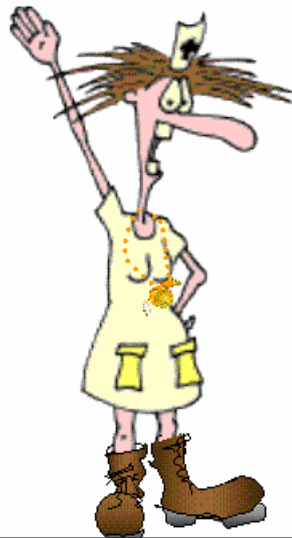


The Nurse Manager Boot Camp E-zine...

Volume 2 # 4

Forecasting Workload

Editor: Leah Curtin, RN, FAAN



CHAT SCHEDULE (1 hour chats)

March 26, 2007 Adjusting for an Aging Workforce
3:00 - 4:00 PM EDT

April 23, 2007 Valuing Employees
3:00 - 4:00 PM EDT

May 14, 2007 Spirit-Based Leadership
3:00 - 4:00 PM EDT

June 11, 2007 Safe Staffing Saves Lives
3:00 - 4:00 PM EDT

A Positive Outlook Improves Memory

The effect of a grateful outlook on psychological and physical well-being was examined. In Studies 1 and 2, participants were randomly assigned to 1 of 3 experimental conditions (hassles, gratitude listing, and either neutral life events or social comparison); they then kept weekly (Study 1) or daily (Study 2) records of their moods, coping behaviors, health behaviors, physical symptoms, and overall life appraisals. In a 3rd study, persons with neuromuscular disease were randomly assigned to either the gratitude condition or to a control condition. The gratitude-outlook groups exhibited heightened well-being across several, though not all, of the outcome measures across the 3 studies, relative to the comparison groups. The effect on positive affect appeared to be the most robust finding. Results suggest that a conscious focus on blessings may have emotional and interpersonal benefits.

Source: Emmons R.A and McCullough M.E., "Counting blessings versus burdens: an experimental investigation of gratitude and subjective well-being in daily life," *Journal of Personality Social Psychology*;84(2):377-389. February 2003

The cornerstone to effective forecasting is predicting workload demand, which is driven by patient care needs. Largely, predicting patient care needs is based upon past experience and good historical data. When preparing an annual budget most managers begin with workload volume data from the previous year and then adjust projections based upon anticipated changes. In preparing the annual budget, managers should have, at a minimum, the following data available:

- Workload volumes by year and month
- Workload volumes by day of week, including midnight census, outpatients or short stay patients, and admissions
- Most frequently occurring workload volumes (mathematical mode),
- Ranges of patient acuity from low needs to high needs
- Desired or legislated patient to RN ratios, Associated skill mix for the anticipated volume and needs, and
- Time of day for admissions and discharges.

These data provide the basic information to develop a clear picture of past patterns. Then the crystal ball work comes into play. What events might increase, decrease or alter the past patterns? For example, census could be anticipated if the community is growing, new physicians have joined the staff, or a local hospital has discontinued a similar service. In addition, high nurse turnover decreases efficiency and usually requires more staff hours.

Evaluating the most frequently occurring workload volume or mathematical mode helps to anchor your decision making to the most realistic range in your workload volume that occurs between the minimum and maximum volumes (e.g., census, patient days, procedures *etc*). In addition, each organization should have a mechanism to determine the skill mix of caregivers matched to patient care demand. Valid and reliable patient acuity information further refines workload predictions. For example, if patient volume is expected to remain the same, but patient acuity is anticipated to increase, both staffing hours of care and skill mix will need to be adjusted.

Be sure to include in your annual budget the unit's historic productive/indirect time defined as paid, worked time but not directly with patients (e.g., orientation, education, mandatory meetings).

Non-Productive Time: Nonproductive time (defined as paid, NON-worked) should also be included in your annual budget. Non-productive time includes everything in the organization's benefit package such as PTO or vacations, sick hours, holidays, leave of absences, and all other planned or unexpected absences. Typically, nonproductive time is 12 -15% of productive (worked) time. To give an example, for a unit with an anticipated ADC of 30, HPPD of 7.0, and nonproductive time of 12% the calculation would be: $30 \text{ patients} \times 7.0 \text{ HPPD} \times 365 \text{ (days/year)} / 2080 \text{ (1 FTE)} \times 0.12 = \text{Total FTE's}$. Remember to include people on disability, FMLA, or other leaves of absence, as these individuals are being charged to your unit even though they are not available to provide patient care. FTE's and their monthly staff schedules. In preparing for the monthly schedule key questions should be considered. For example, Will a key physician be out of town? In some hospitals we have seen the start of hunting season virtually eliminate elective surgery cases for a week-dramatically reducing both the OR case load and inpatient census. Prior to posting your schedule, always compare your planned workload volumes by skill-mix to the budget. You should try to achieve a 90% match between the anticipated workload and budgeted staffing. This may require scheduling different numbers of staff on different days of the week to match anticipated workload.

