118	257	427	646	1090
25	40	123	268	445	673	1135
26	42	127	278	463	699	1180
27	43	132	289	481	726	1226
28	45	137	300	498	753	1271
29	46	142	310	516	780	1317
30	48	147	321	534	807	1362

FIGURE 4

MEDICAL-SURGICAL

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2
49-56	7	1	1	2	1	1	2	1	2	3
57-64	8	1	2	3	1	1	2	1	2	3
65-72	9	1	2	3	1	1	2	2	2	4
73-80	10	1	2	3	1	1	2	2	3	5
81-88	11	1	2	3	1	2	3	2	3	5
89-96	12	2	2	4	1	2	3	2	3	5
97-104	13	2	3	5	1	2	3	2	3	5
105-112	14	2	3	5	1	2	3	2	4	6
113-120	15	2	3	5	2	2	4	2	4	6
121-128	16	2	3	5	2	2	4	3	4	7
129-136	17	2	4	6	2	2	4	3	4	7
137-144	18	2	4	6	2	2	4	3	5	8
145-152	19	3	4	7	2	2	4	3	5	8
153-160	20	3	4	7	2	3	5	3	5	8
161-168	21	3	4	7	2	3	5	4	5	9
169-176	22	3	5	8	2	3	5	4	5	9
177-184	23	3	5	8	2	3	5	4	6	10
185-192	24	3	5	8	2	4	6	4	6	10
193-200	25	4	5	9	2	4	6	4	6	10
201-208	26	4	5	9	2	4	6	4	7	11
209-216 →	27	4	6	10	2	4	6	4	7	11
217-224	28	4	6	10	2	4	6	5	7	12
225-232	29	4	6	10	3	4	7	5	7	12
233-240	30	4	7	11	3	4	7	5	7	12

Shift Distribution: 42% AMS
35% PMS
23% Nights

Staffing Ratio: 40% RN
60% NRN

Daily Summary Sheet (Figure 5).

Procedure for use:

1. Initiate the Daily Summary Sheet on the AM Shift to project staff requirements for the PM Shift, Night Shift, and the following AM Shift.

2. Fill in the blocks to identify the hospital, year, month, day and nursing unit.

3. Transcribe the number of patients in each Category from the Patient Classification Worksheet for each specific nursing unit and total the column.

4. Select the appropriate Nursing Care Hour Requirements Chart for the type of unit from the list below: (See Figure 3 for sample chart)

Medical/Surgical	Pediatric
Psychiatric	Nursery
OB/GYN	Critical Care

5. Use this chart to find the number of patients in each category and read across to determine the Nursing Care Hour Requirements for 24 hours. Record this number in the space provided and total that column. Make a check in the box to indicate which chart was selected.

   NOTE: If patients are classified on each shift, divide the "number of Patients" Column and the "Nursing Care Hour" Column into 3 sections to record the information for each shift.

6. On the Summary Sheet under "staffing," record the actual number of staff who are scheduled to work each shift. This number includes direct care providers and administrative staff.

7. Select the appropriate Personnel Requirements Chart from the list below: (See Figure 4 for sample chart)

Medical/Surgical	Pediatric
Psychiatric	Nursery
OB/GYN	Critical Care

   NOTE: For personnel requirements on an Intensive Care Nursery (ICN) or Pediatric ICU, use the Critical Care Chart.

FIGURE 5

WORKLOAD MANAGEMENT DAILY SUMMARY SHEET

MONTH ☐☐ YEAR ☐☐

HOSPITAL NAME _____

HOSPITAL UIC _____

DAY ☐☐ WARD ☐☐☐

SHIFT HOURS: 8 ☐ 12 ☐ Flex ☐

Monitor Watch: Yes ☐ No ☐

NCHR/PR CHART USED:
☐ MED/SURG ☐ OB/GYN ☐ PEDS ☐ PSYCH ☐ NSY ☐ CRIT CARE

CLASS	NUMBER OF PATIENTS	NURSING CARE HOURS
I		
II		
III		
IV		
V		
VI		
TOTAL		

	STAFFING								
	PM			NIGHT			AM		
	RN	NRN	TOTAL	RN	NRN	TOTAL	RN	NRN	TOTAL
ACTUAL									
RECOMMENDED									
DIFFERENCE									
CHANGES									
TOTAL									
ORIENTEES									

ADMISSIONS _____ _____ _____

DAY ☐☐ WARD ☐☐☐

SHIFT HOURS: 8 ☐ 12 ☐ Flex ☐

Monitor Watch: Yes ☐ No ☐

NCHR/PR CHART USED:
☐ MED/SURG ☐ OB/GYN ☐ PEDS ☐ PSYCH ☐ NSY ☐ CRIT CARE

CLASS	NUMBER OF PATIENTS	NURSING CARE HOURS
I		
II		
III		
IV		
V		
VI		
TOTAL		

STAFFING

	PM			NIGHT			AM		
	RN	NRN	TOTAL	RN	NRN	TOTAL	RN	NRN	TOTAL
ACTUAL									
RECOMMENDED									
DIFFERENCE									
CHANGES									
TOTAL									
ORIENTEES									

ADMISSIONS _____ _____ _____

DAY ☐☐ WARD ☐☐☐

SHIFT HOURS: 8 ☐ 12 ☐ Flex ☐

Monitor Watch: Yes ☐ No ☐

NCHR/PR CHART USED:
☐ MED/SURG ☐ OB/GYN ☐ PEDS ☐ PSYCH ☐ NSY ☐ CRIT CARE

CLASS	NUMBER OF PATIENTS	NURSING CARE HOURS
I		
II		
III		
IV		
V		
VI		
TOTAL		

STAFFING

	PM			NIGHT			AM		
	RN	NRN	TOTAL	RN	NRN	TOTAL	RN	NRN	TOTAL
ACTUAL									
RECOMMENDED									
DIFFERENCE									
CHANGES									
TOTAL									
ORIENTEES									

ADMISSIONS _____ _____ _____

REMARKS

KEY

ACTUAL - STAFF WHO WERE SCHEDULED TO WORK EACH SHIFT (LESS ABSENTEES)

RECOMMENDED - REQUIRED STAFFING LEVEL AS DETERMINED BY NURSING CARE HOURS

DIFFERENCE - SUBTRACT RECOMMENDED FROM ACTUAL

8. Match the total nursing care hours to the total hours on the selected chart to find the 24 hour staffing distribution. Record the recommended staff distribution on the summary sheet.

9. Add the CN next to the recommended number of direct care RNs as +1. The SC is added next to the recommended number of direct care NRNs as +1. See Figure 5A.

   NOTE: If you are initiating the Daily Summary Sheet on Sunday through Thursday for the following 24 hours, you add the CN and SC to the recommended staff. But if you are initiating this form on Friday, Saturday, or the day before a holiday, you do not add the CN and SC.

DAY 09

SHIFT HOURS: 8 ☒ 12 ☐ Flex ☐ | Monitor Watch: Yes ☐ No ☐ | NCHR/PR CHART USED: ☐ MED/SURG ☐ OB/GYN ☐ PEDS ☐ PSYCH ☐ NSY ☐ CRIT CARE

WARD 2 2 A

CLASS	NUMBER OF PATIENTS	NURSING CARE HOURS		STAFFING PM RN	PM NRN	PM TOTAL	NIGHT RN	NIGHT NRN	NIGHT TOTAL	AM RN	AM NRN	AM TOTAL
I	5	8	ACTUAL	3	7	10	1	3	4	5	7	12
II	2	10	RECOMMENDED	4	6	10	2	4	6	4+1	7+1	13
III	9	96	DIFFERENCE	-1	+1	0	-1	-1	-2	0	-1	-1
IV	4	71	CHANGES				+1				+1	
V	1	27	TOTAL	3	7	10	2	3	5	5	8	13
VI	-	-	ORIENTEES									
TOTAL	21	212	ADMISSIONS		2			0			4	

DAILY SUMMARY SHEET EXAMPLE

FIGURE 5A

10. Record the difference by indicating if the actual is more (+) or less (-) than the recommended. For example, if the actual RN is one more than recommended, record a +1 in the difference box. If the paraprofessional is one less record a -1 in the difference box. Then considering both, place a zero (0) in the total difference box.

11. Changes or adjustments are recorded to document if staff was added or pulled. When possible, staff from units that show a +1 should be moved to units that show a -1.

12. Retrospectively, record after "Total" the number of staff who actually worked the shift. Do not count orientees.

13. All personnel newly reporting to nursing service will be considered orientees for a period of 4 weeks. Nursing personnel who are rotated to a specialty area (ICU, CCU, Labor & Delivery, etc.) are to be considered orientees for 2 weeks.

14. Record the number of orientees assigned to work each shift. (Do not include orientees in the Total even though it may be necessary to utilize orientees to fill shortages when other resources are not available.)

15. Retrospectively record the number of admissions per shift.

16. Count clinical instructors as full-time staff when 4 hours or more are spent on a unit orienting personnel to specific activities.

17. Personnel are to be reflected as a change on the Summary Sheet if they are gone from the unit 4 hours or more (-.5 or -1), e.g., ambulance runs for patients other than those on assigned unit.

MONTHLY STAFFING GRAPH: (See Figure 6).

The Monthly Staffing Graph is designed as a tool to identify trends in workload and staffing distribution problems on units for all shifts. The graphic display will document 1) the recommended daily requirements as compared to the actual scheduled staff and 2) the staffing after changes have been made.

Procedure for Use:

1. Complete the graph by using a heavy line to record the recommended number of personnel on each shift including the CN and SC when appropriate. Lightly shade in the space below the heavy line.

2. Use an "X" to indicate the actual scheduled staff, and an "O" to designate the available staff after changes. The position of the "O" in relation to the "X" will reflect the hours of overtime and/or the utilization of float personnel. (See Figure 6 - Example.)

3. Place the letter "N" to indicate the total number of registered nurses on duty, excluding orientees.

4. At the end of the month, calculate the daily average for each category of acuity I to VI and place on the chart in the designated blanks.

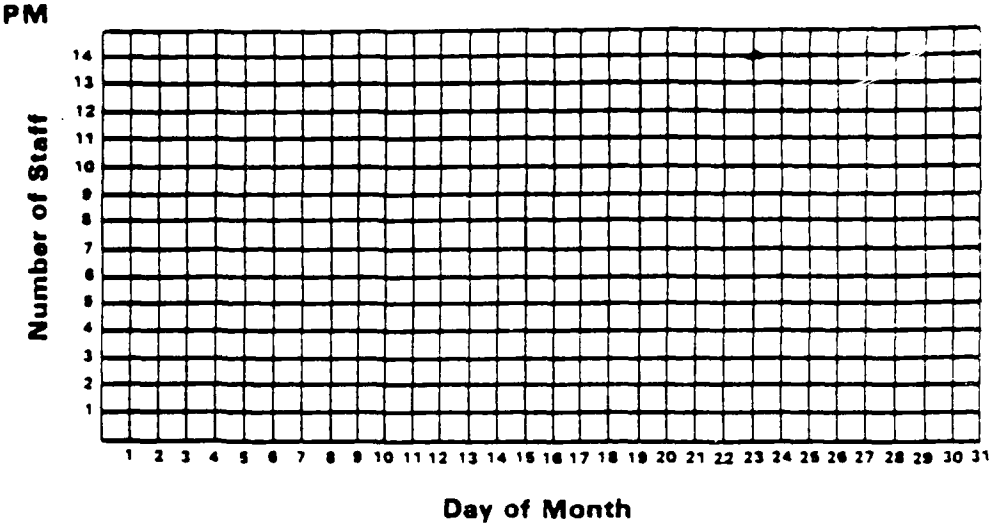
FIGURE 6

WORKLOAD MANAGEMENT MONTHLY STAFFING GRAPH

Unit _____

Month _____

PM



NIGHTS

Daily Averages For Month

I _____

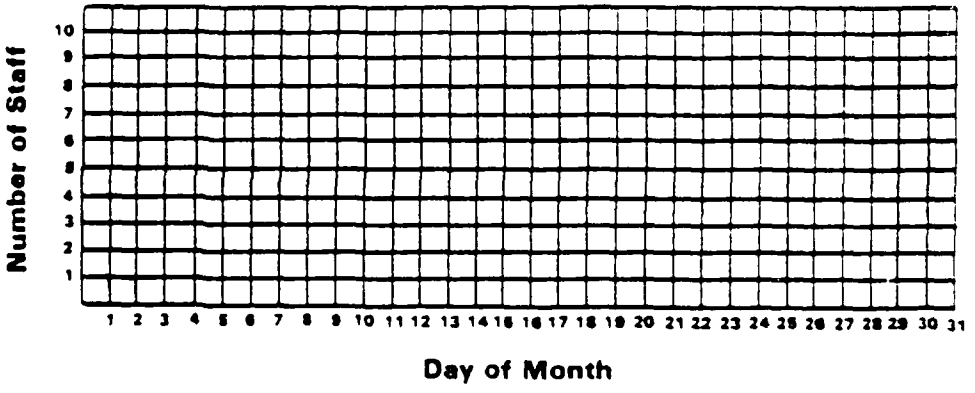
II _____

III _____

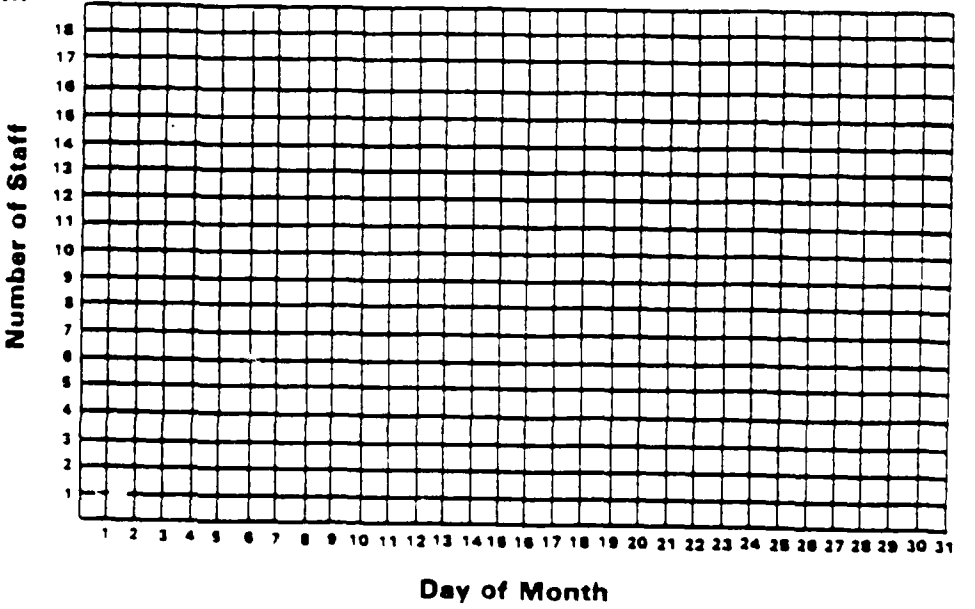
IV _____

V _____

VI _____



AM



—— = Recommended

X = Acutal

O = Number after change

N = RN

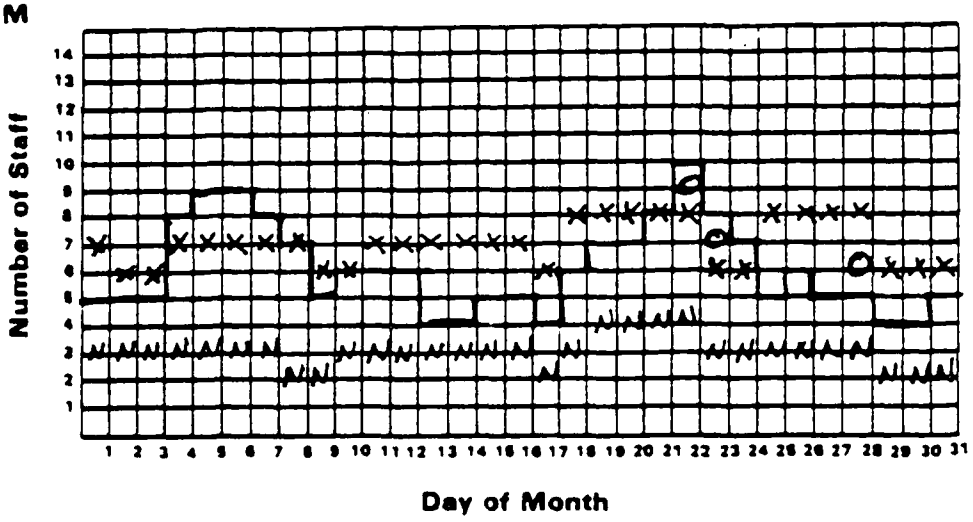
FIGURE 6 - EXAMPLE

WORKLOAD MANAGEMENT MONTHLY STAFFING GRAPH

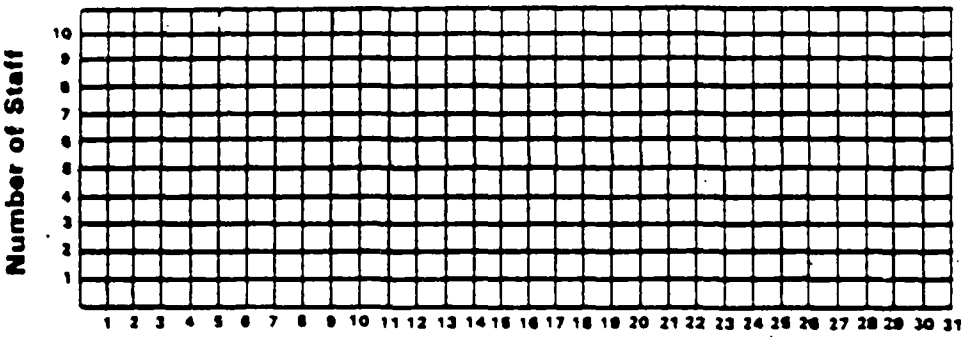
Unit 2E

Month DEC 1984

PM



NIGHTS



Daily Averages For Month

I _____

II _____

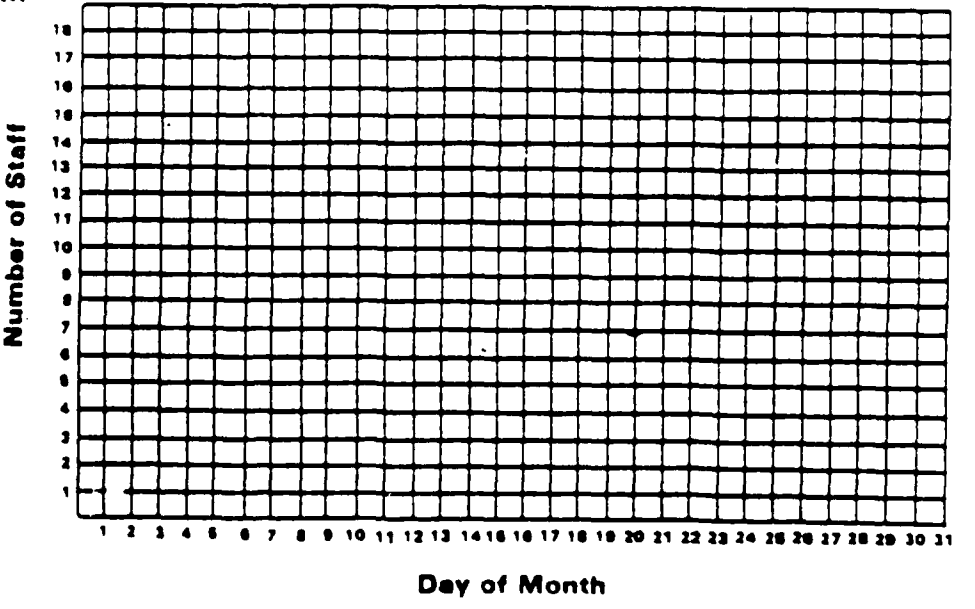
III _____

IV _____

V _____

VI _____

AM



—— = Recommended

X = Acutal

O = Number after change

N = RN

UNIT IV

RELIABILITY METHODOLOGY

I. OBJECTIVES

A. Define inter-rater reliability.

B. Describe the method used for ensuring reliability in Patient Classification.

II. CONTENT

A. Definition and Methods

B. Random Sampling

III. STUDY GUIDE QUESTIONS

A. Identify three purposes for Patient Classification reliability testing.

B. What percentage agreement in categorizing patients is considered acceptable?

C. What percentage of each category of a unit's census is an acceptable random sample?

RELIABILITY MONITORING

In order for the Patient Classification process to generate accurate and usable information, an inter-rater reliability monitoring system must be used on a regular basis. Inter-rater reliability refers to the consistency or stability of measurement of the Patient Classification instrument from user to user. Reliability is evaluated by having two individuals classify the same patient independently on Patient Classification Worksheets. This information is then used to compute an index of equivalence or agreement between classifiers. The purpose and procedure to be used for testing inter-rater reliability at each treatment facility are outlined below.

