

Vermont Psychiatric Care Hospital
A Review of Nurse Staffing

Confidential: Peer-Review Report

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Executive Summary

This report was commissioned to examine issues at Vermont Psychiatric Care Hospital (VPCH) related to nurse recruitment and retention; staffing and scheduling; graduate nursing and training issues. VPCH has been through many changes in the past few years. The original state hospital was closed because of a flood, and this tragedy forced relocation of patients and staff. A decision was made at the department level to redistribute beds throughout the state and build a new Vermont Psychiatric Care Hospital in Berlin. While under construction and in the interim staff and 8 patients were relocated to a temporary facility in Morrisville. In the new facility VPCH, there are 2 units, each unit has 2 wings. Unit 1 consists of two separate wings, one with 5 beds and one with 4 beds. Unit 2 consists of 2 wings, each with a capacity of 8.

Although the new VPCH building is contemporary and spacious, the design is of small distinct units which virtually provide little added efficiency as it relates to staffing. Both units do have a door between back- to-back nurse's stations which can provide some opportunity for back up coverage, assuming the door is not a fire rated door which then would need to be closed at all times.

Attracting and retaining permanent staff at VPCH has been an ongoing challenge since the facility relocated to the new hospital. Recruitment initiatives have been significant but, the state has had to resort to the extended use of traveling nurses. This has been an expensive endeavor and serves as an obstacle for the state as they attempt to move forward and have in place a trauma informed, person centered model of care. Despite this fact, progress has been made toward this end. With the temporary staff in place the hospital has still demonstrated advances in restraint and seclusion reduction and a significant lowering of one-to-one staffing needs.

Voluntary and mandatory overtime (VOT & MOT) had historically been used for staffing emergencies however, at the present time, due to vacancies and some special observations both have been used. It is because of some unresolved issues and a previous consultant's recommendation to revisit staffing after the new hospital was opened for one year that the state of Vermont decided to reach out for additional consultation to assist in review of these issues.

Recommendations for Sustainable Staffing Plan

Staff-to-patient ratios have long been utilized to create staffing plans at the organizational level. The productivity of nursing staff has historically been measured in nursing hours per patient day or HPPD. HPPD is not a reliable formula for forecasting staffing needs primarily because it does not account for important factors such as staff mix, staff competence, mix of overtime versus regular hours, and fluctuations in the census. HPPD can be used as a measure to reflect the average staffing mix across a 24-hour period so; its value may be as a measure for benchmarking numbers of staff used in a 24 hour period.

There is no national standard for staffing any type of hospital, behavioral health or, medical –surgical units. Any research that has been conducted has mostly been in general hospitals and more specifically in specialty units such as ICU type units where acuity is extremely high. Today, even in medical surgical units or high risk specialty units; there is still no standard staffing or definitive formula for staffing a hospital or unit.

The American Psychiatric Nurse Association (APNA), in 2011 attempted to fill this void and developed a position paper for staffing inpatient psychiatric facilities. Several variables were identified for consideration when developing staffing patterns such as patient acuity, staff skill mix, multi-morbidity factors, transfers, admissions, discharges, type of care delivery model and, physical work environment. APNA recommends all of those factors be considered when developing staffing plans and, there is broad consensus that this methodology will yield best results.

In the broader staffing context, nurse availability levels are affected by a range of peripheral issues that no one institution or community has control over. These factors include variables such as recurring nurse shortages, nursing school limitations due to numbers of available faculty, politics and immigration, increasing complexities in patient needs, newer career tracks and technology and, wide-ranging and increased competition for nurses. Additionally, looking forward, the once projected shortage of nurses has been reconsidered and increased from 250,000 to 500,000 by 2020 as an unintended consequence of the Affordable Care Act.

Several states have adopted legislation and/or regulations addressing nurse staffing. Some of these initiatives include developing joint committees for staffing, mandatory staffing ratios, public reporting of staffing levels and evidence-based nurse staffing plans. The American Nurse Association (ANA) is working with state groups to promote legislation “Safe Staffing Saves Lives” which supports minimum nurse staffing ratios. Many are not in favor of mandated nurse-patient ratios and studies that have been conducted in states where this is in effect have not demonstrated statistically significant changes in patient safety and quality outcomes. Those same professional nursing organizations have reached consensus that when developing staffing plans the following criteria should be used.