Next Shift Staffing: Staffing is an incredibly complex process which is requiring more comprehensive considerations than ever before. Legislation or regulation in some states requires organizations to have staffing systems that provide information to project staffing needs beyond the immediate shift. Erroneously, some managers believe that the information from the current shift should be sufficient to predict the staffing needs for the next shift. Seldom does one mathematical formulation of past staffing create an accurate staffing level for the next shift.

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Generally it is not possible to predict the exact number of admissions, number of patient/family crisis, or clinical emergencies. The science of workload estimation requires nurses to use multiple data points to achieve a higher degree of accuracy. In addition to using the historical trend data, effective staffing requires building in plans for responding to sudden or unanticipated changes in workload demand. Thus, the following elements are necessary to project staffing for the next shift:

- Current shift hours of care/skill mix,
- Previous similar shift hours of care / skill mix,
- Actual and projected next shift census,
- Target patient / RN ratios,
- Scheduled caregiver's skill and experience. *Carol Ann Cavouras, RN, MS*

Long Stay Review Meeting Focuses Attention on LOS

Most organizations have mastered the skill of managing length of stay. Nationwide, average lengths of stay have fallen and most have remained low, even for Medicare patients. However, almost all facilities have a small percentage of patients who experience extraordinarily long (by today's standards) length of stay. These patients generate concerns in both clinical and financial arenas, and require focused strategies to address them. One such strategy is the long stay review meeting -- a regular, structured, interdisciplinary meeting that focuses on patients whose length of stay exceeds a trigger point.

The purposes of the meeting are: 1) to identify and maintain an awareness of those patients in the target group on a concurrent basis, 2) to identify factors that contribute to their ongoing stay, and 3) to focus the resources on those factors. One major outcome of the meeting is triaging problems to appropriate staff members. The meetings are held weekly so that new patients are identified expeditiously and follow up on patient problems discussed in previous meetings can be tracked. This helps make the long stay review meetings short and focused because the primary activity is triaging issues to staff for between meeting resolution. Over time, these meetings allow the organization to categorize trends and issues for more system-wide solutions, particularly if representatives from the executive team regularly participate in them.

The first steps toward initiating such meetings is to determine the trigger point for inclusion in the 'long stay group.' And the length of stay cut off point will be lowered over time as the effects of the meeting are felt. For example, one organization had as its initial trigger point 12 days or more gradually lowered to 7 days. The second step is to establish a baseline number of patients within a variety of length of stay categories. Categories might include 7-10 days, 10-15 days, and so on. The goal is to consistently demonstrate a shift towards the lower stay categories. Then, of course, membership must be determined. This usually includes case managers, social workers, physicians and administrators. It is useful to include the Vice-President of Medical Affairs (or an equivalent) as the physician member. The financial and/or clinical Vice-Presidents are great representatives for administration. Ideally, the meeting will be chaired by a Director of Case Management.

The agenda usually begins with a review of patients discussed in previous meetings to determine progress in addressing identified issues. Recurring questions at this stage include: 1) 'What is the plan?' 2) 'What are the impediments to it?' 'Who should focus on the issues?' 'Who needs to contact another team member for assistance?' The chair or other member keeps notes of the plan as well as the staff designated for follow through. The next agenda item is to identify new patients to be discussed by the team. New patients are discussed, again identifying staff accountable for follow through. Everyone leaves with clear assignments and accountability for the next meeting.

It is useful for the chair to review identified issues for trends and opportunities for team discussion and revision or addition. This enables problem solving at a higher, system wide level and begins to move towards prevention and even earlier detection. Long stay review meetings are key to effective and efficient management of patients.

Kathy Bower, RN, PhD, FAAN, Center for Case Management

A Bit of Wisdom from "What the Books Don't Tell You..."