PURPOSE OF RELIABILITY TESTING

1. To measure the percentage of agreement among nurses in selecting Patient Classification categories.

2. To identify the need for updating classification skills and/or revising Patient Classification categories and decision rules.

3. To routinely monitor the Patient Classification Process to assure that all nursing personnel continue to use the process in the manner intended.

PATIENT CLASSIFICATION INTER-RATER TESTING PROCEDURE

1. Arrive unannounced on the ward/unit, close to and preferably after the time the classification has been completed.

2. Utilizing the random sample chart (see Appendix E for procedure and table) select 25% of the unit's population, or a minimum of five patients, whichever is greater.

3. Classify the selected patients utilizing the Patient Profile, Patient Care Plan and Nursing Notes as documentation sources. (See Procedure for classifying patients, page 13).

4. Compare classification done by ward/unit staff to the one you completed. Note agreement by category as well as by factor (critical indicator area, i.e., vital signs, monitoring, etc.)

5. Discuss differences with staff member originally completing the classification worksheet. Determine the nature of the differences.

FIGURE 7

PATIENT CLASSIFICATION RELIABILITY TESTING INSTRUMENT

Hospital: _____

Ward/Unit: _____ Month: _____

Census: _____ Reliability Testing Conducted by: _____

SAMPLE SELECTION $\left(\frac{\text{No. checked}}{\text{census}}\right)$ % Selected

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	TOTAL
sample							
census							

NOTE: If more than 5 patients in a category, randomly select 5 patients.

AGREEMENT BY CATEGORY $\left(\frac{\text{No. agreed}}{\text{No. checked}}\right)$ % Agreement

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	TOTAL
sample agreed							
sample selected							

AGREEMENT BY FACTORS - Factor(s) tested:

A. _____ $\frac{\text{No. agreed}\ (\quad)}{\text{No. checked}\ (\quad)}$ = _____ % agreement

B. _____ $\frac{\text{No. agreed}\ (\quad)}{\text{No. checked}\ (\quad)}$ = _____ % agreement

C. _____ $\frac{\text{No. agreed}\ (\quad)}{\text{No. checked}\ (\quad)}$ = _____ % agreement

Notes explaining differences in factor agreement:

Figure 7 Example

PATIENT CLASSIFICATION RELIABILITY TESTING INSTRUMENT

Hospital: Oceantown NH

Ward/Unit: 5B **Month:** February 85

Census: 14 ***Reliability Testing Conducted by:*** R. Fisher, LT

SAMPLE SELECTION $\left(\frac{\text{No. checked}}{\text{census}}\right)$ $\frac{10}{14}$ **% Selected** 71%

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	TOTAL
sample	0	5	5	0	0	0	10
census	1	5	5	2	1	0	14

NOTE: If more than 5 patients in a category, randomly select 5 patients.

AGREEMENT BY CATEGORY $\left(\frac{\text{No. agreed}}{\text{No. checked}}\right)$ $\frac{10}{10}$ **% Agreement** 100%

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	TOTAL
sample agreed		5	5				10
sample selected		5	5				10

AGREEMENT BY FACTORS - Factor(s) tested:

A. Teaching — No. agreed (10) / No. checked (10) = 100 % agreement

B. Emotional Support — No. agreed (10) / No. checked (10) = 100 % agreement

C. _____ — No. agreed ( ) / No. checked ( ) = _____ % agreement

Notes explaining differences in factor agreement:

6. Complete the Patient Classification Reliability Testing Instrument:

a. FORM: Fill in the unit, month and census on the Patient Classification Reliability Testing Instrument. The signature of the person conducting inter-rater reliability is necessary for accountability. (See Figure 7).

b. SAMPLE SELECTION: Determine the percent agreement by dividing the number of patients classified (# checked) by the ward/unit census. Place the number of patients classified in each category in the appropriate boxes and total.

c. AGREEMENT BY CATEGORY: Determine the percent agreement by dividing the number agreed upon (# agreed), by the sample selected (# checked). Place the number of patients agreed upon in the appropriate boxes and total.

d. AGREEMENT BY FACTOR: To check agreement by factors, select 1 or 2 critical indicator areas (i.e., vital signs or teaching/emotional) each time reliability testing is done on a unit. Concentrate initially on those areas that appear to have the widest discrepancy. Rotate through all the areas so that each critical indicator factor is eventually analyzed. Determine the percent agreement by dividing the number agreed upon (# agreed) by the sample selected (# checked). Indicate the Factor (Critical Indicator Area) which is being evaluated. Place the number of patients agreed upon in the appropriate boxes and total.

e. NOTES EXPLAINING DIFFERENCES IN FACTORS MARKED: Indicate why rater and staff member did not agree (i.e., misinterpretation of critical indicator, no documentation, etc.).

f. A sample of a completed form has been included as Figure 7 - Example.

SPECIAL INSTRUCTIONS FOR CONDUCTING RELIABILITY TESTING

1. Reliability testing is to be conducted by an independent, expert patient classifier appointed by nursing administration. If more than one expert is used, the selected individuals must establish their inter-rater reliability with each other to ensure consistency of findings.

2. Reliability testing is to be done on all nursing units involved in Patient Classification. Each unit will be routinely tested monthly.

3. Results of the reliability testing should be tabulated and shared with the general nursing staff.

4. Testing should occur on different days of the week and on the shift in which the ward classification is conducted.

5. Efforts are to be made to maintain a minimum of 80% inter-rater reliability in patient categories among classifiers.

6. If the percent of agreement by category is below 80%, efforts should be made to increase agreement. These efforts should focus on discussions with unit classifiers to determine the reasons for the disagreement. Corrective action must be taken to increase inter-rater reliability.

7. Classify patients based on the care provided on the current shift (usually A.M.s), i.e., if an IV is started on the A.M. shift, take points for it.

8. Establishment of inter-rater reliability between the charge nurse and staff members is essential for consistency in use of the system and for accuracy of the workload data recorded.

UNIT V

ORIENTATION TO THE WORKLOAD MANAGEMENT SYSTEM IN THE CLINICAL SETTING

I. OBJECTIVES

A. Locate all the materials and references needed for classification on the unit.

B. Perform the task of Patient Classification with 80% reliability (Figure 8).

C. Complete Workload Management System Crossword Puzzle (Figure 9).

II. DIRECTIONS:

The new patient classifier will work with the Charge Nurse or designee to accomplish these objectives. The Charge Nurse designee and the Education Coordinator will decide what is the appropriate timing for this learning experience and coordinate it with the initial centralized orientation. The check list included in this workbook will be used to document the orientee's mastery of the Patient Classification process.

FIGURE 8

EVALUATION OF PERFORMANCE OF PATIENT CLASSIFICATION

Name _____

Unit _____ Date _____

TASK	Date Performed	Satis-factory	Unsatis-factory	Comment
1. Located forms related to pt. classification.				
2. Stated time classification must be completed.				
3. Classified small group of patients correctly.				
4. Classified total unit correctly.				
5. Performed above task within ½ hour.				
6. Filled in patient classification worksheet correctly.				
7. Followed procedure correctly.				
8. Verbalizes reason and importance of patient classification system.				

Need to repeat education component:

	Date Completed	Initials of Instructor
Lesson I _____	_____	_____
Lesson II _____	_____	_____
Lesson III _____	_____	_____
Lesson IV _____	_____	_____

Need to perform patient classification under supervision again. _____

Approved to perform alone. _____

SIGNATURE OF PERSON EVALUATING

_____

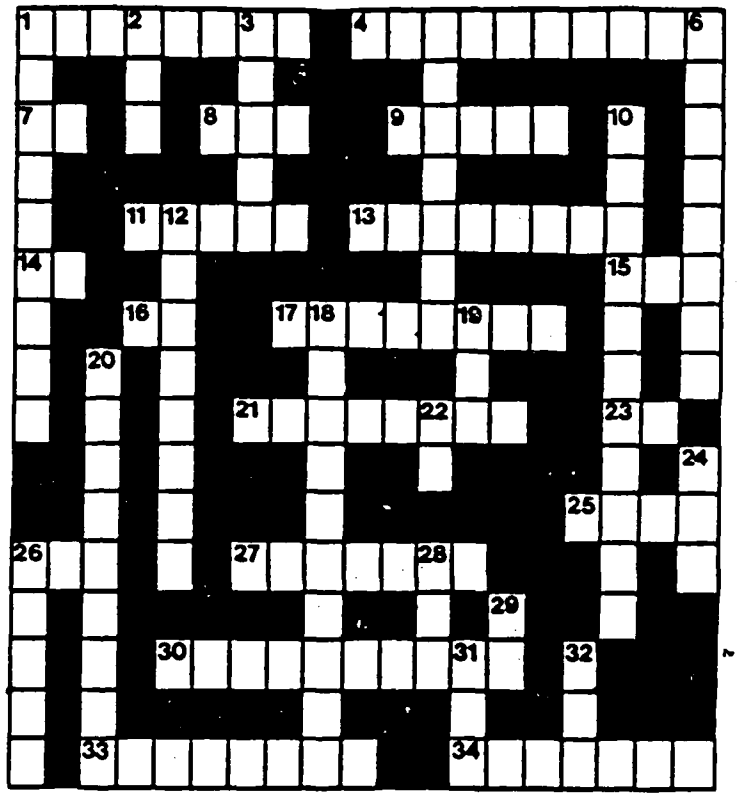
RETURN THIS FORM TO THE EDUCATION DEPT.

FIGURE 9

WORKLOAD MANAGEMENT SYSTEM FOR NURSING PATIENT CLASSIFICATION PUZZLE

ACROSS

1. Begins with classification of patients into specific categories of care.
7. Staff member
8. Factor including infants
9. Monthly graphing will identify any___in staffing
11. This category is 1 staff member to 3 patients
13. This category is more than 1 staff member/patient
14. Found under VS critical indicator
15. Points for acute care
16. Points are between 146-256
17. Grouping of patients according to sum of points derived from the critical indicators
21. Category I patients
23. Category requiring 1 staff to every two patients
25. Number of areas included in the critical indicator list
26. Ward clerks would be included in this group
27. What the Workload Management system attempts to implement and maintain; ____ patient care
30. Category V patients recieve ____direct care
33. Part of the Workload-Management System



DOWN

1. Part of the Patient Classification Instrument
2. Type of IV worth 4 points
3. A purpose of the Workload-Management System
5. RN Staffing based on the identified requirement for ____care.
6. Included in direct care time
10. Purpose of this testing is to measure % of agreement among nurses
12. Indicators that have greatest impact on nursing care time.
18. ____of nursing personnel is integrated into the system
19. ____Hospital is not a teaching hospital
20. Not counted as staff who have actually worked the shift
22. Receives 45% of workload on this shift
24. Maximum # of points for emotional support allowed
26. These checks fall under monitoring
28. Patients discharged prior to____pm are not included in classification system
29. One area on critical indicator list
31. These Hospitals are using the Workload Management System
32. Is the system useful?
34. This area has a separate Nursing Care Hour Requirement chart

Created by LT P. CHAPAR, NC

WORKLOAD MANAGEMENT SYSTEM FOR NURSING PATIENT CLASSIFICATION PUZZLE

ACROSS

1. Begins with classification of patients into specific categories of care.
7. Staff member
8. Factor including infants
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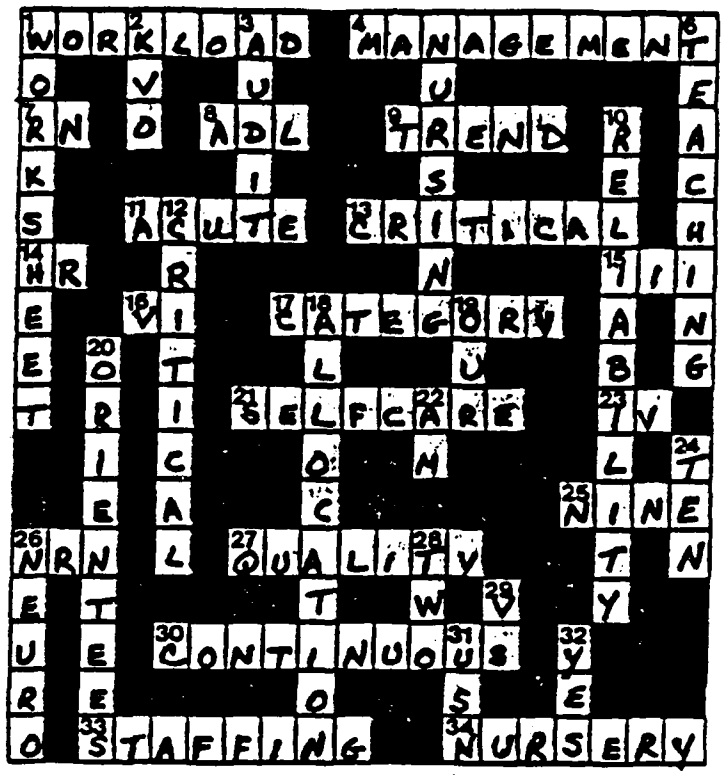
21. Category I patients
23. Category requiring 1 staff to every two patients
25. Number of areas included in the critical indicator list
26. Ward clerks would be included in this group
27. What the Workload Management system attempts to implement and maintain:____patient care
30. Category V patients recieve ____direct care
33. Part of the Workload-Management System



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12. Indicators that have greatest impact on nursing care time.
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22. Receives 45% of workload on this shift
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26. These checks fall under monitoring
28. Patients discharged prior to____pm are not included in classification system
29. One area on critical indicator list
31. These Hospitals are using the Workload Management System
32. Is the system useful?
34. This area has a separate Nursing Care Hour Requirement chart

UNIT VI

PATIENT CLASSIFICATION FOR PSYCHIATRY

I. OBJECTIVES

A. Utilize the WMSN correctly when classifying Psychiatric patients.

B. Describe special instructions in completing the Patient Classification Worksheet for Psychiatry.

C. In a simulated exercise, correctly classify three patients.

II. CONTENT

A. Explanation of the Psychiatric Patient Classification System.

B. Explanation of the Patient Classification Worksheet and the method for completing it.

C. Special instructions for classifying patients.

D. Practice in classifying patients.

E. Complete Posttest (patient simulations).

III. STUDY GUIDE QUESTIONS

Refer to the three questions in Unit II and complete them.

THE WORKLOAD MANAGEMENT SYSTEM FOR NURSES

PSYCHIATRIC SECTION

This system uses a tool to measure direct nursing care time in combination with indirect nursing care time to determine the nursing care hours required to provide quality care to a group of psychiatric patients (Figure 10). When properly used this tool permits the nurse to categorize these patients according to the level of direct care required. The Psychiatric component is designed to be used in the same manner as the WMSN. In order to understand this unique application it is important to complete all the lessons in this section.

GENERAL INSTRUCTIONS

1. Reference patient classification instructions in Unit II as well as the Critical Indicator Instructions described in that unit.

2. Reference Appendix B, Guidelines for Psychiatric Indicators, for operational definitions of terms unique to Psychiatry.

3. Count only those procedures/activities performed by the unit nursing staff.

4. Activities must be documented in the patient's record if they are to be counted.

5. Psychiatric patients who have medical-surgical problems requiring treatments and procedures not listed in the psych specific tool, should also be classified using the generic Critical Indicator tool (Figure 1).

PSYCHIATRIC CRITICAL INDICATOR INSTRUCTIONS

VITAL SIGNS (MANUAL TPR, BP)

1. Reference Appendix A for all critical indicator definitions in this factor.

MONITORING

1. Reference Appendix A for critical indicator definitions on Intake and Output, Circulation checks, and Neurochecks.

FIGURE 10

PSYCHIATRIC PATIENT CLASSIFICATION CRITICAL INDICATORS

VITAL SIGNS (MANUAL TPR, BP)

(1) Vital Signs QID or less
(2) Vital Signs q4h or x 6
(4) Vital Signs q2h or x 12
(8) Vital Signs q1h or x 24

(2) Tilt test q4h or more
(6) Vital Signs Post-procedure (ECT, amytal interview, rapid tranquilization)

MONITORING

(2) Intake and Output q8h or x 3
(2) GOAT q4hrs or x 6
(2) Circulation checks q2h or x 12
(3) Neuro checks q4h or x 6
(4) Patient checks q 30 minutes x 8 hours (sleep patterns)

(8) Restraint checks q 15 minutes x 8 hours
(16) Restraint checks with Vital Signs q 15 minutes x 8 hours
(10) Patient checks q15 minutes x 8 hours (suicide/escape/assault/seclusion room)

ACTIVITIES OF DAILY LIVING

(2) Self/minimal care
(8) Assisted care

FEEDING

(5) Tube feed (bolus) q4h or x 6
(6) Spoon feed x 3 or 1:1 at meals

TREATMENTS/PROCEDURES/MEDICATIONS

Simple > 15 and < 30 Minutes Total

(2) Start IV or EKG or ace wrap
(2) Simple dressing x 2, or tube care x 2 (exclude trach)
(2) Lab studies x 6
(2) Medications (q3h - q8h) include PRNs
(2) Community meeting
(2) Accompany patient off ward > 15 minutes and < 30 minutes
(2) Other activities requiring > 15 minutes and < 30 minutes

Complex > 30 Minutes and < 1 Hour

(4) Complex dressing change
(4) Medications q2h or more (include PRNs)
(4) Accompany patient off ward > 30 min
(4) Other activities requiring > 30 minutes and < 1 hour
(4) Planned recreation x 2 hours (4 patients: 1 staff)
(4) Intake interview, interdisciplinary
(4) Group therapy or workshop
(4) Purposeful interactions (1:1 > 30 min)
(4) Transfer (In-House) - assess and orient
(12) New admission - assess and orient

Special Procedures > 1 Hour < 4 Hours

(8) Accompany patient off ward > 1 hour
(8) Any other activity requiring 1:1 for 1 hour
(8) Continual staff attendance or assistance (amytal interview, ECT, or IV Benadryl)
(2) Each patient accompanied off unit in group for 1 hour (1 staff:4 patients)

TEACHING AND EMOTIONAL SUPPORT

(Must be documented)

Teaching

(2) Group teaching
(4) Special structured teaching, individual (i.e. medications, discharge)
(4) Pre-procedure teaching
(4) Patient work supervision

Emotional Support (in excess of 30 min q 24 hrs)

(4) Patient/family support (i.e., anxiety, denial, loneliness, etc.)
(4) Modification of lifestyle
(4) Reality orientation
(4) Re-direction
(4) Regulation
(6) Sensory deprivation (confused, toxic, mute, deaf, or visually impaired)

CONTINUOUS

(96) Patient requiring 1:1 coverage all shifts (i.e., actively suicidal - staff must sit or move with patient at all times)

Dec 84

2. Adjust points to accomodate frequency, i.e., GOAT q 2 h or X12 = 4.

3. Patient checks q 30 minutes X 8 hours is for any condition that requires a nursing assessment every 30 minutes. One example of this is when a patient is being formally monitored for documentation of sleep patterns. This critical indicator is NOT to be used if a nursing staff member is simply making night rounds on all patients every 30 minutes.

4. Restraint checks every 15 minutes X 8 hours = 8 points. This critical indicator allows a nursing staff member to assess the patient every 15 minutes and includes time to do a circulation check on a patient in restraints. If a patient is in both restraints and the seclusion room, the checks would still be only q 15 minutes so you would NOT double the points.

5. Restraints checks every 15 minutes with Vital Signs X 8 hours = 16 points. These points allow time to do circulation checks and assess patient's status along with vital signs q 15 minutes.

6. Patient checks q 15 minutes X 8 hours for suicide or escape or assault risk or seclusion room is worth 10 points. This is not a cumulative indicator. When classifying a patient who is a suicidal risk and also an escape risk only 10 points are warranted since both checks are being done simultaneously.

ACTIVITIES OF DAILY LIVING (ADL)

1. Self care and assisted care pspychiatric definitions include all the elements listed in Appendix A.

FEEDING

1. Reference Appendix A for the operational definitions of the critical indicators in this factor.

TREATMENTS/PROCEDURES/MEDICATIONS/THERAPY--SIMPLE

1. Reference Appendix A for operational definitions of all Critical Indicators EXCEPT Community Meeting (Appendix B).

2. All treatments/procedures/medications/therapy must be documented in the patient's record to receive points.

TREATMENTS/PROCEDURES/MEDICATIONS/THERAPY--COMPLEX

1. Reference Appendix A for operational definitions of all Critical Indicators EXCEPT Planned recreation, Intake interview (interdisciplinary), Group therapy or Workshop and Purposeful interactions.

2. Accompany patient off ward 15-30 minutes = 4 points. The escort must be a nursing unit staff member to count. No points are awarded to a patient who is accompanied by another patient.

3. Planned recreation is counted only if it involves nursing staff time. Should a self care patient sign off the unit to go to a movie by himself, this would NOT be counted.