- Establish adjustable minimum numbers of RNs;
- Include input from direct care RNs or their exclusive representatives;
- Be based upon census and acuity;
- Take into account the level of training and competency;
- Take into account staff mix;
- Consider staffing levels recommended by specialty nursing organizations, if applicable;
- Take into account outcomes from nurse-sensitive indicators and benchmark with national data;
- Take into account unit geography and available technology;
- Take into account nurse satisfaction surveys and turnover data and;
- Ensure that RNs are not forced to work in units where they are not trained or experienced to work on.

Vermont's Current Staffing Plan

According to the Assistant Director of Nursing (ADON), the monthly schedule is developed based on the approved minimum staffing.

Current Minimum Staffing Requirements as documented on the monthly schedule					
Days 7-3	Staff	Evening 3-11	Staff	Nights 11-7	Staff
Supervisor	1	Supervisor	1	Supervisor	1
Charge Nurse	2	Charge Nurse	2	Charge Nurse	2
RN	5	RN	4	RN	3
MHS	19	MHS	18	MHS	14
Total Number	27	Total	25	Total	20
	1:1.08		1: 1		1: .8

There are no national standards for staffing in behavioral health or medical –surgical nursing. Each hospital assesses their needs and develops their staffing plan. Generally speaking, state hospital systems staff higher than private hospital systems. Common staffing ratios are seen with approximately 1 staff to 4-6 patients on days and evening

shifts and 1 staff to 8 patients at night. There are many variations on the ratios depending on patient acuity; staff mix; training and competence; routine or overtime workers. Forensic patients are generally staffed a little higher or are augmented with security staff. There is no one answer or cookie cutter method of staffing and as such one staffing ratio in one hospital can't be generalized and used at the next hospital.

As stated above, staffing effectiveness is generally measured by nurse sensitive indicators such as patient incidents such as:

- Emergency Involuntary Procedures in 2015 have reduced from a high of 37 per month to a low of approximately 7 per month with a short spike in July of 20 but coming right back to 7-8, this is very good work.
- The 1:1 coverage has declined significantly and seems to be managed on an ongoing basis which is excellent.

Vermont built a beautiful hospital for 25 of their citizens maximizing space and privacy with private rooms and baths in a contemporary designed structure. While the hospital is aesthetically pleasing, the physical layout with small individual units creates a staff intensive setting. The financial benefits gained through efficiencies in a newly constructed building could be minimized by higher staffing needs in compartmentalized units.

The building consists of 2 units with 2 wings. Both units have a door between them, opening into the nursing stations. Unit 1 has wing C with 5 beds and wing D with 4 beds; a total of 9 beds. Unit 2 has wing A and wing B, each with 8 beds and a total of 16. The entire hospital includes 25 beds total

VPCH's population housed in this structure is generally comprised of 60 % civil and 40% forensic patients. There is no segregation of forensic patients, they co-exist with the civil population.

The grid below portrays the distribution of Mental Health Service (MHS) staff to patients using the current authorized minimum staff. This distribution is an only an example of MHS staff to patient ratio based on bed capacity developed for the purpose of demonstrating potential MHS to patient ratio. Any configuration of unit assignment can be used for this example.

Unit 1			Unit 2		
C (5)		D (4)	A (8)		B (8)
Days	3 staff =	3 staff =	D	6 staff =	7 staff =

19 MHS	1 pt. to .6 staff	1 pt. to .75 staff		1 pt to .75 staff	1 pt to .875 staff
E 18 MHS	3 staff = 1 pt to .6 staff	3 staff = 1pt to .75 staff	E	6 staff = 1 pt to .5 staff	6 staff = 1 pt to .5 staff
N 14 MHS	2 staff = 1 pt to .4 staff	2 staff = 1 pt to .5 staff	N	5 staff = 1 pt to .625 staff	5 staff = 1 pt to .625 staff

This grid below includes authorized nursing staff and MHS staff per bed capacity minus supervisor because they are not assigned to a unit.

Unit 1		Unit 2					
C (5)		D (4)		A (8)		B (8)	
Days 26 staff	5=1:1	4=1:1	D	8=1:1	8=1:1	8=1:1	8=1:1
E 24 staff	4=.8:1	4=1:1	E	8=1:1	8=1:1	8=1:1	8=1:1
N 19 staff	2=.4:1	2= .5:1	N	7=.875:1	8=1:1	8=1:1	8=1:1

Despite the abundance of staff depicted in grids above, there was continued use of OT during the period from 8/1/15- 10/31/15, excluding travel nurses overtime there 4136.75 hours of overtime. This was used to cover planned and unplanned absences and 1:1 and 2:1s.

Primary Nursing Model

The organization of care delivery is determined by a variety of factors such as economic issues, leadership beliefs, and the ability to recruit and retain staff. Ideally, evidence of the effect of care models on quality and patient safety should be the major factor in this type of decision making (Jennings, 2012).

Historically, four traditional care models have dominated the organization of inpatient nursing care. Functional and team nursing are task-oriented and use a mix of nursing personnel; total patient care and primary nursing are patient-oriented and rely on registered nurses (RNs) to deliver care. In the late 1980s, a number of nontraditional

nursing care delivery models emerged that use various mixes of licensed and unlicensed nursing personnel.

Despite the interest in a variety of care models, it is difficult to discern which models work best. Neither the traditional nor the nontraditional inpatient nursing care models have been evaluated rigorously for their effects on patient safety. When considering a type of nursing model, many factors need to be thought through and sometimes reality drives the decisions. Currently, on paper, VPCH is staffed for two models; Team and Primary Nursing. Although the DON believes additional nursing positions are required to follow a primary nursing model, it seems apparent one discussion has not occurred as of yet; what are the plans for all of the MHS's. In a unionized environment it would probably not be considered favorable to eliminate most of the MHS positions. Primary Nursing generally includes staffing with primarily nurses. Before a true Primary Nursing model is pursued, it appears these basic questions related to current staff mix and the availability of Registered Nurses need to have further consideration. So, for the purpose of this consultation, let us assume a multidisciplinary team-based model of trauma informed, person centered care will be followed. Primary Nursing, when possible, is an excellent model of care but cannot be considered from a safety perspective where recruitment and retention is a daily struggle.

That said, there is no absolute staffing number and no one schedule can suffice for another hospital. All factors listed earlier should be considered. Any number of altered staffing patterns could be considered for VPCH. Example a 1:4 staff to patient ratio could provide a sufficient staffing and yet an improvement from where the hospital is now. That staffing ratio would be consistent with hospitals that staff with a higher ratio than others.

It is infrequent to see more than 1 RN or charge nurse for 4 - 5 patients. Even with eight patients it is difficult to rationalize that 2 nurses would be so busy on the day shift regardless of medication administration, MD orders, treatment planning and programs.

In review of the current staff to patient ratio, it would be reasonable to state that the population in total does not require one to one staffing. Staffing should be safe and have reasonableness as a factor in the overall analysis of need. The units are small and as such, if staff are trained appropriately, they should feel confident in their roles on the units. If this is not the case, leadership should drill down and find out what is required to bring staff to the level of competence necessary for staff to feel comfortable in their interactions with clients and duties on the unit. The ratio of forensic patients at VPCH is generally at about 40 % of the general population. They are not centralized but are distributed throughout the hospitals units.

Although there are no absolute staffing models, based on patient mix, consultation in many like-kind facilities and professional experience, the following staff configurations are offered for consideration:

Proposed Staffing for Consideration				
Census of 4		Census of 5	Census of 8	Census of 8
D RN	1	1	1	1
MHS	2	3	5	5
E RN	1	1	1	1
MHS	2	3	5	5
N RN	1**	1**	1	1
MHS	2	2	3	3

**** Explanation below**

One RN in Charge should be on every unit, every shift with the possible exception of one unit on nights. This can't be determined by consultant and requires thoughtful consideration of VPCH leadership team. If the adjoining door between the wings of unit 1 with 4 and 5 patients is not a fire rated door, and in no circumstance would create a life- safety issue, and if the door can be kept open and is not designed to remain closed, then a consideration could be given to have one RN in charge for both sides on the night shift only.