4. Should a nursing unit staff member accompany four patients to a planned recreational activity that lasted 120 minutes, this would count as 4 points per patient.

5. Allocate points for each staff members' participation in an interdisciplinary intake interview. Documentation of this session should be found in the patient's record.

6. Count points for each group meeting in which a patient participates.

7. Count 4 points for a workshop only if patient supervision is required by a nursing unit staff member. A self care patient who signs off the unit to go to a workshop supervised by O.T. personnel would not receive points.

TREATMENTS/PROCEDURES/MEDICATIONS/THERAPY--SPECIAL

1. Count 8 points for each hour of 1:1 continuous staff attendance, i.e., accompany the patient off the ward; assist with a procedure such as ECT; or any other activity that requires close supervision. Reference Appendix A for operational definitions. Note that if a patient requires greater than 4 hours of continuous 1:1 care, DO NOT use this critical indicator, use the "Continuous" critical indicator.

2. Count 2 points for each hour a group of patients is accompanied off the unit by a staff member. This is counted per patient. One staff member may accompany 2-5 patients in a group. Example: Two staff members accompany 8 patients off the unit for 2 hours. Each patient would receive 4 points (2 points for each hour).

TEACHING

1. Points for teaching should be given ONLY for structured instruction that is in excess of 30 minutes of staff time. This must be documented in the patient's record.

2. Time allowance for routine assessment, observation and teaching has been incorporated into the times for each critical indicator.

EMOTIONAL SUPPORT

1. Though Psychiatric Nursing is essentially emotional support, this does NOT mean that all patients are to receive points in this category. Award points in this area to individual patients ONLY if they require support in excess of 30 minutes of staff time every 24 hours. Remember one half hour of staff intervention has been included as part of the patient's activity of daily living. This additional need for emotional support must be documented in the patient's record.

2. Family Support -- Unit staff members must have documented interaction with the patient's family in excess of 30 minutes if this critical indicator is to be counted.

CONTINUOUS

1. The continuous section is to be used to score (classify) patients who obviously require 1:1, or greater care, such as an actively suicidal patient who must be monitored constantly.

2. See Guidelines in Appendix A for a more complete explanation.

PSYCHIATRIC NURSING

PRACTICAL EXERCISE

Using the Patient Classification Worksheet, the Psychiatric Nursing Critical Indicator Sheet, and the Guidelines for Interpreting the Meaning of the Critical Indicators (Appendices A & B), classify the three patients whose data are found on the following pages.

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-006-5560

	ACTIVITY	DATE		BATH	DATE		DIET	DATE		VITAL SIGNS	FREQ		SPECIAL NOTES
	Bedrest			Bed bath			NPO			Temp			Dentures
	Bathroom Privileges		X	Shower	11/13					Pulse			Speech impediment
	Up in Chair			Tub					X	Resp	B/4	MEDS	Language barrier
X	Ambulate	11/13		Needs assistance			Regular	11/13	X	B/P	B/4	MEDS	Prosthetic device
	Commode									Other			Visual impairment
	Needs assistance												Blind
X	Restricted to unit	11/13											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE								Glasses
	Other		X	Self	11/13		FEEDING	DATE		FLUIDS			Hearing aid set
				Needs assistance			Self	11/13		Forced to			Other
				Special			Needs assistance			Restricted to			
							Gavage			I & O	q shift		

DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
11/13		Pt checks q 30 min x 8 hrs (sleep patterns)					
11/13		Pt checks q 15 min q 8 hrs (Suicide & Excape Risk over 24 hr period					
11/13		Intake interview Interdisciplinary					
11/13		Admit to ward					

ADDRESSOGRAPH

s6 Patient was admitted to acute care psychiatric ward at 0200 on Tuesday, 13 November

DIAGNOSIS

Schizophreniform Disorder

AGE	HEIGHT	WEIGHT
20	72"	150

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

FINDINGS:

	DATE ON	DATE OFF
BI		
VSI		
RELIGIOUS RITES		

ALLERGIES

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
				11/13	CBC		
				"	UA		
				"	VDRL		
11/13		HALDOL 5 MG P.O. 08-16-	2200	"	CHEM PANEL		
11/13		COGENTIN 2 MG P.O. 08	2200		ETOH LEVEL		
				"	TOXICOLOGY		
				11/13	SCREEN, BLOOD		
				"	& URINE		
				"	T3, T4		

ADDRESSOGRAPH

#6 Schizophreniform Disorder

PATIENT CARE PLAN
NAVMED 6850/13 (8-88) S/N 0105-LF-106-5565

DATE	DISCHARGE OBJECTIVES	REFERRAL ACTIVITIES	DATE

DATE	PROB. #	PROBLEMS/ EXPECTED OUTCOMES	REEVAL DATE/ TIME	ACTIONS/ORDERS
11/13	1	Suicide/Escape Risk	q24h	1. Pt. checks q 15 min.
		(In response to command		2. Regulate self-destructive
		hallucination, pt. ran in front		behavior.
		of moving car and now says he		3. Reassure pt. that staff
		wants to "finish the job")		will help him to control
		E.O.: No suicide attempts/will		his impulse to harm self
		not leave ward		4. Check with pt. twice ea.
		(E.O. = expected outcome)		shift (AM & PM) for
				presence of hallucination-
				Use PRN Meds if unable to
				re-direct pt. when he is
				experiencing command
				hallucinations
11/13	2	Poor self-care practices		1. I&O x 24 hrs/ to check
		E.O.: Adequate intake of food/		baseline I&O
		fluids, good hygiene, regular		2. Weigh q week (Pt's ID card
		elimination		weight is 30# > than
				present weight (150# 11/13)

ADDRESSOGRAPH

#6 Schizopheniform Disorder

DATE	PROB #	PROBLEMS/ EXPECTED OUTCOMES	RESOLVED DATE/ TIME	ACTIONS/PROCESS
				3. MAA q AM will ensure that pt. has showered, shaved and is dressed in clean pajamas by 0730.
11/13	3	Persecutory Delusions "I am a terrible person. I've sinned and now I must die." E.O.: Pt. able to talk about his feelings and able to ask for help when he experiences the delusions.		1. Provide reality orientation for pt. by encouraging involvement in activities and ward meetings. Focus on concrete tasks that will promote reality orientation. 2. Give positive feedback when pt. is able to talk about anything other than his persecutory delusions.

PATIENT PROFILE

NAVMED 6556/13 (5-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges		X	Shower	11/9	Regular	11/9		Pulse			Speech impairment
	Up in chair			Tub					Resp			Language barrier
X	Ambulate	11/9		Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance										✓	Sling
X	Restricted to unit	11/9										Contact lenses
X	Hospital Privileges	11/14		ORAL HYGIENE	DATE							Glasses
	Other		X	Self	11/14	FEEDING	DATE		FLUIDS			Hearing defect
				Needs assistance		X Self	11/9		Forced to			Other
				Special		Needs assistance			Restricted to			
						Gavage			I & O			

DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
11/13		Escort Status					
11/13		Pt checks q 30 min					
		x 8 hrs (sleep patterns)					

Escort:

Mon: 1 Community, 2 Workshops, 1 Group

Tue: 1 Community, 1 Workshop, 2 Groups

Wed: 1 Community, 2 Workshops, 1 Group Field Trip Wed (Drop one workshop)

Thu: 1 Community, 1 Workshop, 1 Group

Fri: 1 Community, 2 Workshops

ADDRESSOGRAPH

7 Patient is on an intermediate care psychiatric ward. You are classifying him on Wednesday, 14 Nov.

DIAGNOSIS

Depression
Suicide Attempt

AGE	HEIGHT	WEIGHT
35	6'	190

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

PINNINGS:

	DATE ON	DATE OFF
M		
VSI		
RELIGIOUS RITES		

ALLERGIES:

DATE ORD	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
11/14		Imipramine 150 mg.p.o.	q HS	11/9	CBC	11/9	11/10
					UA		
					VDRL		
					Tox Screen		
				↓	ETOH	↓	↓

ADDRESSOGRAPH

#7 Depressive Suicide Attempt

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984—705-012/7804

PATIENT CARE PLAN
NAVMED 6550/13 (5-80) S/N 0105-LF-286-5565

DATE	DISCHARGE OBJECTIVES	REFERRAL ACTIVITIES	DATE
11/13	Able to identify possible and realistic coping strategies.		
	Able to identify resources to assist with coping and readjustment after discharge.		

DATE	PROB. #	PROBLEMS/ EXPECTED OUTCOMES	RESOLVED DATE/ TIME	ACTIONS/ORDERS
11/9	1	Suicide Risk	Resolved	1. Suicide checks Q 15 min
		E.O.: No suicidal ideations		2. Assess suicide potential OS and/or prn
		No suicide attempts		3. Be supportive - assure pt of a safe, controlled environment
				4. Involve in and/or redirect to milieu activities
				5. Regulate self destructive behavior
11/9	2	Feelings of Depression	11/14	1. Assess degree self care i.e. hygiene, interaction, involvement in milieu) or observe for vegetative signs
		E.O.: Increase range of affect stated mood less depressed or increased feeling well being		2. Provide emotional support- encourage ventilation of feelings; redirect and encourage increased involvement and increased self care
		Decreased or no vegetative signs		3. Assess mood, affect, mental status, social interaction as needed
		Independent with self care		

ADDRESSOGRAPH

7 Depressive Suicide Attempt

ATE	PROB #	PROBLEMS/ EXPECTED OUTCOMES	RESOLVED DATE/ TIME	ACTIONS/ORDERS
				4. Provide feedback to patient about behavior and be supportive of any progress/) improvement
11/13	3	Poor Coping Skills E.O.: Increased insight into coping behavior/ strategies	11/20	1. Encourage pt to analyze past coping strategies and assist to explore alternative strategies for future 2. Assist pt to identify opportunities during hospitalization when can practice new strategies 3. Provide feedback as appropriate
11/13	4	Medication Education E.O.: Describe correctly a. action-indication of med b. regimen of med c. desired effects of med d. side or toxic effects of med	11/20	1. Answer questions pt may have 2. Provide essential info about med 3. Check with pt to test knowledge base and retention
11/13	5	Discharge Plans E.O.: Able to identify possible and realistic coping strategies Able to identify resources to assist with coping and readjustment after discharge	AT D/C	1. Encourage discussion of possible resources available 2. Encourage identification and discussion coping strategies as in problem #3 3. Recommend social services consult if needed

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-208-5560

ACTIVITY	DATE	BATH	DATE	DIET	DATE	VITAL SIGNS	FREQ	SPECIAL NOTES
Bedrest		Bed bath		NPO		Temp	q AM	Denture
Bathroom Privileges		X Shower	11/10	Regular	11/10	X Pulse		Speech impairment
Up in chair		Tub				X Resp		Language barrier
X Ambulate	11/10	Needs assistance				X B/P		Prosthetic device
Commode						Other		Visual impairment
Needs assistance						X Lithium	flow sheet	
X Restricted to unit	11/10							Contact lenses
Hospital Privileges		ORAL HYGIENE	DATE					X Glasses
Other		X Self	11/10	FEEDING	DATE	FLUIDS		Hearing defect
		Needs assistance		X Self	11/10	Forced fl.		Other
		Special		Needs assistance		Restricted to		
				Gavage		I & O		

DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
11/10		Escape Risk					
11/10	11/15	Purposeful Interactions					
11/10		Ward Restricted					
11/13	11/20	Holding teaching until Pt					
		is calmer and more oriented					
11/10		Pt checks q 30 min/8 hrs					
		(sleep patterns)					
Ward Restricted/Step 1							

Therapeutic Treatments

	0700 - 1500	1500 - 2300
SUN		PM Group
MON	AM COM MTG AM WKSHP	PM WKSHP PM Group
TUE	Therapy GRP AM WKSHP	PM WKSHP PM Group
WED	AM COM MTG AM WKSHP	PM WKSHP PM Group-Step 1 Fld Trps (Wed)
THU	Therapy Group AM WKSHP	PM WKSHP
FRI	AM COM MTG AM WKSHP	PM WKSHP PM Group-Step 1 CTM (THCA) (Fri)
SAT	AM COM MTG AM WKSHP	PM WKSHP

ADDRESSOGRAPH

Patient is on an acute care psychiatric ward. She is being classifed on Tuesday, 13 November

DIAGNOSIS

Bipolar Disorder-Manic

AGE	HEIGHT	WEIGHT
24	70"	153

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

FINDINGS:

	DATE ON	DATE OFF
RELIGIOUS RITES		

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
11/10		Haldol 5 mgs PO/IM QID	08-11 16-22	11/10	CBC	11/10	11/12
11/11		Cogentin 1 mg PO QID	08-16		UA		
11/13		Lithium 600 mgs PO QID	08-16 16-22		UDRL		
					TOX Screen		⌄
					ETOH		11/12
					T3, T4	⌄	11/13
				⌄	EKG	11/10	11/10

ADDRESSOGRAPH

#8 Bipolar Disorder - Manic

* U.S. GOVERNMENT PRINTING OFFICE: 1984—708-012/7804

PATIENT CARE PLAN
NAVMED 6550/13 (9-80) S/N 0105-LF-206-5565

DATE	DISCHARGE OBJECTIVES	REFERRAL ACTIVITIES	DATE

DATE	PROB. #	PROBLEMS/ EXPECTED OUTCOMES	RESOLVED DATE/ TIME	ACTIONS/ORDERS
11/10	1	Hyperactivity (including rapid	11/20	1. Decrease stimuli
		speech)		2. Support for Restlessness
		O: Speech and actions at		3. Redirect to less
		normal pace.		stimulating environment
11/10	2	Confusion (including grandi-	11/20	1. Provide reality
		osity, loose association, tang-		orientation
		ability)		2. Assist to differentiate
		O: Able to speak accurately		reality from fantasy
		about self and relations		3. Brief interactions,
		with others		avoid confrontation
11/10	3	Sexual Acting Out	11/20	1. Regulate expression of
		O: Able to associate with		sexual feelings
		females being sexual		2. Distract attention,
				redirect to alternate
				activities when being
				sexual
11/10	4	Medical Education	11/30	1. Teach about
		O: Able to describe correctly		Haldol
		a. drug regimen		Cogentin
		b. desired effects		Lithium
		c. side effects		
		d. toxic effects		

ADDRESSOGRAPH

#8 Bipolar Disorder - Manic

ATE	PROB #	PROBLEMS/ EXPECTED OUTCOMES	REEVAL. DATE/ TIME	ACTIONS/ORDERS

[illegible]

ANSWERS TO PSYCHIATRIC

PRACTICAL EXERCISES

WORKLOAD MANAGEMENT

PATIENT CLASSIFICATION WORKSHEET

UNIT _____

DATE _____

TIME _____

SIGNATURE

_____

	PATIENT NAMES	Schizophreniform Disorder		Depression Suicide Attempt		Bipolar Disorder, Manic	
VITAL SIGNS		1		0		1	
MONITORING		32		4		30	
ACTIVITIES		2		2		2	
FEEDING		0		0		0	
SIMPLE		2		2		2	
COMPLEX		28		12		16	
SPECIAL		0		0		0	
RESP THERAPY		0		0		0	
IV THERAPY		0		0		0	
TEACH/EMOT		0/16				0/16	
CONTINUOUS							
TOTAL POINTS		81		36		67	

I	0-12						0	I
II	13-31						0	II
III	32-63			X			1	III
IV	64-95	X				X	2	IV
V	96-145						0	V
VI	+ 146						0	VI
							3	TOTAL

NOTES: 1. Double points for any treatment/procedure that requires 2 nursing staff members.

2. Adjust points to accomodate frequency, i.e., IPPB q2h = 12 points.

PATIENT #6	DIAGNOSIS:	Schizophreniform Disorder
Factor	Points	Rationale
Vital Signs	1	BP & Pulse before meds
Monitoring	2	I & O q shift
	0	Patient checks q30 min (sleep patterns) - included in patient checks below
	30	Patient checks q15 min x 8 work hrs for (suicide and escape risk) over 24 hrs (each 8 hr period worth 10 pts)
ADL	2	Self-care
Simple	2	Medications, q8 hrs
Complex	4	Inpatient group therapy
	4	Intake interview interdisciplinary
	8	AM & PM workshop
	12	New admission
Emotional Support	10	Maximum points for emotional support
Total Points	75	Category IV

PATIENT #7	DIAGNOSIS:	Depression/Suicide Attempt
Factor	Points	Rationale
Vital Signs	0	
Monitoring	4	Patient checks, q30 min/8 hrs (sleep patterns)
ADL	2	Self-care
Simple	0	Medications q HS
	2	Community meeting
Complex	4	AM workshop
	4	Planned recreation (field trip scheduled for Wed PM)
	4	PM group
Teaching	4	Individual teaching/medication
Emotional Support	10	Maximum points for emotional support
Total Points	34	Category III

PATIENT #8	DIAGNOSIS:	Bipolar Disorder, Manic
Factor	Points	Rationale
Vital Signs	1	VS q AM with meds
Monitoring	30	Patient checks q15 min/8 hrs (escape risk) over 24 hrs (each 8 hr period worth 10 pts)
	0	Patient checks q30 min (sleep patterns) - included in patient checks above
ADL	2	Self-care
Simple	2	Medication QID
Complex	4	Inpatient therapy group
	8	AM & PM workshops
	4	Evening group
	0	Purposeful interactions held until patient is calmer; restrict interactions to 30 min)
Teaching	0	Individual teaching/medication - held until pt is calmer and more oriented
Emotional Support	4	Regulation (needed because of inability to control sexual impulses)
		Note: Other emotional support activities being conducted concurrently during monitoring for escape risks
Total Points	55	Category III

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APPENDIX B

GUIDELINES FOR PSYCHIATRIC INDICATORS

GUIDELINES FOR INTERPRETING THE MEANING OF THE CRITICAL INDICATORS

The following information provides operational descriptions of each specific activity included under a critical indicator heading.

For each operational definition time is included for the succeeding activities: (1) Identify and screen the patient; (2) Explain the procedure to the patient; (3) Raise, lower, or adjust the bed before and after the nursing activity; (4) Clean and straighten area; and (5) Record any activity done at the bedside; and (6) Spend time at the patient's bedside providing information, answering patient questions and interacting with patients.

The critical indicators are listed in the order that they appear on the patient acuity worksheet. An alphabetical index is located at the end of this appendix for quick reference.

Operational descriptions linked by the work "and" are included in the time allowance (point value) for that critical indicator.

Operational descriptions linked by the word "or" indicate that the same time allowance (point value) is to be assigned to each of the operational descriptions.

Special considerations or explanations are designated by the word "Note".

VITAL SIGNS: (Manual Temp, Pulse, Respiration and Blood Pressure)

Instructions: Select point allowance to fit vital sign frequency. Add points when using an alternate method of taking pulses or temperatures if taken QID or more often.

Example:

VS q 4 hours	=	2 points
Rectal temps	=	2 points
Apical Pulses	=	2 points
		6 points

- (1) VS QID OR LESS
  (2) VS Q 4 HOURS OR X 6
  (4) VS Q 2 HOURS OR X 12
  (8) VS Q 1 HOUR OR X 24

  . Oral Temperature, Pulse and Respirations: Includes time to place equipment at bedside, and position temperature probe or thermometer. Count respiratory rate while fingers are placed over radial artery pulse. Remove fingers from radial pulse rate, record results of measurements, and then remove equipment from area.

and

. Blood Pressure, Manual: Includes time to place equipment at bedside, place cuff around extremity, position stethoscope, measure blood pressure, remove cuff, record results, and remove equipment from area.

or

. Blood Pressure, Arteriosonde: Includes time to apply electrode gel to cuff, position cuff around extremity, measure blood pressure, remove cuff, cleanse gel from extremity, store equipment at bedside, and record results.

• (2) RECTAL OR AXILLARY TEMPS OR APICAL PULSES: If taken QID or more often.

Note: Do not increase allowance for increased frequency.

. Temperature - Rectal, Electronic/Mercury: Includes time to place equipment at bedside, adjust clothing, insert temperature probe or thermometer in anus, measure temperature, remove temperature probe or thermometer, record, and remove equipment from area.

or

. Temperature - Axillary, Electronic/Mercury: Includes time to place equipment at bedside, place temperature probe or thermometer in axillary area, measure temperature, remove temperature probe or thermometer, record, and remove equipment from area.

or

. Pulse - Apical: Includes time to place equipment at bedside, place stethoscope over apex of heart and count rate, remove stethoscope, record pulse rate, and remove equipment from area.

• (2) PEDAL OR FEMORAL OR POPLITEAL PULSE OR FHT: If taken at least q 4 hours or more often daily.

Note: Do not increase allowance for increased frequency. Add 2 points for each activity required.

. Pulse - Pedal or Femoral or Popliteal: Includes time to place fingers on the dorsalis pedis artery pulse, femoral or popiteal pulse, and count rate. Remove fingers from area and record results.

or

. Pulse - Doppler: Includes time to place equipment at bedside, place sensor over pulse area, assess and record pulse rate, and remove equipment from area.

or

. Fetal Heart Tones, Manual: Includes time to expose abdominal area, assess fetal heart tones with stethoscope, record FHTs, and remove equipment from area.

or

. Fetal Heart Tones, Doppler: Includes time to expose abdominal area, locate FHT with fetascope, assess fetal heart tones utilizing the doptone, record results, and remove equipment from area.

• (2) TILT TEST: If taken at least q 4 hours or more often.

Note: Do not increase allowance for increased frequency. Includes additional time for repeating and recording blood pressure and pulse in the sitting and standing position.

• (6) POST-OP OR POST PARTUM OR POST NEWBORN: Refers to VS of decreasing frequency following any special procedure.

Note: Includes post partum vital signs. (q 15 x 4, q 30 x 4, q 1 hr x 4, then q 4 hr) and vital signs taken during first 24 hours of newborn's life.

MONITORING:

Instruction: Increase point allowance for increased frequency.

• (2) INTAKE AND OUTPUT Q 8 HOURS OR X 3
(8) INTAKE AND OUTPUT Q 2 HOURS OR X 12

. Measuring and Recording Intake: Includes time to place calibrated cylinder/container at bedside, measure or calculate fluids, record amount on Intake and Output record, and remove equipment from area.

and

- Measuring and Recording Output - Urine: Includes time to place calibrated cylinder at bedside, measure or calculate volume, record amount on Intake and Output record; then remove equipment from area.

  and/or

- Measuring and Recording Output - Liquid Feces: Includes time to remove bedpan from patient's bedside, measure feces in calibrated cylinder, and record amount on Intake and Output record.

  and/or

- Measuring and Recording Output - Vomitus: Includes time to remove emesis from patient's bedside, measure vomitus in calibrated cylinder, and record amount on Intake and Output record.

  and/or

- Measuring and Recording Output - Drainage Bottles/All Types: Includes time to place calibrated cylinder at bedside, pour contents from drainage bottle into calibrated cylinder, measure or calculate volume, replace drainage bottle, record amount on Intake and Output record, and remove equipment from area.

  and/or

- Output Weight, Diaper or Bed Linens: Includes time to complete the procedure for diaper change and bed linen change, remove items to be weighed, weigh on weight scales, and record results.

• (2) CIRCULATION CHECKS OR FUNDUS CHECK Q 2 HOURS OR X 12

Note: Add points for each activity required.

- Circulation Check: Includes time to arrive at bedside, check extremity for swelling, numbness, and tingling, evaluate temperature and color of the skin, and assess the patient's ability to move the part.

  or

- Fundus Massage: Includes time to arrive at the bedside, expose patient's lower abdominal area, massage fundus and assess height of uterus; then record type and amount of lochia.

- (3) NEURO CHECKS Q 4 HOURS OR X 6
  (6) NEURO CHECKS Q 2 HOURS OR X 12

  . Pupil Reflexes: Includes time to place equipment at the bedside, adjust room lighting, assess pupillary reflexes with flashlight, and remove equipment from area.

  and

  . Mental Alertness: Includes time to arrive at the bedside, make inquiries within framework of interviewing that will give information about the patient's level of consciousness, memory, intellectual performance, and judgement; record results.

  and

  . Orientation: Includes time to arrive at the bedside, make inquiries within the framework that will give information about patient's orientation to time, place, and person; record results.

  and

  . Sensory Discrimination: Includes time to screen for pain, vibration, light touch, and sterognosis intact, and record results.

  or

  . Motor or Sensory Testing: Includes time to arrive at the bedside, and assess extremities for sensation awareness and muscle strength.

- (2) CVP OR ICP (MANUAL) Q 2 HOURS OR X 12

  Note: Add points for each activity required.

  . Central Venous Pressure: Includes time to set up equipment for measurement of pressure, position patient and assess sternal angle, measure pressure, restore equipment to original position, and record results. Does not include insertion time.

  or

  . Intracranial Pressure: Includes time to set up equipment, measure pressure, restore equipment to original position and record results. Does not include insertion time.

• (6) CARDIAC/APNEA/TEMP PROBE/PRESSURE MONITORS (not additive)

Note: Points are not additive. Take 6 points for all or one of these monitors.

. Adjusting Monitors or Connecting Leads or Reset Alarms: Upon arrival at the bedside, adjust monitor, connect leads or reset the alarm; then depart the area. Also includes time for observation of monitors.

or

. Off Ward Telemetry: Patient located on one unit but monitored at a different location. Includes time for the monitoring unit to check monitor alibrations and maintain monitor watch.

• (6) TRANSCUTANEOUS MONITOR

. Transcutaneous Monitor: Includes time to place equipment at bedside, apply new probe, check monitor calibration, remove equipment from area q 4 hours. Also includes time for observation of monitor.

• (4) ARTERIAL LINE OR ICP (MONITOR) OR SWAN GANZ SETUP

Note: Add points for each activity required.

. Arterial Line Setup or Transducer Exchange: Includes time to place equipment at bedside, and set up transducer tray, IV solution, and cardiac monitor. Calibrate the monitor and measure the transducer current with a mercury sphygmometer. Measure and record pulmonary artery pressure and/or pulmonary artery wedge. Remove equipment from area. Does not include insertion time.

or

. ICP Line Setup or Transducer Exchange: Includes time to set up transducer tray, IV solution, and ICP monitor. Calibrate the monitor and measure transducer current with mercury sphygmometer. Remove equipment from area. Does not include insertion time.

or

. Swan Ganz Catheter Setup or Transducer Exchange: Includes time to place equipment at bedside and set up transducer tray, IV solution, and cardiac monitor. Calibrate the cardiac monitor and then measure the transducer current with a mercury sphygmometer. Measure and record pulmonary artery pressure and/or pulmonary wedge. Remove equipment from area. Does not include insertion time.

• (2) ARTERIAL LINE OR ICP (MONITOR) Q 2 HOURS OR X 12

Note: Add points for each activity required.

. Blood Pressure Arterial Line: Includes time to arrive at the bedside, flush line, assess, calculate pressure, and record results.

or

. Intracranial Pressure (Monitor): Includes time to arrive at the bedside, flush line, assess, calculate pressure, and record the results.

• (2) PAP/PA WEDGE Q 4 HOURS OR X 6
(4) PAP/PA WEDGE Q 2 HOURS OR X 12

. Pulmonary Artery Pressure: Includes time to arrive at the bedside, assess and record findings.

and

. Pulmonary Artery Pressure Wedge: Includes time to arrive at the bedside, flush line, slowly inject air into Swan-Ganz Catheter, assess and calculate wedge pressure, and record the results.

• (2) CARDIAC OUTPUT TID OR X 3

. Cardiac Output Measurement: Includes time to place equipment at bedside, assist or complete measurement, and remove equipment from area.

ACTIVITIES OF DAILY LIVING

Instruction: All patients must be classified in this critical indicator group. Point may not be doubled.

• (6) INFANT OR TODDLER CARE (0-5 YEARS)

Note: Includes neonates and premature infants; administration of nonintravenous medication - Bid or less.

. Bathing, Complete: Includes time to place equipment at bedside; remove shirt and diaper; bathe face, chest, chest, abdomer and extremities; change water, bathe back, buttocks, and perineal area; replace shirt and diaper; and remove equipment from area.

or

- Tub Bath: Includes time to arrive in the bathroom, assist patient in undressing, into bathtub, with bath, and in redressing; and back into bed.

and

- AM Care: Includes time to place equipment at the bedside, assist patient with bathing face, and hands and brushing teeth; and remove equipment from area.

and

- PM Care: Includes time to place equipment at the beside; bathe face and hands, brush teeth, and rub back; tighten and straighten bed linens; and remove equipment from area.

and

- Umbilical Cord Care: Place equipment at bedside, cleanse umbilicus with antiseptic solution, expose to air and dry, and remove equiment from bedside.

and

- Bathing, Face and Hands (Routine and PRN): Includes time to arrive at the bedside, bathe face and hands, and remove used equipment from the area.

and

- Diaper Change: Includes time to arrive at the bedside, expose baby, remove soiled diaper, cleanse buttocks and genitalia, diaper baby, position and cover baby, and remove equipment from area.

or

- Assist to Bathroom: Includes time to assist toilet trained toddler to bathroom, removing pants, cleansing buttocks and genitalia, and replace pants.

and

- Changing Shirt: Includes time to arrive at the bedside, change soiled shirt, and remove soiled shirt from area.

and

- Occupied Bed: Includes time to place linen at the bedside, turn patient on side, roll linen to one side of bed, replace with clean linen, turn patient to freshly made side of bed, remove soiled linen and complete bed making, and remove soiled linen from bed.

  or

- Unoccupied Bed: Includes time to place linen at the bedside, remove soiled linen, place bottom sheet on mattress, then place on top sheet; change pillow cases, and remove soiled linen from area.

  and

- Ambulatory Weight: Includes time to place equipment at the bedside, assist patient onto the scales, balance scales, read and record weight reading, assist patient off the scales, and remove equipment from area.

  or

- Weight - Infant: Includes time to arrive at the bedside, remove clothing, place baby on balanced Infant Weight Scales, assess and record weight, return baby to bed, dress baby, and remove used equipment from area.

  and

- Serving Meal Tray, Preparation Required: Includes time to place tray at the bedside, prepare food and utensils, and prepare towel or napkin as bib.

  and

- Nursing Assessment: Includes time spent at patient bedside assessing patient condition and problems; formulating nursing diagnoses and interventions; and evaluating effectiveness of interventions.

• (2) SELF CARE/MINIMAL CARE (ADULT OR CHILD) (≥5 YEARS)

Note: Includes administration of nonintravenous medications Bid or less

- Bathing: Includes time to place equipment at the beside, allow time for patient to bathe and change pajamas, and remove equipment from area.

  and

- Serving Meal Tray: Includes time to place tray at bedside.

  and

- Unoccupied Bed: Includes time to place linen at bedside, remove soiled linen, place bottom sheet on mattress, then top sheet; change pillow cases, and remove soiled linen from area.

  and

- Nursing Assessment: Includes time spent at patient's bedside assessing patient condition and problems; formulating nursing diagnoses and interventions; and evaluating effectiveness of interventions.

• (6) ASSISTED CARE (ADULT OR CHILD ≥ 5 YEARS)

Note: Includes administration of nonintravaneous medications Bid or less.

- Bathing, Assist with Back and Legs: Includes time to place equipment at the bedside; remove pajamas, allow for patient bathing, change water, bathe back and lower extremities; replace pajamas; and remove equipment from area.

  or

- Sitting Shower or Shower with Assistance: Includes time to arrive in the shower room, assist patient in undressing, into shower, with bath and hair shampoo, assist in redressing, and back into bed. Remain with patient.

  or

- Tub Bath: Includes time to arrive in the bathroom, assist patient in undressing, into bathtub, with bath and assist in redressing; and back into the bed. Remain with patient.

  and

- AM Care: Includes time to place equipment at the bedside, assist patient with bathing face, and hands and brushing teeth; and remove equipment from area.

  or

- AM Care, Partial: Includes time to place equipment at the bedside, prepare bath water, put toothpaste on tooth brush; and remove equipment from area.

  and

- PM Care: Includes time to place equipment at the bedside; assist patient to bathe face and hands and brush teeth; give back rub; tighten and straighten bed linens; and remove equipment from area.

  and

- Serving Meal Tray, Preparation Required: Includes time to place tray at the bedside, prepare food and utensils, and prepare towel or napkin as bib.

  and

- Ambulatory Weight: Includes time to place equipment at the bedside, balance scales, assist patient onto the scales, read and record weight, assist patient off the scales, and remove equipment from area.

  and

- Unoccupied Bed: Includes time to place linen at the bedside; remove soiled linen, place bottom sheet on mattress, and then top sheet; change pillow cases; and remove soiled linen from area.

  and

- Answering Patient's Questions: Includes time spent answering patient's questions or in response to the patient's call system.

  and

- Nursing Assessment: Includes time spent at the patient's bedside assessing patient condition and problems; formulating nursing diagnoses and interventions; and evaluating effectiveness of interventions.

●(14) COMPLETE CARE (ADULT OR CHILD ≥ 5 YEARS)

Note: Includes administration of nonintravenous medications--Bid or less.

- Bathing, Complete: Includes time to place equipment at bedside; remove pajamas; bathe face, chest, abdomen and extremities; change water; bathe back, buttocks, and perineal area; replace pajamas; and remove equipment from area.

  and

- AM Care: Includes time to place equipment at bedside, assist patient with bathing face, hands, and brushing teeth; and remove equipment from area.

  and

- PM Care: Includes time to place equipment at bedside; assist patient to bathe face, hands, and brush teeth; rub back; tighten and straighten bed linens; and remove equipment from area.

  and

- Weight: Includes time to place equipment at the bedside, balance scales, assist patient onto the scales, read and record weight, assist patient in getting off the scales, and remove equipment from area.

  and

- Giving a Bedpan: Includes time to place a bedpan at the bedside, place patient onto bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove from area.

  and

- Giving a Urinal: Includes time to place urinal at the patient's bedside, remove cover, adjust patient's pajamas for placement of urinal, remove urinal from patient, replace cover, and remove urinal from area.

  and

- Occupied Bed: Includes time to place linen at bedside; turn patient on side; roll linen to one side of bed and replace with clean linen; turn patient to freshly made side of bed; remove soiled linen and complete bed making; and remove soiled linen from bed.

  and

- Serving Meal Tray, Preparation Required: Includes time to place tray at bedside, prepare food and utensils, and prepare towel or napkin as bib.

  and

- Assist with Positioning: Includes time to remove support pillows and assist patient to new position.

  and

- Answering Patient's Questions: Includes time spent in answering the patient's questions or in response to the patient's call system.

  and

- Nursing Assessment: Includes time spent at patient's bedside assessing patient condition and problems; formulating nursing diagnoses and interventions; and evaluating effectiveness of interventions.

●(32) TOTAL CARE (ADULT OR CHILD ≥ 5 YEARS)

Note: Includes administration of nonintravenous medications Bid or less.

- Bathing, Complete: Includes time to place equipment at the bedside; remove pajamas; bathe face, chest, abdomen, and extremities; change water; bathe back, buttocks, and perineal area; replace pajama; and remove equipment from area.

  and

- AM Care: Includes time to place equipment at the bedside, assist patient with bathing face, hands, and brushing teeth, and remove equipment from area.

  and

- PM Care: Includes time to place equipment at the bedside; bathe face, hands, and brush teeth; rub back; tighten and straighten bed linens; and remove equipment from area.

  and

- Skin Care: Place equipment at the bedside, cleanse and dry areas for special care (buttocks, hips, shoulders, and heels), apply lotion, and remove equipment from area q 2 hours.

  and

- Oral Hygiene: Includes time to place equipment at the bedside; turn patient to side; cleanse gums, teeth, and mouth with applicators; and remove equipment from area, q 4 hours.

  and

- Occupied Bed: Includes time to place linen at the bedside; turn patient on side; roll linen to one side of bed and replace with clean linen; turn patient to freshly made side of bed; complete bed making; remove soiled linen from bed, 2 times per day.

  and

- Turn Patient: Includes time to remove support pillows, reposition patient, and reapply support pillows, q 2 h.

  and

- Giving a Bedpan: Includes time to place bedpan at the bedside, place patient onto bedpan, provide toilet tissue, remove patient from bedpan, cover bedpan, and remove bedpan from area.

  and

- Giving a Urinal: Includes time to place urinal at the patient's bedside; remove cover; adjust patient's pajamas for placement of urinal; remove urinal from patient and replace cover; and remove urinal from area.

  and

- Bed Scales Weight: Includes time to place equipment at bedside, balance scales, assist patient onto the scales, read and record weight, assist patient in getting off the scales, and remove equipment from area.

  and

- Answering Patient's Questions: Includes time spent in answering patient's questions or in response to the patient's questions or in response to the patient's call system.

  and

- Nursing Assessment: Includes time spent at patient's bedside assessing patient's condition and problems; formulating nursing diagnoses and interventions; and evaluating effectiveness of interventions.

• (4) EXTRA LINEN CHANGE WITH PARTIAL BATH (2X per Shift)

Note: Any time a patient requires an extra linen change and partial bath 2 x per shift, for any reason, i.e., vomiting, incontinence, or diaphoresis.

. Incontinent Care: Includes time to place equipment at the patient's bedside; bathe buttocks, perineum, and thighs; change bedding; and remove equipment and soiled linen from area, 2 x per shift.

. Diaphoretic: Includes time to place equipment at the bedside, dry patient's skin, change pajamas, change bedding, remove equipment from area, 2 x per shift.

•(14) TURNING FRAME

. Turning Frame, All Types: Includes time to remove or secure support pillows and devices, place and secure restraining straps, unlock frame, turn frame according to specification, lock frame, remove restraining straps, adjust pillows and support devices. Includes time for two people to turn q 2 hours.

• (8) PEDIATRIC RECREATION AND OBSERVATION (0-12 YEARS)

Note: Exclude nursery.

. Planned Recreational Activity Session: Includes time spent in supervising recreational activity.

or

. Answering Patient's Question and Crying: Includes time spent in answering patient's questions or in response to the patient's call system or patient crying.

or

. Visiting with Patient or Purposeful Interaction: Includes time spent at patient's bedside without providing any direct physical care to patient but which is not in response to patient call system or patient questions.

. Holding - Infant: Includes time to arrive at the bedside, wrap baby in blanket, pick up and hold baby. When completed, position in bed and cover with blanket.

FEEDING

Note: Parenteral nutrition is to be treated as an IV line.

• (5) TUBE FEED ADULT/CHILD/NEONATE Q 4 HOURS OR X 6 BOLUS

(10) TUBE FEED ADULT/CHILD/NEONATE Q 2 HOURS OR X 12 BOLUS

Instruction: If feeding is administered by bottle, count each feeding. If feeding is administered by continuous infusion, count each bottle change.

. Nasogastric: Includes time to place feeding at bedside, unclamp tube, assess placement of tube, administer tube feeding, flush tube with water, clamp tube, record, and remove feeding equipment from area.

or

. Gastrostomy: Includes time to place feeding at the bedside, uncoil and unclamp tube; assess for placement, administer feeding, flush tube with water, clamp tube, replace tube, and remove feeding equipment from area.

• (2) TUBE FEED ADULT/CHILD/NEONATE (CONTINUOUS)

. Nasogastric or Enteral Hyperalimentation (Continuous) Feeding with Gastric Feeding Equipment: Includes time to place equipment at bedside; assess for tube placement; connect to feeding tube/naso-gastric tube; adjust flow rate; record on intake and output record; and remove equipment as necessary.

or

. Nasogastric, Continuous with Infusion Pump: Includes time to place equipment at bedside; remove and/or position feeding bottle; assess placement of tube; connect to feeding tube, set up through flow rate adjuster or equipment; establish flow rate; record on Intake and Output record; and remove equipment from area.

or

. Oral Gastric Tube: Includes time to place equipment at bedside; position baby, insert feeding tube; assess placement; check stomach for residual; instill feeding, remove feeding tube; bubble baby; position; and remove equipment as necessary.

or

. Oral-Jejunostomy Tube: Includes time to place equipment at bedside; uncoil and unclamp tube; assess placement; administer feeding; flush tube with water; clamp tube; replace tube; and remove feeding equipment from area.

• (6) ADULT MEALS (SPOON FEED) X 3 ≥ 5 YEARS

(10) CHILD MEALS (SPOON FEED) X 3 ≥ 5 YEARS

. Spoonfeeding: Place meal tray at bedside; place towel or napkin as bib; prepare the food; feed patient slowly; and remove tray from area. 3 x per day.

• (2) INFANT/NEONATE - BOTTLE X 1 Feeding

(12) INFANT/NEONATE - BOTTLE Q 4 HOURS or X 6

(24) INFANT/NEONATE - BOTTLE Q 2 HOURS or X 12

. Feeding - Graduated Feeder: Includes time to place equipment at the bedside, pick up baby, wrap in blanket, hold in feeding position, feed baby, bubble baby, reposition in bed (Isolette, Incubator, etc.), and remove equipment from area.

or

. Feeding - Bottle: Includes time to place equipment at the bedside, pick up baby, wrap in blanket, hold in feeding position, feed baby, bubble baby, reposition in bed and remove equipment from area.

TREATMENTS, PROCEDURES AND MEDICATIONS

Instruction: Activities that require less than 15 minutes are not included in the critical indicator list and should not be considered.

SIMPLE > 15 Minutes and < 30 Minutes total

• (2) INTRAVENOUS INFUSION - INITIATING

. Intravenous Infusion - Initiating: Includes time to place equipment at bedside, apply tourniquet to extremity, cleanse site, perform venipuncture, connect IV tubing, apply ointment and dressing, and tape securely. Time, date, and initial dressing. Calculate and regulate flow rate, record an I&O record, and remove equipment from area. This is only for STARTING the IV. Refer to I.V. Section for explanation of maintaining Intravenous infusion.