The term charge nurse refers to nurses with the appropriate skills to be in charge. All RNs except new graduate nurses who are not licensed should be able to be in charge. Once licensed and trained, a new nurse with the appropriate support and mentorship should be able to take charge. RN supervisors shall be available every shift seven days a week. The above proposed staffing plan reduces staffing needs by 11 MHS staff and 5 RNs.

One additional consideration involves the use of a new position, referred to in this report as therapeutic security technicians (TSTs). These are essentially MHS type staff with additional security training whose role is that of security that continuously rove through the buildings and units. They are not MHS staff and should not generally be used in that capacity but, have the knowledge and skills of an MHS and may also provide some level of career ladder. These individuals wear a different type of uniform so will easily be recognized by staff and patients. They can be called by radio is patients are escalating, should be available in corridors when patients are being transported and should be available for all codes. A compliment of 2-3 on day and evening shifts could be considered and 2 on nights. This new position would further bolster staffing and provide a sense of safety for staff.

Additional Factors for Consideration

The State of Vermont offers generous benefits and staff routinely take their allotted time off. Additionally, according to the ADON, there has not been full enforcement of the

Time and Attendance policy. This adds to the problem with staffing. According to the ADON, nursing leadership has not consistently held staff accountable for time and attendance infractions. Progressive disciplinary action should be applied in a fair and consistent manner across all departments. Staff believes little consequence will occur from their unexcused absences. A review of the absenteeism data should be studied to determine what type of patterns of days off staff take and how many staff may be misusing the system. Aside from accrued time off, staffs are also off on short term disability, workers compensation and family medical leave (FMLA). A review the latest version of Time and Attendance policy was conducted and it could be strengthened.

One recommendation regarding absenteeism is to identify an executive leadership team member who could meet weekly with nursing leadership and human resources to review the time and attendance policy infractions and agree upon next steps in the progressive disciplinary actions. This of course should occur only after the executive team has committed to inform all hospital staff of the position they will take regarding time and attendance staff accountability. A sample Time and Attendance policy is attached for review and consideration. It could be used as a resource to further modify the current proposed policy. It is understood that all OT is not just because of absenteeism, this also includes workers compensation, family medical leave, 1:1 or 2:1 observations.

Special Observation

Special observation status is necessary to ensure that all clients are treated in the least restrictive environment while ensuring that all clients are protected from behaviors that may be harmful to themselves and/or others. The use of special precautions shall be utilized for situations that have been identified with adequate and appropriate clinical justification, based on the client's assessed needs and, when less restrictive alternatives have been considered and used.

Adding special precautions to a client's treatment regimen is indicative of a change in their level of need, essentially, a change in condition. It is most often used for suicidal or aggressive behavior. Direct observation and or a one-to-one precaution status is the highest level care available in the psychiatric setting. The use of special precautions should only be used for short periods and only when medical necessity criteria exist. Generally speaking, too often prescribers address the medical necessity criteria when the order is written but does not routinely, or on a 24 hour basis, re-examine the need to continue the precaution. Special precautions can be quite burdensome on nurse staffing. In the case of VPCH, there was a time in 2015 when the hours of staff time used in 1:1 coverage was quite high however, there has been a significant decrease and is evidence of a successful effort by leadership to contain this process.

If necessary, consideration should be given to developing a utilization review process to determine what the team is doing to get the client off precautions and whether medical necessity is evident. Another suggestion includes requiring a consultation by the

medical director if this level of care continues beyond a set number of days or, it could trigger a peer review.

The use of restraint and seclusion in this facility is another example of a successful initiative by leadership and direct care staff. Although not at zero usage, which may never occur, staff have made considerable effort in the reduction of restraints and seclusion. The majority of events are physical holds, not mechanical restraints.