- (2) CATHETERIZATION - FOLEY

  . Catheterization - Foley: Place equipment at bedside, prepare patient and insert Foley Catheter, inflate ballon, tape catheter in position, connect to urinary drainage bag, and remove used equipment from area.

- (2) NASOGASTRIC TUBE - INSERTION

  . Nasogastric Tube - Insertion: Includes time to place equipment at the bedside, secure towel around patient's neck, give patient glass of water, instruct patient on how to swallow tube, lubricate tube, insert tube, assess for placement, tape in position, and remove equipment from area.

- (2) 12 LEAD ECG

  . 12 Lead ECG: Includes time to place equipment at bedside, connect leads to patient and obtain ECG. Record name, date, and time on ECG. Remove leads and clean skin, and remove equipment from area, x 1.

- (2) SURGICAL PREP, LOCAL

  . Surgical Prep: Includes time to place equipment at bedside prepare skin for prep, shave area specified, and remove used equipment from area.

- (2) ENEMA

  . Enema - Cleansing: Includes time to place equipment at bedside, position patient, administer solution, and remove equipment from area.

  or

  Enema - Retention: Includes time to place equipment at bedside, position patient, administer solution, and remove equipment from area.

- (2) ACE WRAPS or ELASTIC STOCKINGS

  Elastic Stockings: Includes time to place stockings at bedside. Expose lower extremities, and put elastic stockings on lower extremities, q shift or X 3.

  or

  . Ace Bandage: Includes time to place equipment at bedside, wrap extremity securely with ace bandage, and secure in place with tape or metal hooks, q shift or X 3.

- (2) SIMPLE DRESSING X 2

  . Small Dressing Change, <4"x8" X 2: Includes time to place equipment at bedside, remove soiled dressing, cleanse skin, apply dressing to site, and remove equipment from area, X 2.

  or

  . Reinforcing Dressing: Includes time to place equipment at bedside, appply dressing to present dressing for reinforcement, and remove equipment from area, X 2.

- (2) TUBE CARE X 2

  . Tube Care: Includes time to set up equipment at bedside, remove dressing around tube, cleanse skin, replace dressing, tape securely, and remove used equipment from area.

  or

  . Foley Cathether Care: Includes time to place equipment at bedside, cleanse area around catheter, apply ointment (if used), and remove used equipment from area, BID.

- (2) SPECIFIC GRAVITY X 6

  . Specific Gravity: Includes time to place equipment at bedside, collect sample, measure specific gravity, record results, and remove equipment from area, x 6.

- (2) SUGAR & ACETONE X 6

  . Sugar & Acetone: Includes time to place equipment at bedside, collect sample, measure sugar and acetone, record results, and remove equipment from area, x 6.

- (2) GUAIAC TESTING X 6

  . Guaiac Testing - Feces or Vomitus or GI Drainage: Upon obtaining sample, test for blood, record results, and remove equipment from area, x 6.

- (2) SPIN HEMATOCRIT X 6

  Note: the hematocrit must be processed on the unit.

  . Hematocrit: After obtaining the blood sample, includes time to process, assess, and record the results, X 6.

- (2) BILIRUBIN TESTING X 6

  . Bilirubin Testing: Includes time to place equipment at bedside, position infant, stick heel and draw blood into capillary tube, spin down serum, place serum on slide, and read slide, X 6.

- (2) LAB STUDIES X 6

  Note: Include only those specimens obtained by nursing personnel on ward and sent to the laboratory for processing. May be any combination of the following to total 6 activities per 24 hours.

  . Venipuncture - Blood Sample: Includes time to place equipment at bedside. Apply tourniquet to extremity, cleanse site, perform venipuncture, withdraw blood sample, and apply pressure to puncture site. Attach labels on blood tubes and remove equipment from area.

  or

  . Sputum - Culture: Includes time to place equipment at bedside, position patient, obtain specimen, apply label to specimen, and remove equipment from area.

  or

  . Urine Specimen: Place equipment at bedside: instruct patient on how to collect specimen or collect sample from Foley catheter; label specimen; and remove specimen from area.

  or

  . Intraveneous/Arterial Line - Blood Sample: Place equipment at bedside, clear system, obtain blood sample through stopcock, flush system, label samples, and then remove equipment from area.

- (2) ARTERIAL BLOOD GASES X 3

  . Arterial - Blood Gases: Includes time to place equipment at bedside, locate arterial puncture site, perform puncture, draw blood, place sample on ice, apply pressure to puncture site; label sample, and remove equipment from area, X 3.

- (2) BLOOD CULTURE X 3

  . Blood Culture: Includes time to place equipment at bedside, apply tourniquet to extremity, clean site, perform venipunctue and withdraw blood sample, apply pressure to puncture site, apply labels on blood culture bottle, and remove equipment from area, X 3.

- (2) MEDICATION Q 3 HOURS - O 8 (UP TO 12 TRIPS PER PATIENT)

  Note: This includes PRN Medications but excludes IV medication.

  . Oral: Upon arrival at the bedside, includes time to obtain a glass of water and administer the oral medication.

  or

  . Intramuscular: Includes time to place equipment at bedside, locate site for injection, administer medication, and remove equipment from area.

  or

  . Topical: Includes time to place equipment at the bedside, locate and expose site for topical application of medication, apply medication, and remove equipment from area.

  or

  . Sublingual: Includes time to place equipment at bedside, place medication under patient's tongue, and remove equipment from area.

  or

  . Subcutaneous: Includes time to place equipment at bedside, locate site for injection, administer medication, and remove equipment from area.

  or

- Suppository, Rectal or Vaginal: Includes time to place equipment at bedside, prepare and administer suppository, and remove equipment from area.

  or

- Eye Drops: Upon arrival at bedside, includes time to position patient, instill eye drops, and remove equipment from area.

  or

- Ear Drops: Upon arrival at bedside, includes time to position patient, instill ear drops, and remove equipment from area.

  or

- Nose Drops: Upon arrival at bedside, includes time to position patient, instill ear drops, and remove equipment from area.

• (2) IRRIGATIONS OR INSTILLATION X 4 OR LESS

- Irrigation: Includes time to place irrigation solution at bedside, unclamp or disconnect tube, irrigate, reclamp or reconnect tube, and remove equipment from area.

  or

- Instillation: Includes time to place medication and/or normal saline at bedside, unclamp or disconnect tube, instill solution, reclamp or reconnect tubing, and remove equipment from area.

• (2) RESTRAINTS (2 OR 4 POINT OR POSEY)

- Restraints 2 or 4 Point or Posey: Upon arrival at bedside, includes time to replace or apply 2 or 4 point restraints or a posey restraint and conduct periodic checks for circulation.

• (2) ASSIST TO CHAIR OR STRETCHER AND RETURN X 3

- Bed to Stretcher: Includes time to place stretcher at bedside, transfer patient to stretcher, fasten safety straps or adjust side rail, remove stretcher from bedside, and reverse procedures, X 3.

or

. Bed to Chair or Bedside Commode: Includes time to position chair/wheelchair/commode at bedside; assist patient into sitting position; bring patient into an upright standing position; assist into chair; and reverse process, X 3.

• (2) ASSIST TO WALK AND RETURN X 1

. Assistance While Walking: Includes time to assist patient into a sitting position on side of bed; bring patient into an upright standing position, assist with ambulation, and assist back into bed, X 1.

• (2) INFANT CIRCUMCISION OR PHOTOTHERAPY

. Circumcision: Includes time to place equipment in treatment room, secure baby in restraints, assist physician with procedure, apply dressing to surgical site, remove restraints, and return baby to newborn nursery.

or

. Phototherapy Treatment: Includes time to place equipment at bedside, expose baby, apply and maintain eye pads, position phototherapy lights, and assess infant frequently.

• (2) ACCOMPANY PATIENT OFF WARD < 30 MINUTES

. Accompany Patient Off Ward < 30 Minutes: Any absence from the unit to accompany a patient requiring > 15 minutes and < 30 minutes, i.e., accompany patient to x-ray, lab, etc.

• (2) OTHER ACTIVITIES REQUIRING > 15 MINUTES AND < 30 MINUTES

. Other Activities Requiring > 15 Minutes and < 30 Minutes: Points may be given for direct care activities that require greater than 15 minutes but less than 30 minutes and are not found on the critical indicator list. These activities must be listed on the patient profile or patient care plan.

• (2) ISOLATION (MASK, GOWNING, AND GLOVES) - NOT WOUND ISOLATION

. Isolation, Gowning, and Gloving: Upon arrival at isolation area, wash hands, put on isolation gown, mask and gloves, or when departing the isolation area, remove isolation gown, mask and gloves,; then wash hands 8 X day.

COMPLEX > 30 MINUTES < 1 HOUR TOTAL:

- (4) CHEST TUBE INSERTION

  . Chest Tube Insertion: Includes time to place all equipment at bedside; assist physician with insertion of chest tube; prepare water-sealed drainage bottles; tape all connections and drainage bottles; and remove equipment from area.

- (4) LUMBAR PUNCTURE

  . Lumbar Puncture: Includes time to place equipment at bedside, assist physician with procedure, and remove equipment from area.

- (4) THORACENTESIS

  . Thoracentesis: Includes time to place equipment at bedside, obtain vital signs, assist physician, support patient during the procedure, repeat vital signs, measure and record aspiration fluids, and remove equipment from area.

- (4) PARACENTESIS

  . Paracentesis: Includes time to place equipment at bedside, measure vital signs, prepare patient and tray for procedure, assist physician, support patient during the procedure, measure vital signs, and remove equipment from area.

- (4) COMPLEX DRESSING CHANGE (> 30 MINUTES TO COMPLETE)

  . Complex Dressing Change: Includes time to place equipment at bedside, remove soiled dressing, don gloves, administer irrigation solution if needed, reapply dressing; and remove equipment from area.

- (4) STRAIGHT CATHETERIZATION

  . Straight Catherization: Includes time to place equipment at bedside, prepare patient, insert catheter, empty bladder, remove straight catheter, and remove used equipment from area, x 4 or more.

• (4) MEDICATION Q 2 HOURS OR MORE (≤ 12 TRIPS PER PATIENT)

Note: This includes PRN medications but excludes IV medication.

. Oral: Upon arrival at bedside, includes time to obtain a glass of water, and administer the oral medication.

or

. Topical: Includes time to place equipment at bedside, locate and expose site for topical application of medication, apply medication, and remove equipment from area.

or

. Intramuscular: Includes time to place equipment at bedside, locate site for injection, administer medication, and remove equipment from area.

or

. Subcutaneous: Includes time to place equipment at bedside, locate site for injection, administer medication, and remove equipmenty from area.

or

. Sublingual: Includes time to place equipment at bedside, place medication under patient's tongue, and remove equipment from area.

or

. Suppository, Rectal or Vaginal: Includes time to place equipment at bedside, prepare and administer suppository, and remove equipment from area.

or

. Ear Drops: Upon arrival at bedside, includes time to position patient, instill ear drops, and remove equipment from area.

or

. Nose Drops: Upon arrival at bedside, includes time to position patient, instill nose drops, and remove equipment from bedside.

• (4) RANGE OF MOTION EXERCISES X 3 (MAY BE 3 X IN ONE SHIFT OR ONE TIME PER SHIFT FOR 3 SHIFTS)

. ROM Exercise - Active: Includes time to supervise the patient actively performing the prescribed exercise program.

or

. ROM Exercise - Passive: Includes time to manually move the patient's extremities through the prescribed exercise program.

• (4) ACCOMPANY PATIENT OFF WARD >30 MINUTES

. Accompany Patient Off Ward >30 Minutes: Any absence from the unit requiring more than 30 minutes but less than 1 hour, i.e., accompany patient to lab, etc.

• (4) OTHER ACTIVITIES REQUIRING >30 MINUTES AND < 1 HOUR

. Other Activities Requiring >30 Minutes and <1 Hour: Points may be given for direct care activities that require greater than 30 minutes but less than 1 hour and are not found on the critical indicator list. These activities must be listed on the patient profile or patient care plan.

• (4) TRANSFER (IN-HOUSE): (ASSESSMENT AND ORIENTATION)

. Transfer (In-House) (Assessment and Orientation): This factor is to be used for any patient transferred from one unit to another. The points include time for reviewing the patient's record, assessing the patient, and orienting the patient to the new unit and its personnel.

•(12) NEW ADMISSION: (ASSESSMENT AND ORIENTATION)

. New Admission (Assessment and Orientation): This factor is to be used for all new admissions and includes time for all admission assessment and orientation activities. Example: Nursing data base--the physical assessment and nursing history; orientation to the unit; instructions about hospital regulations; and explanations about ward policies.

Other nursing activities may be added to the initial 12 points for admission.

Example:		
	Admission	12
	V.S.	1
	Self Care	2
		15

SPECIAL PROCEDURES 1 HOUR

- (8) SPECIAL PROCEDURES < 1 HOUR BUT > 4 HOURS

  . Special Procedures 1 Hour But 4 Hours: Assignment of one member of the nursing team to observe and provide direct nursing care to the patient during a specific activity up to 4 hours. This care and observation is specific to a given activity and time limited. Examples of when this indicator should be used include:

  1. Cardiac arrest (CPR).
  2. Unstable patient awaiting transfer to an ICU.
  3. Severely agitated patient requiring staff attendance while sedation takes effect.

  If the patient requires a staff member (1:1) for longer than 4 hours do not use this indicator. Instead use the continuous care indicator.

RESPIRATORY THERAPY

- (2) OXYGEN THERAPY OR OXYHOOD

  . Oxygen Administration - Prongs: Includes time to place equipment at bedside, fit nasal prongs and adjust headband, regulate oxygen rate, and evaluate patient's adjustment to oxygen and equipment.

  or

  . Oxygen Administration - Mask: Includes time to place equipment at bedside, turn on oxygen, fit the mask over the mouth and nose, adjust headband, evaluate fit and patient's adjustment to the equipment, and regulate oxygen glow rate.

  or

  . Oxygen Administration - Nasal: Includes time to place equipment at bedside, turn on oxygen. lubricate and insert nasal catheter, secure with tape, evaluate patient response, and regulate oxygen flow rate.

  or

  . Oxygen Administration - Mist with Collar or Face Tent: Includes time to place equipment at bedside, turn on oxygen, position equipment, secure equipment, evaluate patient response, and regulate oxygen flow rate.

  or

. Oxyhood - Application or Replacement: Includes time to place oxyhood over infant's head, position oxygen sensor, assess the oxygen concentration using the oxygen analyzer, adjust the oxygen flow if indicated, evaluate patient response, and record results.

• (2) INCENTIVE SPIROMETER OR COUGH AND DEEP BREATHE Q 4 HOURS OR X 6

. Incentive Spirometer: Includes time to place spirometer at bedside, assist patient during the procedure, determine proper usage of spirometer, then locate equipment at bedside for next treatment.

or

. Blow Bottles: Includes time to place equipment at bedside, assist with placement of bottles, have patient perform procedure, then locate equipment at bedside for next treatment.

or

. Cough And Deep Breathe: Upon arrival at the bedside, have patient cough and deep breathe. If cough is productive, then dispose of sputum.

• (2) IPPB OR MAXIMIST Q 12 HOURS OR X 2

• (4) IPPB OR MAXIMIST Q 6 HOURS OR X 4

• (6) IPPB OR MAXIMIST Q 4 HOURS OR X 6

. IPPB Treatment: Upon arrival at bedside, includes time to prepare nebulizer, position patient, assure proper breathing technique, and administer treatment.

or

. Maximist Treatment: Upon arrival at bedside, includes time to prepare nebulizer, position patient, assure proper breathing technique, and administer treatment.

- (8) CROUP TENT OR MIST TENT

  . Croup Tent or Mist Tent: Place equipment at bedside, position equipment over the bed, fill vaporizer with solution, place thermometer, assess status of patient's adjustment to croup tent, and assess temperature inside croup tent, q 4 hours.

- (2) CHEST PULMONARY THERAPY Q 12 HOURS OR X 2

- (4) CHEST PULMONARY THERAPY Q 6 HOURS OR X 4

- (6) CHEST PULMONARY THERAPY Q 4 HOURS OR X 6

  . Chest Pulmonary Therapy - Frappage with Postural Drainage: Upon arrival at bedside, includes time to position patient and initiate treatment by auscultation of lung fields, perform percussion to each involved segment followed by vibration, and evaluate patient response.

- (2) SUCTIONING Q 4 HOURS X 6

- (4) SUCTIONING Q 2 HOURS X 12

  . Suctioning - Oral: Includes time to place equipment or set up equipment at bedside; suction oral cavity with suction catheter or oral suction tip; flush catheter before and after each aspiration; replace used equipment; and remove used equipment from area. Includes oral bulb syringe suctioning for infants.

  or

  . Suctioning - Tracheostomy: Includes time to set up equipment; put on sterile gloves; suction and flush catheter before and after each aspiration; replace used equipment; and remove used equipment from area.

  or

  . Suctioning - Naso-tracheal: Includes time to set up equipment at bedside; put on sterile gloves; pass nasal catheter and suction; flush catheter before and after each aspiration; replace used equipment; and remove used equipment from area.

  or

. Suctioning - Endotracheal: Includes time to set up sterile equipment at bedside; put on sterile gloves; suction through endotracheal tube; flush catheter before and after each use; bag breathe between each aspiration; remove gloves; replace used equipment; and remove used equipment from area.

• (4) TRACHEOSTOMY CARE X 3

. Tracheostomy - Cleaning Cannula: Includes time to place equipment at bedside; complete tracheostomy suction; remove, clean and replace inner tube; and remove soiled equipment and replace with clean equipment.

and

. Tracheostomy - Dressing Change: Includes time to place equipment at bedside, remove soiled dressing, cleanse skin, replace dry dressing, change tracheostomy ties as indicated, and remove soiled equipment from area.

•(10) VENTILATOR

. Oxygen Administration - Ventilator: Upon arrival at bedside, includes time to assess and/or regulate oxygen and ventilator pressures; assess all tubing for patency and collection of fluids within tubing; assess fluid level in water vapor container; and assess proper position of alarms q 1 hour.

and

. Responding to Ventilator Alarm: Upon arrival at the bedside, includes time to assess situation and reset alarm.

IV THERAPY

Instructions: Hyperalimentation (parenteral) is to be included in this section. The appropriate IV indicator depends upon the frequency of the bottle change.

• (4) KVO - (Change IV BID or less)

. Intravenous Infusion - Changing IV Bottle: Includes time to place equipment at bedside; remove used IV container and replace new IV container; calculate and regulate flow rate; record on I&O record; and remove equipment from area.

and

- Intravenous Infusion - Flow Rate: Upon arrival at bedside, includes time to calculate and adjust flow rate q 1 hour.

  and

- Intravenous Infusion - IV Catheter Care: Includes time to place equipment at bedside; remove dressing from IV catheter site; cleanse skin; apply ointment; replace dressing; date, time and initial the dressing; change IV tubing qd or qod; and remove equipment from area.

• (4) HEPARIN LOCK OR BROVIAC

- Heparin - Flush Solution: Includes time to place equipment at bedside, select site for injection of Heparin flush solution, administerHeparin flush solution, and remove equipment from area q 4 hours.

  and

- Intravenous Infusion - IV Catheter Care: Includes time to place equipment at bedside; remove dressing from IV catheter site; cleanse skin and apply ointment (if used); replace dressing; date, time and initial the dressing; change IV tubing qd or qod; and remove equipment from area.

• (6) SIMPLE (CHANGE BOTTLE TID OR OID)

- Intravenous Infusion - Flow Rate: Upon arrival at bedside, includes time to calculate and adjust flow rate q 1 hour.

  and

- Intravenous Infusion - Changing IV Bottle: Includes time to place equipment at bedside; remove used IV container and replace with new IV container; calculate and regulate flow rate; record on I&O record; and remove equipment from area.

  and

- Intravenous Infusion - IV Catheter Care: Includes time to place equipment at bedside; remove dressing from IV catheter site; don gloves if needed; cleanse skin and apply ointment (if used); replace dressing; date, time and initial the dressing; change IV tubing qd or qod; and remove equipment from area.

- (8) COMPLEX (TWO SITES OR MORE; OR MULTI-LUMEN LINE; OR CHANGE BOTTLE Q 4 HOURS)

  . Intravenous Infusion - Changing IV Bottle: Includes time to place equipment at bedside; remove used IV container and replace with new IV container; calculate and regulate flow rate; record on I&O record; and remove equipment from area.

  and

  . Intravenous Infusion - Flow Rate: Upon arrival, includes time to calculate and adjust flow rate q 1 hour.

  and

  . Intravenous Infusion - IV Catheter Care: Includes time to place equipment at bedside; remove dressing from IV catheter site: cleanse skin and apply ointment (if used); replace dressing; date, time and initial the dressing; change IV tubing qd or qod; and remove equipment from area.

- (2) MEDICATION Q 8 HOURS OR X 3

- (3) MEDICATION Q 6 HOURS OR X 4

- (4) MEDICATION Q 4 HOURS OR X 6

  Note: Score the appropriate number of points for each IV medication given.

  . Intravenous Infusion - IV Push Medication: Includes time to place equipment at bedside, select site for administration of solution, administer solution, record on Intake and Output record, and remove equipment from area.

- (2) BLOOD PRODUCTS (EACH UNIT)

  Note: Any patient receiving blood will get 2 points for each unit regardless of the number of units of blood or blood products administered. A six pack of platelets count as one unit.

  . Intravenous Infusion - Blood: Includes time to place equipment at bedside, assure correct transfusion, etc., take initial vital signs, connect to present intravenous system, monitor frequently, record on I&O record, and remove equipment from area. Includes changing IV lines and filters between units.

  or

. Intravenous Infusion - Platelets or Plasma: Includes time to place equipment at bedside, connect to present intravenous system, monitor frequently, record on I&O record; and remove used equipment from area. Includes changing IV lines and filters between units.

TEACHING

Note: Time allowance for routine assessment observation and teaching has been incorporated in times for critical indicators above. Points for teaching should be given only for structured instruction as outlined below. These classes must be documented in the patient care plan and nursing notes.

• (2) SPECIAL STRUCTURED TEACHING - GROUP

. Special Structured Teaching - Group: Each patient attending group instruction will receive 2 points for each hour of structured teaching.

• (4) PRE-OP TEACHING

. Pre-op Teaching: Includes time to provide individual instruction to patient and family and to answer questions.

• (4) SPECIAL STRUCTURED TEACHING - INDIVIDUAL (DIABETIC, CARDIAC, COLOSTOMY CARE, POST PARUM FIRST 24 HOURS, NEWBORN, MEDICATIONS, AND DISCHARGE TEACHING)

. Special Structured Teaching (Diabetic, Newborn,Cardiac, Colostomy Care, Post Partum First 24 Hours, Medications, and Discharge): Includes time to provide individual instruction, regarding the nature and scope of a disease process or a recent event (post-delivery); special care requirements, limitations and/or restrictions related to a disease or illness; and to answer questions.

EMOTIONAL SUPPORT IN EXCESS OF 30 MINUTES Q 24 HOURS

Note: Time allowance for routine assessment, observation and interaction has been incorporated in times for critical indicators above. Mark this category only if emotional support is required in excess of 30 minutes in 24 hours. This must be documented on patient care plan and nursing notes. Maximum point allowance is 10.

• (4) PATIENT AND FAMILY SUPPORT (ANXIETY, LONELINESS, DENIAL, RESTLESSNESS)

. Patient and Family Support: Includes extra time needed to individually interact with a patient or family member and to provide emotional support.

• (4) MODIFICATION OF LIFESTYLE (NEW PROTHESIS, ALTERATION OF BODY IMAGE)

. Modification of Lifestyle: Includes time to provide individual support regarding limitations and restrictions of a new prothesis, the necessary alteration of lifestyle, and coping with a body image change or illness.

• (6) SENSORY DEPRIVATION

. Sensory Deprivation: Includes the extra time that must be taken for interaction with certain patients, i.e., retarded, deaf, blind, foreign speaking, unable to speak, bilaterally patched, confused.

•(10) MAXIMUM POINTS FOR EMOTIONAL SUPPORT

. Maximum Emotional Support: Points in the Emotional Support area are not additive. For example, do not add 4 + 4 + 10 = 18; or 4 + 4 + 6 = 14, etc. You may select only one of the four indicators in this area for any one patient.

CONTINUOUS

Note: The continuous section is to be used to score (classify) patients who obviously require 1:1 or greater care . If this section is used DO NOT use any of the other critical indicators.

•(96) PATIENTS REQUIRING 1:1 COVERAGE ALL SHIFTS

. 1:1 Coverage All Shifts: Includes time for one staff member per shift to render all care to a specific patient.

Example #1: An RN may be assigned to a patient requiring continuous observation (monitoring) to include managing the I.V., administering medications/-treatments, performing assessments, etc. In this example the RN provides ALL care.

Example #2: A para or technician may be assigned to a patient requiring continuous observation (for safety reasons, etc.) and will provide physical care, but the patient needs no IV's, treatments, medications, etc. The Professional nurse, who may have limited contact, is still responsible for assessing the patient/situation and providing instructions to the para/tech. This amount of professional nurse time is already included in the percent of time allocated for unpredicted needs.

Note: If a para or tech is assigned 1:1 but the professional nurse must provide a portion of the care, i.e., physical assessment, start IV's, administer medications, etc., DO NOT use this critical indicator. Use the indicator, "Patients requiring greater than 1:1 coverage". (This is acuity code #141).

●(146) PATIENT REQUIRING GREATER THAN 1:1 COVERAGE ALL SHIFTS

. 1:1 Coverage All Shifts: Includes time for more than one staff member to render all care to a specific patient.

Example #1: More than one staff member is assigned to one patient for all care given during each entire shift.

Example #2: One para/tech may be assigned to a patient for continuous care and observation; however, a professional nurse will make the physical assessments, help plan care, administer medications/treatments, give instructions, etc. This example constitutes a 1 1/2:1 status and would therefore capture the professional nursing care workload. One RN could manage two continous care patients with a tech/para assigned specifically to each of the patients.

INDEX

APPENDIX A

GUIDELINES FOR CRITICAL INDICATORS

GUIDELINES FOR INTERPRETING THE MEANING OF THE CRITICAL INDICATORS FOR PSYCHIATRIC PATIENTS

The following information provides operational descriptions of each specific activity included under a critical indicator heading.

For each operational definition time is included for the succeeding activities: (1) Identify and screen the patient; (2) Explain the procedure to the patient ; (3) Raise, lower, adjust the bed before and after the nursing activity; (4) Clean and straighten area; (5) Record any activity done at the bedside; and (6) Spend time at the patient's bedside providing information, answering patients questions and interacting with patients.

Critical indicators listed on the Medical-Surgical-Pediatric Patient Classification Form are defined in Appendix A.

Psychiatric critical indicators are listed in the order that they appear on the Patient Classification Form (Psychiatric). An alphabetical index is located at the end of this appendix for quick reference.

Special considerations or explanations are designated by the word "Note."

VITAL SIGNS: (Manual Temperature, Pulse, Respirations and Blood Pressure)

- ALL CRITICAL INDICATORS: see Appendix A, page A-1 to A-3.

MONITORING:

- (2) INTAKE AND OUTPUT Q 8 HOURS OR X 3
  - See Appendix A, page A-3.
- (2) CIRCULATION CHECKS Q 2 HOURS OR X 12
  - See Appendix A, page A-4.
- (3) NEURO CHECKS Q 4 HOURS OR X 6
  - See Appendix A, page A-5.
- (2) GALVESTON ORIENTATION AND AMNESIA TEST Q 4 HOURS OR X 6
  - Galveston Orientation and Amnesia Test: Includes time to go to patient's bedside, ask the questions, record responses and score responses. Also includes time to observe patient's orientation.

o (4) PATIENT CHECKS Q 30 MINUTES (SLEEP PATTERNS) X 8 HOURS

. Patient Checks: Includes time to go to the bedside, assess the patient, and record observations at the bedside every 30 minutes for an eight hour time period. Assessment must be documented every 30 minutes. For sleep pattern checks note if insomnia, restlessness, sleepwalking, or issues of safety occur.

o (8) . RESTRAINT CHECKS Q 30 MINUTES X 8 HOURS

. Restraint Checks: Includes time to go to the bedside or Quiet Room and physically assess the skin and circulation every 30 minutes for 8 hours. Also includes time to assess patient's mental status and negotiate a written or verbal behavioral contract for release from restraints.

o (16) RESTRAINT CHECKS Q 15 MINUTES WITH VITAL SIGN X 8 HOURS

. Restraint Checks: Includes time to go to the bedside or Quiet Room to physically assess the skin and circulation and take Vital Signs q 15 minutes x 8 hours. Also includes time spent with patient psychologically assessing the patient's mental status and obtaining a written verbal behavioral contract (what behavior the patient must exhibit to be released from restraints, e.g., agree not to hurt self or others).

o (10) PATIENT CHECKS Q 15 MINUTES X 8 HOURS (SUICIDE/ESCAPE/ASSAULT RISK OR SECLUSION ROOM)

. Patient Checks: Includes time spent finding the patient on the ward or going to the bedside and making an asessment. Assessment includes:

a. Removal of all environmental hazards (guns, knives, ropes, objects, toxic substances, uniform items, belts and anything else which could be used in a lethal manner) and placing hazardous items under lock and key;

b. Talking with the patient to determine if he is currently assaultive, suicidal or if he is attempting to leave the ward;

c. Checking the patient for safety and activity (if in seclusion).

Assessment must be documented q 15 minutes.

ACTIVITIES OF DAILY LIVING

Instruction: Includes time allowances to perform all activities as described in Appendix A-9 to A-13.

NOTE: A, B, C, and D Status refers to a patient activity restriction code used to indicate the level of observation/restriction that a patient requires. For facilities that do not use this code, ignore activity restrictions as described below.

- (2) SELF CARE

  . Self Care: Patients that are allowed to sign off the unit unaccompanied and patients that are allowed to sign off the unit in the company of another patient. Includes time to provide physical care (see Appendix A, page A-9).

- (8) ASSISTED CARE

  . Assisted Care: Patients that are confined to the unit. They may leave the unit in small groups if accompanied by a staff member. Includes time to provide physical care (see Appendix A, page A-10).

FEEDING

- ALL CRITICAL INDICATORS: See Appendix A, page A-16 to A-17.

TREATMENTS, PROCEDURES, MEDICATIONS, AND THERAPY

Instruction: Activities that require less than 15 minutes are not included and should not be considered.

SIMPLE > 15 MINUTES AND < 30 MINUTES TOTAL

- (2) START IV OR EKG OR ACE WRAP

  . See Appendix A, page A-17 and A-18.

- (2) SIMPLE DRESSING OR TUBE CARE

  . See Appendix A, page A-19.

- (2) LAB STUDIES X 6

  . See Appendix A, page A-20.

- (2) MEDICATIONS Q 3-8 HOURS (INCLUDE PRNs)

  . See Appendix A, page A-21.

- (2) COMMUNITY MEETING

  . Community Meeting: Includes time for some staff to act as facilitators and resource persons to patient community. The focus of the meeting is ward management and problem solving in a large community.

- (2) ACCOMPANY PATIENT OFF WARD 15 TO 30 MINUTES

  . See Appendix A, page A-23.

- (2) ANY OTHER ACTIVITY REQUIRING 15 TO 30 MINUTES

  . See Appendix A, page A-23.

COMPLEX > 30 MINUTES AND < 60 MINUTES TOTAL

- (4) COMPLEX DRESSINGS

  . See Appendix A, page A-24.

- (4) MEDICATIONS Q 2 HOURS OR MORE (INCLUDE PRNs)

  . See Appendix A, page A-25.

- (4) ACCOMPANY PATIENT OFF WARD 30-60 MINUTES

  . See Appendix A, page A-26.

- (4) ANY OTHER ACTIVITY REQUIRING 30 TO 60 MINUTES

  . See Appendix A, page A-26.

- (4) PLANNED RECREATION X 2 HOURS

  . Planned Recreation: Includes time to determine where to go, arrange transportation, food and medication, and supervise patients in a public place with a minimum of a 1:4 staff/patient ratio.

- (4) INTAKE INTERVIEW, INTERDISCIPLINARY

  . Intake Interview, Interdisciplinary: Includes time to arrive at at the conference room, provide nursing input, discuss and collaborate with members of an interdisciplinary team in developing a treatment plan for and with the patient.

o (4) GROUP THERAPY

. Group Therapy: Includes time for the staff to participate as leaders, observers, facilitators, or resource persons in a group of patients.

o (4) WORKSHOP

. Workshop: Includes time for the staff to plan activity on the unit, explain the workshop to the patient, participate in the workshop, and observe the patient's responses.

o (4) PURPOSEFUL INTERACTION (1:1 > 30 MINUTES)

. Purposeful Interaction for>30 Minutes: Includes time spent with a patient by a staff member without providing any direct physical care and which is not in response to a patient call system or a patient question. May include impromptu recreation that involves one to one staff participation .

o (4) TRANSFER (IN HOUSE) - ASSESS AND ORIENT

. See Appendix A, page A-26.

o (12) NEW ADMISSION - ASSESS AND ORIENT

. See Appendix A, page A-26.

SPECIAL PROCEDURES > 1 HOUR < 4 HOURS

o (8) ACCOMPANY PATIENT OFF WARD FOR 60 MINUTES

. Accompany Patient Off Ward for ≥ 60 Minutes: Any absence from the unit that requires greater than one hour.

o (8) CONTINUAL STAFF ATTENDANCE OR ASSISTANCE (ECT)

. See Appendix A, page A-27 'Special Procedures 1 Hour.'

o (8) ANY OTHER ACTIVITY REQUIRING 1:1 FOR 60 MINUTES

. See Appendix A, page A-27 'Special Procedures 1 Hour.'

o (2) EACH PATIENT ACCOMPANIED OFF THE UNIT IN A GROUP FOR 1 HOUR (1 STAFF : 4 PATIENTS)

. Each Patient Accompanied Off the Unit in a Group for 1 Hour: Includes time for a staff member to observe, monitor, and interact with a group of patients off the unit. Note: Each patient in the group will receive 2 points for each hour away from the unit. The group must be accompanied by a nursing staff member in a ratio of one staff member to 2-4 patients.

TEACHING

Instruction: Points for teaching should be given only for structured instruction. These individual classes or one-to-one teaching sessions must be documented in the patient's medical center.

o (2) TEACHING, GROUP

. See Appendix A, page A-29.

o (4) SPECIAL STRUCTURED TEACHING, INDIVIDUAL

. See Appendix A, page A-33.

o (4) PRE-PROCEDURE TEACHING

. Pre-Procedure Teaching: Includes time to provide individual instruction to the patient and family and to answer questions on special procedures, such as: sleep deprived EEG, CT scan, ECT or sodium amytal interview.

(4) WORK SUPERVISION

. Work Supervision: Includes time to assign a patient to a job, explain the required duties, monitor progress, give feedback information to the patient regarding the progress or lack of progress, and observe the patient's responses to the work demands.
Note: This supervison must be done by the psychiatric unit nursing staff.

EMOTIONAL SUPPORT IN EXCESS OF 30 MINUTES Q 24 HOURS

Instruction: It is recognized that psychiatric nursing involves emotional support for all patients. These critical indicators are to be used to distinguish special needs of specific patients. This need must be documented in the patient's record.

o (4) PATIENT/FAMILY SUPPORT (ANXIETY, DENIAL, LONELINESS)

. See Appendix A, page A-34.

o (4) MODIFICATION OF LIFESTYLE

. Modification of Lifestyle: Includes time to provide individual support regarding limitations and restrictions of a new prosthesis, the necessary alteration of lifestyle, and coping with a body image change or an illness. It also includes assisting the patient to identify alternate coping mechanisms.

- (4) REALITY ORIENTATION

  - Reality Orientation: Includes time that must be taken with patients who are hallucinating, delusional or display other severe disorders of perception.

- (4) REDIRECTION

  - Redirection: Includes time to restructure patient time on an hourly or more frequent basis. This is necessary for patients who require behavioral intervention due to delusions, ideas of reference, flight of ideas, suspicion or retarded thought processes that prevent them from organizing their own time.

- (4) REGULATION

  - Regulation: Includes time for the staff to assess and limit inappropriate or socially unacceptable behavior. This includes interventions to modify verbalized anger, combative behavior, hyperactivity, and impulsivity.

- (6) SENSORY DEPRIVATION

  - Sensory Deprivation: Inlcudes the extra time that must be taken with certain patients, i.e., confused, retarded, deaf, blind, foreign speaking, or mute. Includes assessment of and protection from environmental hazards.

CONTINUOUS

Instruction: The continuous section is to be used to classify patients who obviously require 1:1 care.

- (96) PATIENT REQUIRING 1:1 COVERAGE ALL SHIFTS (SUICIDE)

  - Patients Requiring 1:1 Coverage: Includes time for one staff member to render ALL care to a specific patient requiring continual one-to-one observation, such as a suicide patient who must be kept within arms reach, or within line of sight.

INDEX

PSYCHIATRIC CRITICAL INDICATORS

Page(s)

APPENDIX C

NURSING CARE HOUR REQUIREMENTS CHARTS

MEDICAL-SURGICAL

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	2	5	11	18	27	45
2	3	10	21	36	54	91
3	5	15	32	53	81	136
4	6	20	43	71	108	182
5	8	25	54	89	135	227
6	10	29	64	107	161	272
7	11	34	75	125	188	318
8	13	39	86	142	215	363
9	14	44	96	160	242	409
10	16	49	107	178	269	454
11	18	54	118	196	296	499
12	19	59	128	214	323	545
13	21	64	139	231	350	590
14	22	69	150	249	377	636
15	24	74	161	267	404	681
16	26	78	171	285	430	726
17	27	83	182	303	457	772
18	29	88	193	320	484	817
19	30	93	203	338	511	863
20	32	98	214	356	538	908
21	34	103	225	374	565	953
22	35	108	235	392	592	999
23	37	113	246	409	619	1044
24	38	118	257	427	646	1090
25	40	123	268	445	673	1135
26	42	127	278	463	699	1180
27	43	132	289	481	726	1226
28	45	137	300	498	753	1271
29	46	142	310	516	780	1317
30	48	147	321	534	807	1362

PSYCHIATRIC

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	2	5	10	17	26	43
2	3	9	20	34	51	87
3	5	14	31	51	77	130
4	6	19	41	68	103	174
5	8	24	51	85	129	217
6	9	28	61	102	154	260
7	11	33	71	119	180	304
8	12	38	82	136	206	347
9	14	42	92	153	231	391
10	15	47	102	170	257	434
11	17	52	112	187	283	477
12	18	56	122	204	308	521
13	30	61	133	221	334	564
14	21	66	143	238	360	608
15	23	71	153	255	386	651
16	24	75	163	272	411	694
17	26	80	173	289	437	738
18	27	85	184	306	463	781
19	29	89	194	323	488	825
20	30	94	204	340	514	868
21	32	98	214	357	540	911
22	33	103	224	374	565	955
23	35	108	235	391	591	998
24	36	112	245	408	617	1042
25	38	117	255	425	643	1085
26	39	122	265	442	668	1128
27	41	126	275	459	694	1172
28	42	131	286	476	720	1215
29	44	136	296	493	745	1259
30	45	140	306	510	771	1302

OB-GYN

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	2	5	11	18	27	46
2	3	10	22	36	54	91
3	5	15	32	54	81	137
4	6	20	43	72	108	183
5	8	25	54	90	136	229
6	10	29	65	107	163	274
7	11	34	76	125	190	320
8	13	39	86	143	217	366
9	14	44	97	161	244	411
10	16	49	108	179	271	457
11	18	54	119	197	298	503
12	19	59	130	215	325	548
13	21	64	140	233	352	594
14	22	69	151	251	379	640
15	24	74	162	269	407	686
16	26	78	173	286	434	731
17	27	83	184	304	461	777
18	29	88	194	322	488	823
19	39	73	205	340	515	868
20	32	98	216	358	542	914
21	34	103	227	376	569	960
22	35	108	238	394	596	1005
23	37	113	248	412	623	1051
24	38	118	259	430	650	1097
25	40	123	270	448	678	1143
26	42	127	281	465	705	1188
27	43	132	292	483	732	1234
28	45	137	302	501	759	1280
29	46	142	313	519	786	1325
30	48	147	324	537	813	1371

PEDIATRICS -PEDS ICU

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	2	5	10	18	26	45
2	3	10	21	35	53	89
3	5	14	31	53	79	134
4	6	19	42	70	106	178
5	8	24	52	88	132	223
6	9	29	62	105	158	267
7	11	34	73	123	185	312
8	12	38	83	140	211	356
9	14	43	94	158	238	401
10	15	48	104	175	264	445
11	17	53	114	193	290	490
12	18	58	125	210	317	534
13	20	62	135	228	343	579
14	21	67	146	245	370	623
15	23	72	156	263	396	668
16	24	77	166	280	422	712
17	26	82	177	298	449	757
18	27	86	187	315	475	801
19	29	91	198	333	502	846
20	30	96	208	350	528	870
21	32	101	218	368	554	935
22	33	106	229	385	581	979
23	35	110	239	403	607	1024
24	36	115	250	420	634	1068
25	38	120	260	438	C60	1113
26	39	125	270	455	686	1157
27	41	130	281	473	713	1202
28	42	135	291	490	739	1246
29	44	139	302	508	766	1291
30	45	144	312	425	792	1335

NURSERY-ICN

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	1	5	10	17	25	42
2	3	9	20	33	50	84
3	4	14	30	50	75	126
4	6	18	40	66	100	168
5	7	23	50	83	125	211
6	8	27	59	99	149	253
7	10	32	69	116	174	295
8	11	36	79	132	199	337
9	13	41	89	149	224	379
10	14	45	99	165	249	421
11	15	50	109	182	274	463
12	17	54	119	198	299	505
13	18	59	129	215	324	547
14	20	63	139	231	349	589
15	21	68	149	248	374	632
16	22	72	158	264	398	674
17	24	77	168	281	423	716
18	25	81	178	297	448	758
19	27	86	188	314	473	800
20	28	90	198	330	498	842
21	29	95	208	347	523	884
22	31	99	218	363	548	926
23	32	104	228	380	573	968
24	34	108	238	396	598	1010
25	35	113	248	413	623	1053
26	36	117	257	429	647	1095
27	38	122	267	446	672	1137
28	39	126	277	462	697	1179
29	41	131	287	479	722	1221
30	42	135	297	495	747	1263

CRITICAL CARE

NURSING CARE HOUR REQUIREMENTS CHART

PATIENTS	CATEGORY					
	I	II	III	IV	V	VI
1	1	5	10	17	25	43
2	3	9	20	34	51	85
3	4	14	30	50	76	128
4	6	18	40	67	101	171
5	7	23	51	84	127	214
6	8	28	61	101	152	256
7	10	32	71	118	177	299
8	11	37	81	134	202	342
9	13	41	91	151	228	384
10	14	46	101	168	253	427
11	15	51	111	185	278	470
12	17	55	121	202	304	512
13	18	60	131	218	329	555
14	20	64	141	235	354	598
15	21	69	152	252	380	641
16	22	74	162	269	405	683
17	24	78	172	286	420	726
18	25	83	182	302	455	769
19	27	87	102	319	481	811
20	28	92	202	336	506	854
21	29	97	212	353	531	897
22	31	101	222	370	557	939
23	32	106	232	386	582	982
24	34	110	242	403	607	1025
25	35	115	253	420	633	1068
26	36	120	263	437	658	1110
27	38	124	273	454	683	1153
28	39	129	283	470	708	1196
29	41	133	293	487	734	1238
30	42	138	303	504	759	1281

APPENDIX D

PERSONNEL REQUIREMENTS CHARTS

MEDICAL-SURGICAL

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2
49-56	7	1	1	2	1	1	2	1	2	3
57-64	8	1	2	3	1	1	2	1	2	3
65-72	9	1	2	3	1	1	2	2	2	4
73-80	10	1	2	3	1	1	2	2	3	5
81-88	11	1	2	3	1	2	3	2	3	5
89-96	12	2	2	4	1	2	3	2	3	5
97-104	13	2	3	5	1	2	3	2	3	5
105-112	14	2	3	5	1	2	3	2	4	6
113-120	15	2	3	5	2	2	4	2	4	6
121-128	16	2	3	5	2	2	4	3	4	7
129-136	17	2	4	6	2	2	4	3	4	7
137-144	18	2	4	6	2	2	4	3	5	8
145-152	19	3	4	7	2	2	4	3	5	8
153-160	20	3	4	7	2	3	5	3	5	8
161-168	21	3	4	7	2	3	5	4	5	9
169-176	22	3	5	8	2	3	5	4	5	9
177-184	23	3	5	8	2	3	5	4	6	10
185-192	24	3	5	8	2	4	6	4	6	10
193-200	25	4	5	9	2	4	6	4	6	10
201-208	26	4	5	9	2	4	6	4	7	11
209-216	27	4	6	10	2	4	6	4	7	11
217-224	28	4	6	10	2	4	6	5	7	12
225-232	29	4	6	10	3	4	7	5	7	12
233-240	30	4	7	11	3	4	7	5	7	12

Shift Distribution: 42% AMS
35% PMS
23% Nights

Staffing Ratio: 40% RN
60% NRN

MEDICAL-SURGICAL

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
241-248	31	4	7	11	3	4	7	5	8	13
249-256	32	4	7	11	3	5	8	5	8	13
257-264	33	5	7	12	3	5	8	5	8	13
265-272	34	5	7	12	3	5	8	6	8	14
273-280	35	5	7	12	3	5	8	6	9	15
281-288	36	5	8	13	3	5	8	6	9	15
289-296	37	5	8	13	4	5	9	6	9	15
297-304	38	5	8	13	4	5	9	6	10	16
305-312	39	6	8	14	4	5	9	6	10	16
313-320	40	6	8	14	4	6	10	6	10	16
321-328	41	6	8	14	4	6	10	7	10	17
329-336	42	6	9	15	4	6	10	7	10	17
337-344	43	6	9	15	4	6	10	7	11	18
345-352	44	6	9	15	4	7	11	7	11	18
353-360	45	6	9	15	4	7	11	8	11	19
361-368	46	6	10	16	4	7	11	8	11	19
369-376	47	6	10	16	4	7	11	8	12	20
377-384	48	7	10	17	4	7	11	8	12	20
385-392	49	7	10	17	4	7	11	8	13	21
393-400	50	7	10	17	5	7	12	8	13	21
401-408	51	7	11	18	5	7	12	8	13	21
409-416	52	7	11	18	5	7	12	9	13	22
417-424	53	8	11	19	5	7	12	9	13	22
425-432	54	8	11	19	5	8	13	9	13	23
433-440	55	8	11	19	5	8	13	9	14	23

PSYCHIATRY

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2.
49-56	7	1	1	2	1	1	2	1	2	3
57-64	8	1	2	3	1	1	2	1	2	3
65-72	9	1	2	3	1	1	2	2	2	4
73-80	10	1	2	3	1	1	2	2	3	5
81-88	11	1	2	3	1	2	3	2	3	5
89-96	12	2	2	4	1	2	3	2	3	5
97-104	13	2	3	5	1	2	3	2	3	5
105-112	14	2	3	5	1	2	3	2	4	6
113-120	15	2	3	5	2	2	4	2	4	6
121-128	16	2	3	5	2	2	4	3	4	7
129-136	17	2	4	6	2	2	4	3	4	7
137-144	18	2	4	6	2	2	4	3	5	8
145-152	19	3	4	7	2	2	4	3	5	8
153-160	20	3	4	7	2	3	5	3	5	8
161-168	21	3	4	7	2	3	5	4	5	9
169-176	22	3	5	8	2	3	5	4	5	9
177-184	23	3	5	8	2	3	5	4	6	10
185-192	24	3	5	8	2	4	6	4	6	10
193-200	25	4	5	9	2	4	6	4	6	10
201-208	26	4	5	9	2	4	6	4	7	11
209-216	27	4	6	10	2	4	6	4	7	11
217-224	28	4	6	10	2	4	6	5	7	12
225-232	29	4	6	10	3	4	7	5	7	12
233-240	30	4	7	11	3	4	7	5	7	12

Shift Distribution: 42% AMS
35% PMS
23% Nights

Staffing Ratio: 40% RN
60% NRN

PSYCHIATRY

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
241-248	31	4	7	11	3	4	7	5	8	13
249-256	32	4	7	11	3	5	8	5	8	13
257-264	33	5	7	12	3	5	8	5	8	13
265-272	34	5	7	12	3	5	8	6	8	14
273-280	35	5	7	12	3	5	8	6	9	15
281-288	36	5	8	13	3	5	8	6	9	15
289-296	37	5	8	13	4	5	9	6	9	15
297-304	38	5	8	13	4	5	9	6	10	16
305-312	39	6	8	14	4	5	9	6	10	16
313-320	40	6	8	14	4	6	10	6	10	16
321-328	41	6	8	14	4	6	10	7	10	17
329-336	42	6	9	15	4	6	10	7	10	17
337-344	43	6	9	15	4	6	10	7	11	18
345-352	44	6	9	15	4	7	11	7	11	18
353-360	45	6	9	15	4	7	11	8	11	19
361-368	46	6	10	16	4	7	11	8	11	19
369-376	47	6	10	16	4	7	11	8	12	20
377-384	48	7	10	17	4	7	11	8	12	20
385-392	49	7	10	17	4	7	11	8	13	21
393-400	50	7	10	17	5	7	12	8	13	21
401-408	51	7	11	18	5	7	12	8	13	21
409-416	52	7	11	18	5	7	12	9	13	22
417-424	53	8	11	19	5	7	12	9	13	22
425-432	54	8	11	19	5	8	13	9	13	23
433-440	55	8	11	19	5	8	13	9	14	23

OB-GYN

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2
49-56	7	1	1	2	1	1	2	1	2	3
57-64	8	1	2	3	1	1	2	1	2	3
65-72	9	1	2	3	1	1	2	2	2	4
73-80	10	1	2	3	1	1	2	2	3	5
81-88	11	1	2	3	1	2	3	2	3	5
89-96	12	2	2	4	1	2	3	2	3	5
97-104	13	2	3	5	1	2	3	2	3	5
105-112	14	2	3	5	1	2	3	2	4	6
113-120	15	2	3	5	2	2	4	2	4	6
121-128	16	2	3	5	2	2	4	3	4	7
129-136	17	2	4	6	2	2	4	3	4	7
137-144	18	2	4	6	2	2	4	3	5	8
145-152	19	3	4	7	2	2	4	3	5	8
153-160	20	3	4	7	2	3	5	3	5	8
161-168	21	3	4	7	2	3	5	4	5	9
169-176	22	3	5	8	2	3	5	4	5	9
177-184	23	3	5	8	2	3	5	4	6	10
185-192	24	3	5	8	2	4	6	4	6	10
193-200	25	4	5	9	2	4	6	4	6	10
201-208	26	4	5	9	2	4	6	4	7	11
209-216	27	4	6	10	2	4	6	4	7	11
217-224	28	4	6	10	2	4	6	5	7	12
225-232	29	4	6	10	3	4	7	5	7	12
233-240	30	4	7	11	3	4	7	5	7	12

Shift Distribution: 42% AMS
35% PMS
23% Nights

Staffing Ratio: 40% RN
60% NRN

OB-GYN

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
241-248	31	4	7	11	3	4	7	5	8	13
249-256	32	4	7	11	3	5	8	5	8	13
257-264	33	5	7	12	3	5	8	5	8	13
265-272	34	5	7	12	3	5	8	6	8	14
273-280	35	5	7	12	3	5	8	6	9	15
281-288	36	5	8	13	3	5	8	6	9	15
289-296	37	5	8	13	4	5	9	6	9	15
297-304	38	5	8	13	4	5	9	6	10	16
305-312	39	6	8	14	4	5	9	6	10	16
313-320	40	6	8	14	4	6	10	6	10	16
321-328	41	6	8	14	4	6	10	7	10	17
329-336	42	6	9	15	4	6	10	7	10	17
337-344	43	6	9	15	4	6	10	7	11	18
345-352	44	6	9	15	4	7	11	7	11	18
353-360	45	6	9	15	4	7	11	8	11	19
361-368	46	6	10	16	4	7	11	8	11	19
369-376	47	6	10	16	4	7	11	8	12	20
377-384	48	7	10	17	4	7	11	8	12	20
385-392	49	7	10	17	4	7	11	8	13	21
393-400	50	7	10	17	5	7	12	8	13	21
401-408	51	7	11	18	5	7	12	8	13	21
409-416	52	7	11	18	5	7	12	9	13	22
417-424	53	8	11	19	5	7	12	9	13	22
425-432	54	8	11	19	5	8	13	9	13	23
433-440	55	8	11	19	5	8	13	9	14	23

PEDIATRICS

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2
49-56	7	1	1	2	1	1	2	1	2	3
57-64	8	1	2	3	1	1	2	1	2	3
65-72	9	1	2	3	1	1	2	2	2	4
73-80	10	1	2	3	1	1	2	2	3	5
81-88	11	1	2	3	1	2	3	2	3	5
89-96	12	2	2	4	1	2	3	2	3	5
97-104	13	2	3	5	1	2	3	2	3	5
105-112	14	2	3	5	1	2	3	2	4	6
113-120	15	2	3	5	2	2	4	2	4	6
121-128	16	2	3	5	2	2	4	3	4	7
129-136	17	2	4	6	2	2	4	3	4	7
137-144	18	2	4	6	2	2	4	3	5	8
145-152	19	3	4	7	2	2	4	3	5	8
153-160	20	3	4	7	2	3	5	3	5	8
161-168	21	3	4	7	2	3	5	4	5	9
169-176	22	3	5	8	2	3	5	4	5	9
177-184	23	3	5	8	2	3	5	4	6	10
185-192	24	3	5	8	2	4	6	4	6	10
193-200	25	4	5	9	2	4	6	4	6	10
201-208	26	4	5	9	2	4	6	4	7	11
209-216	27	4	6	10	2	4	6	4	7	11
217-224	28	4	6	10	2	4	6	5	7	12
225-232	29	4	6	10	3	4	7	5	7	12
233-240	30	4	7	11	3	4	7	5	7	12

Shift Distribution: 42% AMS
35% PMS
23% Nights

Staffing Ratio: 40% RN
60% NRN

PEDIATRICS

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
241-248	31	4	7	11	3	4	7	5	8	13
249-256	32	4	7	11	3	5	8	5	8	13
257-264	33	5	7	12	3	5	8	5	8	13
265-272	34	5	7	12	3	5	8	6	8	14
273-280	35	5	7	12	3	5	8	6	9	15
281-288	36	5	8	13	3	5	8	6	9	15
289-296	37	5	8	13	4	5	9	6	9	15
297-304	38	5	8	13	4	5	9	6	10	16
305-312	39	6	8	14	4	5	9	6	10	16
313-320	40	6	8	14	4	6	10	6	10	16
321-328	41	6	8	14	4	6	10	7	10	17
329-336	42	6	9	15	4	6	10	7	10	17
337-344	43	6	9	15	4	6	10	7	11	18
345-352	44	6	9	15	4	7	11	7	11	18
353-360	45	6	9	15	4	7	11	8	11	19
361-368	46	6	10	16	4	7	11	8	11	19
369-376	47	6	10	16	4	7	11	8	12	20
377-384	48	7	10	17	4	7	11	8	12	20
385-392	49	7	10	17	4	7	11	8	13	21
393-400	50	7	10	17	5	7	12	8	13	21
401-408	51	7	11	18	5	7	12	8	13	21
409-416	52	7	11	18	5	7	12	9	13	22
417-424	53	8	11	19	5	7	12	9	13	22
425-432	54	8	11	19	5	8	13	9	13	23
433-440	55	8	11	19	5	8	13	9	14	23

NURSERY

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2
49-56	7	1	1	2	1	1	2	1	2	3
57-64	8	1	2	3	1	1	2	1	2	3
65-72	9	1	2	3	1	2	3	1	2	3
73-80	10	2	2	3	1	2	3	2	2	4
81-88	11	2	2	4	1	2	3	2	2	4
89-96	12	2	2	4	2	2	4	2	2	4
97-104	13	2	2	4	2	2	4	2	3	5
105-112	14	2	3	5	2	2	4	2	3	5
113-120	15	2	3	5	2	3	5	2	3	5
121-128	16	2	3	5	2	3	5	2	4	6
129-136	17	2	4	6	2	3	5	2	4	6
137-144	18	2	4	6	2	4	6	2	4	6
145-152	19	2	4	6	2	4	6	3	4	7
153-160	20	3	4	7	2	4	6	3	4	7
161-168	21	3	4	7	3	4	7	3	4	7
169-176	22	3	4	7	3	4	7	3	5	8
177-184	23	3	5	8	3	4	7	3	5	8
185-192	24	3	5	8	3	5	8	3	5	8
193-200	25	3	5	8	3	5	8	4	5	9
201-208	26	4	5	9	3	5	8	4	5	9
209-216	27	4	5	9	4	5	9	4	5	9
217-224	28	4	5	9	4	5	9	4	6	10
225-232	29	4	6	10	4	5	9	4	6	10
233-240	30	4	6	10	4	6	10	4	6	10

Shift Distribution: 33% AMS
33% PMS
33% Nights

Staffing Ratio: 40% RN
60% NRN

NURSERY

PERSONNEL REQUIREMENTS CHART

8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
241-248	31	4	6	10	4	6	10	4	7	11
249-256	32	4	7	11	4	6	10	4	7	11
257-264	33	4	7	11	4	7	11	4	7	11
265-272	34	4	7	11	4	7	11	5	7	12
273-280	35	5	7	12	4	7	11	5	7	12
281-288	36	5	7	12	5	7	12	5	7	12
289-296	37	5	7	12	5	7	12	5	8	13
297-304	38	5	8	13	5	7	12	5	8	13
305-312	39	5	8	13	5	8	13	5	8	13
313-320	40	5	8	13	5	8	13	6	8	14
321-328	41	6	8	14	5	8	13	6	8	14
329-336	42	6	8	14	6	8	14	6	8	14
337-344	43	6	8	14	6	8	14	6	9	15
345-352	44	6	9	15	6	8	14	6	9	15
353-360	45	6	9	15	6	9	15	6	9	15
361-368	46	6	9	15	6	9	15	6	10	16
369-376	47	6	10	16	6	9	15	6	10	16
377-384	48	6	10	16	6	10	16	6	10	16
385-392	49	6	10	16	6	10	16	7	10	17
393-400	50	7	10	17	6	10	16	7	10	17
401-408	51	7	10	17	7	10	17	7	10	17
409-416	52	7	10	17	7	10	17	7	11	18
417-424	53	7	11	18	7	10	17	7	11	18
425-432	54	7	11	18	7	11	18	7	11	18
433-440	55	7	11	18	7	11	18	8	11	19

CRITICAL CARE

PERSONNEL REQUIREMENTS CHART

8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	6	1	1	2	1	1	2	1	1	2
49-56	7	1	1	2	1	1	2	2	1	3
57-64	8	2	1	3	1	1	2	2	1	3
65-72	9	2	1	3	2	1	3	2	1	3
73-80	10	2	1	3	2	1	3	2	2	4
81-88	11	2	2	4	2	1	3	2	2	4
89-96	12	2	2	4	2	2	4	2	2	4
97-104	13	2	2	4	2	2	4	3	2	5
105-112	14	3	2	5	2	2	4	3	2	5
113-120	15	3	2	5	3	2	5	3	2	5
121-128	16	3	2	5	3	2	5	4	2	6
129-136	17	4	2	6	3	2	5	4	2	6
137-144	18	4	2	6	4	2	6	4	2	6
145-152	19	4	2	6	4	2	6	4	3	7
153-160	20	4	3	7	4	2	6	4	3	7
161-168	21	4	3	7	4	3	7	4	3	7
169-176	22	4	3	7	4	3	7	5	3	8
177-184	23	5	3	8	4	3	7	5	3	8
185-192	24	5	3	8	5	3	8	5	3	8
193-200	25	5	3	8	5	3	8	5	4	9
201-208	26	5	4	9	5	3	8	5	4	9
209-216	27	5	4	9	5	4	9	5	4	9
217-224	28	5	4	9	5	4	9	6	4	10
225-232	29	6	4	10	5	4	9	6	4	10
233-240	30	6	4	10	6	4	10	6	4	10

Shift Distribution 33% AMS
33% PMS
33% Nights

Staffing Ratio: 60% RN
40% NRN

CRITICAL CARE

PERSONNEL REQUIREMENTS CHART
8 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
241-248	31	6	4	10	6	4	10	7	4	11
249-256	32	7	4	11	6	4	10	7	4	11
257-264	33	7	4	11	7	4	11	7	4	11
265-272	34	7	4	11	7	4	11	7	5	12
273-280	35	7	5	12	7	4	11	7	5	12
281-288	36	7	5	12	7	5	12	7	5	12
289-296	37	7	5	12	7	5	12	8	5	13
297-304	38	8	5	13	7	5	12	8	5	13
305-312	39	8	5	13	8	5	13	8	5	13
313-320	40	8	5	13	8	5	13	8	6	14
321-328	41	8	6	14	8	5	13	8	6	14
329-336	42	8	6	14	8	6	14	8	6	14
337-344	43	8	6	14	8	6	14	9	6	15
345-352	44	9	6	15	8	6	14	9	6	15
353-360	45	9	6	15	9	6	15	9	6	15
361-368	46	9	6	15	9	6	15	10	6	16
369-376	47	10	6	16	9	6	15	10	6	16
377-384	48	10	6	16	10	6	16	10	6	16
385-392	49	10	6	16	10	6	16	10	7	17
393-400	50	10	7	17	10	6	16	10	7	17
401-408	51	10	7	17	10	7	17	10	7	17
409-416	52	10	7	17	10	7	17	11	7	18
417-424	53	11	7	18	10	7	17	11	7	18
425-432	54	11	7	18	11	7	18	11	7	18
433-440	55	11	7	18	11	7	18	11	8	19

MEDICAL-SURGICAL

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	4				1	1	2	1	1	2
49-60	5				1	1	2	1	2	3
61-72	6				1	1	2	2	2	4
73-84	7				1	2	3	2	2	4
85-96	8				1	2	3	2	3	5
97-108	9				2	2	4	2	3	5
109-120	10				2	2	4	2	4	6
121-132	11				2	2	4	3	4	7
133-144	12				2	3	5	3	4	7
145-156	13				2	3	5	3	5	8
157-168	14				2	4	6	3	5	8
169-180	15				2	4	6	4	5	9
181-192	16				2	4	6	4	6	10
193-204	17				3	4	7	4	6	10
205-216	18				3	4	7	4	7	11
217-228	19				3	5	8	4	7	11
229-240	20				3	5	8	5	7	12
241-252	21				3	5	8	5	8	13
253-264	22				4	5	9	5	8	13
265-276	23				4	5	9	6	8	14
277-288	24				4	6	10	6	8	14
289-300	25				4	6	10	6	9	15
301-312	26				4	7	11	6	9	15
313-324	27				4	7	11	6	10	16

Shift Distribution: 60% AMS
40% Nights

Staffing Ratio: 40% RN
60% NRN

MEDICAL-SURGICAL

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
325-336	28				4	7	11	7	10	17
337-348	29				5	7	12	7	10	17
349-360	30				5	7	12	7	11	18
361-372	31				5	7	12	8	11	19
373-384	32				5	8	13	8	11	19
385-396	33				5	8	13	8	12	20
397-408	34				6	8	14	8	12	20
409-420	35				6	8	14	8	13	21
421-432	36				6	8	14	9	13	22
433-444	37				6	9	15	9	13	22
445-456	38				6	9	15	9	14	23
457-468	39				6	10	16	9	14	23
469-480	40				6	10	16	10	14	24
481-492	41				7	10	17	10	14	24
493-504	42				7	10	17	10	15	25
505-516	43				7	10	17	11	15	26
517-528	44				7	11	18	11	15	26
529-540	45				7	11	18	11	16	27
541-552	46				7	11	18	11	17	28
553-564	47				8	11	19	11	17	28
565-576	48				8	11	19	12	17	29
577-588	49				8	12	20	12	17	29
589-600	50				8	12	20	12	18	30

PSYCHIATRIC

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	4				1	1	2	1	1	2
49-60	5				1	1	2	1	2	3
61-72	6				1	1	2	2	2	4
73-84	7				1	2	3	2	2	4
85-96	8				1	2	3	2	3	5
97-108	9				2	2	4	2	3	5
109-120	10				2	2	4	2	4	6
121-132	11				2	2	4	3	4	7
133-144	12				2	3	5	3	4	7
145-156	13				2	3	5	3	5	8
157-168	14				2	4	6	3	5	8
169-180	15				2	4	6	4	5	9
181-192	16				2	4	6	4	6	10
193-204	17				3	4	7	4	6	10
205-216	18				3	4	7	4	7	11
217-228	19				3	5	8	4	7	11
229-240	20				3	5	8	5	7	12
241-252	21				3	5	8	5	8	13
253-264	22				4	5	9	5	8	13
265-276	23				4	5	9	6	8	14
277-288	24				4	6	10	6	8	14
289-300	25				4	6	10	6	9	15
301-312	26				4	7	11	6	9	15
313-324	27				4	7	11	6	10	16

Shift Distribution: 60% AMS
40% Nights

Staffing Ratio: 40% RN
60% NRN

PSYCHIATRIC

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
325-336	28				4	7	11	7	10	17
337-348	29				5	7	12	7	10	17
349-360	30				5	7	12	7	11	18
361-372	31				5	7	12	8	11	19
373-384	32				5	8	13	8	11	19
385-396	33				5	8	13	8	12	20
397-408	34				6	8	14	8	12	20
409-420	35				6	8	14	8	13	21
421-432	36				6	8	14	9	13	22
433-444	37				6	9	15	9	13	22
445-456	38				6	9	15	9	14	23
457-468	39				6	10	16	9	14	23
469-480	40				6	10	16	10	14	24
481-492	41				7	10	17	10	14	24
493-504	42				7	10	17	10	15	25
505-516	43				7	10	17	11	15	26
517-528	44				7	11	18	11	15	26
529-540	45				7	11	18	11	16	27
541-552	46				7	11	18	11	17	28
553-564	47				8	11	19	11	17	28
565-576	48				8	11	19	12	17	29
577-588	49				8	12	20	12	17	29
589-600	50				8	12	20	12	18	30

OB-GYN

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	4				1	1	2	1	1	2
49-60	5				1	1	2	1	2	3
61-72	6				1	1	2	2	2	4
73-84	7				1	2	3	2	2	4
85-96	8				1	2	3	2	3	5
97-108	9				2	2	4	2	3	5
109-120	10				2	2	4	2	4	6
121-132	11				2	2	4	3	4	7
133-144	12				2	3	5	3	4	7
145-156	13				2	3	5	3	5	8
157-168	14				2	4	6	3	5	8
169-180	15				2	4	6	4	5	9
181-192	16				2	4	6	4	6	10
193-204	17				3	4	7	4	6	10
205-216	18				3	4	7	4	7	11
217-228	19				3	5	8	4	7	11
229-240	20				3	5	8	5	7	12
241-252	21				3	5	8	5	8	13
253-264	22				4	5	9	5	8	13
265-276	23				4	5	9	6	8	14
277-288	24				4	6	10	6	8	14
289-300	25				4	6	10	6	9	15
301-312	26				4	7	11	6	9	15
313-324	27				4	7	11	6	10	16

Shift Distribution: 60% AMS
40% Nights

Staffing Ratio: 40% RN
60% NRN

OB-GYN

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
325-336	28				4	7	11	7	10	17
337-348	29				5	7	12	7	10	17
349-360	30				5	7	12	7	11	18
361-372	31				5	7	12	8	11	19
373-384	32				5	8	13	8	11	19
385-396	33				5	8	13	8	12	20
397-408	34				6	8	14	8	12	20
409-420	35				6	8	14	8	13	21
421-432	36				6	8	14	9	13	22
433-444	37				6	9	15	9	13	22
445-456	38				6	9	15	9	14	23
457-468	39				6	10	16	9	14	23
469-480	40				6	10	16	10	14	24
481-492	41				7	10	17	10	14	24
493-504	42				7	10	17	10	15	25
505-516	43				7	10	17	11	15	26
517-528	44				7	11	18	11	15	26
529-540	45				7	11	18	11	16	27
5- 52	46				7	11	18	11	17	28
553-564	47				8	11	19	11	17	28
565-576	48				8	11	19	12	17	29
577-588	49				8	12	20	12	17	29
589-600	50				8	12	20	12	18	30

PEDIATRICS

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	4				1	1	2	1	1	2
49-60	5				1	1	2	1	2	3
61-72	6				1	1	2	2	2	4
73-84	7				1	2	3	2	2	4
85-96	8				1	2	3	2	3	5
97-108	9				2	2	4	2	3	5
109-120	10				2	2	4	2	4	6
121-132	11				2	2	4	3	4	7
133-144	12				2	3	5	3	4	7
145-156	13				2	3	5	3	5	8
157-168	14				2	4	6	3	5	8
169-180	15				2	4	6	4	5	9
181-192	16				2	4	6	4	6	10
193-204	17				3	4	7	4	6	10
205-216	18				3	4	7	4	7	11
217-228	19				3	5	8	4	7	11
229-240	20				3	5	8	5	7	12
241-252	21				3	5	8	5	8	13
253-264	22				4	5	9	5	8	13
265-276	23				4	5	9	6	8	14
277-288	24				4	6	10	6	8	14
289-300	25				4	6	10	6	9	15
301-312	26				4	7	11	6	9	15
313-324	27				4	7	11	6	10	16

Shift Distribution: 60% AMS
40% Nights

Staffing Ratio: 40% RN
60% NRN

PEDIATRICS

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
325-336	28				4	7	11	7	10	17
337-348	29				5	7	12	7	10	17
349-360	30				5	7	12	7	11	18
361-372	31				5	7	12	8	11	19
373-384	32				5	8	13	8	11	19
385-396	33				5	8	13	8	12	20
397-408	34				6	8	14	8	12	20
409-420	35				6	8	14	8	13	21
421-432	36				6	8	14	9	13	22
433-444	37				6	9	15	9	13	22
445-456	38				6	9	15	9	14	23
457-468	39				6	10	16	9	14	23
469-480	40				6	10	16	10	14	24
481-492	41				7	10	17	10	14	24
493-504	42				7	10	17	10	15	25
505-516	43				7	10	17	11	15	26
517-528	44				7	11	18	11	15	26
529-540	45				7	11	18	11	16	27
541-552	46				7	11	18	11	17	28
553-564	47				8	11	19	11	17	28
565-576	48				8	11	19	12	17	29
577-588	49				8	12	20	12	17	29
589-600	50				8	12	20	12	18	30

NURSERY

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	4				1	1	2	1	1	2
49-60	5				1	1	2	2	1	3
61-72	6				2	1	3	2	1	3
73-84	7				2	1	3	2	2	4
85-96	8				2	2	4	2	2	4
97-108	9				2	2	4	3	2	5
109-120	10				3	2	5	3	2	5
121-132	11				3	2	5	3	3	6
133-144	12				3	3	6	3	3	6
145-156	13				3	3	6	4	3	7
157-168	14				4	3	7	4	3	7
169-180	15				4	3	7	4	4	8
181-192	16				4	4	8	4	4	8
193-204	17				4	4	8	5	4	9
205-216	18				5	4	9	5	4	9
217-228	19				5	4	9	6	4	10
229-240	20				6	4	10	6	4	10
241-252	21				6	4	10	6	5	11
253-264	22				6	5	11	6	5	11
265-276	23				6	5	11	7	5	12
277-288	24				7	5	12	7	5	12
289-300	25				7	5	12	7	6	13
301-312	26				7	6	13	7	6	13
313-324	27				7	6	13	8	6	14

NURSERY

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
325-336	28				8	6	14	8	6	14
337-348	29				8	6	14	8	7	15
349-360	30				8	7	15	8	7	15
361-372	31				8	7	15	9	7	16
373-384	32				9	7	16	9	7	16
385-396	33				9	7	16	10	7	17
397-408	34				10	7	17	10	7	17
409-420	35				10	7	17	10	8	18
421-432	36				10	8	18	10	8	18
433-444	37				10	8	18	11	8	19
445-456	38				11	8	19	11	8	19
457-468	39				11	8	19	11	9	20
469-480	40				11	9	20	11	9	20
481-492	41				11	9	20	12	9	21
493-504	42				12	9	21	12	9	21
505-516	43				12	9	21	12	10	22
517-528	44				12	10	22	12	10	22
529-540	45				12	10	22	13	10	23
541-552	46				13	10	23	13	10	23
553-564	47				13	10	23	13	11	24
565-576	48				13	11	24	13	11	24
577-588	49				13	11	24	14	11	25
589-600	50				14	11	25	14	11	25

CRITICAL CARE

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
0-48	4				1	1	2	1	1	2
49-60	5				1	1	2	2	1	3
61-72	6				2	1	3	2	1	3
73-84	7				2	1	3	2	2	4
85-96	8				2	2	4	2	2	4
97-108	9				2	2	4	3	2	5
109-120	10				3	2	5	3	2	5
121-132	11				3	2	5	4	2	6
133-144	12				4	2	6	4	2	6
145-156	13				4	2	6	4	3	7
157-168	14				4	3	7	4	3	7
169-180	15				4	3	7	5	3	8
181-192	16				5	3	8	5	3	8
193-204	17				5	3	8	5	4	9
205-216	18				5	4	9	5	4	9
217-228	19				5	4	9	6	4	10
229-240	20				6	4	10	6	4	10
241-252	21				6	4	10	7	4	11
253-264	22				7	4	11	7	4	11
265-276	23				7	4	11	7	5	12
277-288	24				7	5	12	7	5	12
289-300	25				7	5	12	8	5	13
301-312	26				8	5	13	8	5	13
313-324	27				8	5	13	8	6	14

CRITICAL CARE

PERSONNEL REQUIREMENTS CHART
12 Hour Shift

TOTAL HOURS	TOTAL 24 HOUR STAFF	EVENINGS			NIGHTS			DAYS		
		RN	NRN	Total	RN	NRN	Total	RN	NRN	Total
325-336	28				8	6	14	8	6	14
337-348	29				8	6	14	9	6	15
349-360	30				9	6	15	9	6	15
361-372	31				9	6	15	10	6	16
373-384	32				10	6	16	10	6	16
385-396	33				10	6	16	10	7	17
397-408	34				10	7	17	10	7	17
409-420	35				10	7	17	11	7	18
421-432	36				11	7	18	11	7	18
433-444	37				11	7	18	11	8	19
445-456	38				11	8	19	11	8	19
457-468	39				11	8	19	12	8	20
469-480	40				12	8	20	12	8	20
481-492	41				12	8	20	13	8	21
493-504	42				13	8	21	13	8	21
505-516	43				13	8	21	13	9	22
517-528	44				13	9	22	13	9	22
529-540	45				13	9	22	14	9	23
541-552	46				14	9	23	14	9	23
553-564	47				14	9	23	14	10	24
565-576	48				14	10	24	14	10	24
577-588	49				14	10	24	15	10	25
589-600	50				15	10	25	15	10	25

PERSONNEL REQUIREMENTS CHART

Light Care

TOTAL HOURS	TOTAL 24 HOUR STAFF	PM		NIGHT		AM	
		RN	PARA	RN	PARA	RN	PARA
0- 72	5	.5	1	.5	1	1	1
73-100	6	1	1	1	1	1	1

APPENDIX E

RANDOM NUMBERS TABLE

USE OF THE RANDOM NUMBERS TABLE

The term "random" means that every patient in each category has an equal chance of being selected for the reliability testing procedure. Use of a random numbers table will facilitate the randomization process. A random numbers table is set up by using the numbers 0 to 9 in such a way that each number is equally likely to follow any other. Going in any direction from any point on the table produces a random sequence.

PROCEDURE FOR USE

1. Assign the patients on the ward/unit a number. For example, if you have twenty (20) patients, assign each a number, 1 through 20 as follows:

1. Mr. A	11. Mr. K
2. Mr. B	12. Mr. L
3. Ms. C	13. Ms. M
4. Ms. D	14. Mr. N
5. Mr. E	15. Mr. O
6. Mr. F	16. Ms. P
7. Ms. G	17. Mr. Q
8. Mr. H	18. Ms. R
9. Mr. I	19. Mr. S
10. Ms. J	20. Mr. T

2. Determine the sample size you will need for the test. This will be 25% of the patients on the ward/unit or five patients, whichever is greater. For example, let's say that today on your unit you have 20 patients. Twenty-five (25%) of 20 is 5 therefore you would classify 5 patients. NOTE: Always round up to the nearest whole number.

3. To select which 5 patients will be in the sample, go to the random numbers table and select a starting point. A simple procedure for selecting a starting point is to close your eyes and let your finger fall at some point on the table. Let us assume you have done this and the starting point is 52 as circled on Table 1.

4. The task is to select the first five numbers that fall between 1 and 20 (census = 20). Move from the starting point down the column looking at two-digit combinations for numbers between 1 and 20. The first number we come to between 1 and 20 is number 12, so Mr. L, the patient assigned the number 12 will be part of the sample. Continuing to move down the column, the next number we can use is 15, so Mr. O, the patient assigned the number 15 will be in the sample. Continue to move down the columns until five numbers have been selected.

5. If you are using the table correctly, the following five patients will be selected: (Obviously, the same number cannot be used twice)

12 Mr. L
15 Mr. O
02 Mr. B
05 Mr. E
06 Mr. F

Small Table of Random Digits

46	85	05	23	26	34	67	75	83	00	74	91	06	43	45
69	24	89	34	60	45	30	50	75	21	61	31	83	18	55
14	01	33	17	92	59	74	76	72	77	76	50	33	45	13
56	30	38	73	15	16	52	06	96	76	11	65	49	98	93
81	30	44	85	85	68	65	22	73	76	92	85	25	58	66
70	28	42	43	26	79	37	59	52	20	01	15	96	32	67
90	41	59	36	14	33	52	12	66	65	55	82	34	76	41
39	90	40	21	15	59	58	94	90	67	66	82	14	15	75
88	15	20	00	80	20	55	49	14	09	96	27	74	[illegible]	57
45	13	46	35	45	59	40	47	20	59	43	94	75	16	80
70	01	41	50	21	41	29	06	73	12	71	85	71	59	57
37	23	93	32	95	05	87	00	11	19	92	78	42	63	40
18	63	73	75	09	82	44	49	90	05	04	92	17	37	01
05	32	78	21	62	20	24	78	17	59	45	19	72	53	32
95	09	66	79	46	48	46	08	55	58	15	19	11	87	82
43	25	38	41	45	60	83	32	59	83	01	29	14	13	49
80	85	40	92	79	43	52	90	63	18	38	38	47	47	61
80	08	87	70	74	88	72	25	67	36	66	16	44	94	31
80	89	01	80	02	94	81	33	19	00	54	15	58	34	35
93	12	81	84	64	74	45	79	05	61	72	84	81	18	34
82	47	42	55	93	48	54	53	52	47	18	61	91	36	74
53	34	24	42	76	75	12	21	17	24	74	62	77	37	07
82	64	12	28	20	92	90	41	31	41	32	39	21	97	63
13	57	41	72	00	69	90	26	37	42	78	46	42	25	01
29	59	38	86	27	94	97	21	15	98	62	09	53	67	87
86	88	75	50	87	19	15	20	00	23	12	30	28	07	83
44	98	91	68	22	36	02	40	08	67	76	37	84	16	05
93	39	94	55	47	94	45	87	42	84	05	04	14	98	07
52	16	29	02	86	54	15	83	42	43	46	97	83	54	82
04	73	72	10	31	75	05	19	30	29	47	66	56	43	82

Table 1

Reprinted from Nursing Research: Principles and Methods.
J.B. Lippincott Company, Philadelphia, 1978.

APPENDIX F

STUDY GUIDE ANSWERS FOR

UNITS I-VI

INTRODUCTION TO

WORKLOAD MANAGEMENT

UNIT I

STUDY GUIDE ANSWERS

A. The Workload Management System is a process which begins with the classification of patients into categories of care. From these categories, nursing hour requirements and provider mix are determined. If staffing requirements differ from available staffing, adjustments are made to insure the delivery of quality of care.

B. Critical Indicators are those activities that have the greatest impact or requirement on nursing care time. They include ten areas of care. Four examples would include:

1. monitoring
2. feeding
3. treatments/procedures/medications
4. IV therapy.

C. The Workload Management System impacts on Navy-wide and hospital-wide planning and affects patient care quality ultimately by:

1. justifying budgets
2. providing guidelines for allocating staff
3. providing a mechanism for audit.

WORKLOAD MANAGEMENT SYSTEM

PATIENT CLASSIFICATION

UNIT II

STUDY GUIDE ANSWERS

A. Three forms for classifying patients include:

- Patient Classification Worksheet
- Critical Indicator Worksheet
- Guidelines for Using Critical Indicators

B. 1200-1400

C. Category V

WORKLOAD MANAGEMENT SYSTEM

STAFFING METHODOLOGY

UNIT III

STUDY GUIDE ANSWERS

A. The six Nursing Care Hour Requirement Charts identify time to care for patients on six specialty nursing units:

Medical/Surgical	Pediatric
Psychiatric	Nursery
OB/GYN	Critical Care

A different percentage of direct to indirect care time has been calculated for each patient on each specialty unit.

B. The Personnel Requirements Chargs identify staff distributions for each specialty area. This distribution is based on provider mix, (i.e., RN's to non-RN's) and the percentage of providers assigned to each shift.

C. The Monthly Staffing Summary will display trends in the workload (required staffing) and indicate how available staff have been distributed across nursing units.

D. This information can be helpful to supervisors in developing staffing policies and schedules which meet workload requirements.

WORKLOAD MANAGEMENT SYSTEM

RELIABILITY TESTING

UNIT IV

STUDY GUIDE ANSWERS

A. Three purposes for reliability testing:

- measures percentage of agreement among nurse classifiers
- identifies the need for updating classification skills and/or classification categories
- insures that nursing personnel use the process as intended

B. Acceptable percentage of agreement = 80%

C. 25% of each category using an acceptable random sample, or a minimum of five patients, whichever is greater.

WORKLOAD MANAGEMENT SYSTEM

PATIENT CLASSIFICATION FOR PSYCHIATRY

UNIT VI

STUDY GUIDE ANSWERS

A. Three forms for classifying patients include:

- o Patient Classification Worksheet
- o Critical Indicator Worksheet
- o Guidelines for Using Critical Indicators

B. 1200-1400

C. Category V

(Same answers as in Unit II)

GENERAL INDEX

GENERAL INDEX

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