Recruitment and Retention

According to Hertel (2013) the work environment is a major part of the day-to-day tedium that effects retention (or turnover) of RNs. In hospitals, many issues influence nurses decisions like staff relationship, patient population, safety, nurse-to-patient ratio and unit layout. Many nurse leaders have had the experience of seeing a shift or a unit becomes unhinged when one key staff member leaves the department. In no time, such a departure can produce a mass exodus within a formerly solid work group.

For years the quality of the nursing practice environment has been associated with nurse recruitment, retention and quality patient outcomes (Aiken, Clarke, Sloane, Lake, & Cheney, 2008). Shaping nursing practice environments to promote desired outcomes requires valid and reliable measures to assess practice environments prior to, during, and following efforts to implement change. The Practice Environment Scale of the Nursing Work Index (PES-NWI),(Lake, 2002) is the most widely reported measure used to gauge the state of nursing practice environments and it is one measure recommended by several United States organizations promoting quality healthcare, such as the Healthcare Quality Forum. It is now being used internationally and is supported by the International Council of Nurses.

University of Pennsylvania, school of Nursing conducted a study using the PES- NWI. The study sample consisted of 353 psychiatric nurses from 67 hospitals (Hanrahan, Aiken, McClaine and Hanlon, 2010). The focus of the study was to determine how the work environment effected nurse retention. The findings demonstrated an important link between the skill level of the nurse leaders and psychiatric nurses' stress. Manager's skill and nursing leadership sustained the highest significance in relationship to emotional exhaustion and depersonalization. Findings suggest that skilled managers on psychiatric units are incredibly important to the well-being of psychiatric nurses. These leaders provide supervision, organization and direction for the nurses. This study also revealed a strong relationship between psychiatric nurses' experience of feeling valued and retention.

According to Lewis (2015) turnover rates for new RN's tend to be higher than with experienced RN's. According to Read and Laschinger (2015), graduate nurses surveyed reported exposure to workplace mistreatment identified as incivility and bullying. These behaviors are directly associated with lack of job satisfaction and turnover. Therefore, it is imperative that agencies who desire putting in place graduate nurses must have evidence that this form of workplace harassment is not a factor. Anecdotally, in many state hospitals exit surveys have revealed that new employees do

not feel welcomed. Often there are groups of longer term employees, bonded, do not greet new employees well. The newer employees have reported feeling like an “outsider”. Leadership staff would do well by spending time with newer employees, develop relationships of trust and attempt to tease out any perception of mistreatment by other employees in their environments.

Exit Interviews

Retention experts are emphasizing the need for effective exit interviews more than ever before. Recent statistics showing that as many as 60% of new hires are leaving prior to their first-year anniversary. There are inconsistencies in the reasons why nurses are departing so soon. For some, it is a lack of clear communication, unsatisfactory relationships with management and coworkers, or a poor work-life balance. Others report dissatisfaction with the scheduling process, believed there was an unfair distribution of the workload, or felt there was a lack of recognition from management.

Exit interviews uncover information employers can utilize to improve their operations. Departing employees may provide insight into process improvements, staff development, and even potential litigation issues. In addition, giving the departing employee the opportunity to provide feedback about their experiences allows them to leave with positive feelings, which is always beneficial.

Alternative Shifts

Consideration could be given to providing incentives to staff for excellent attendance. Offering an alternative schedule of two- twelve hour and two- eight hour shifts. This benefits both the staff and hospital. Many staff desire 3 days off and this opportunity may impress upon others the benefit of better attendance. Only staff with excellent attendance should be considered. Having a few staff work 12 hour shift provides a benefit of having an overlap of 4 hours. This is often viewed favorably by staff.

Staff Recognition

One of the greatest challenges of any recognition program is maintaining the momentum once begun, typically for these programs to start out strong and then fade away. Other priorities seem to monopolize leadership’s time. VPHC could look at the at direct services staff to take this initiative on. They can plan the events for appreciation and fund raising events to support the program. The selected team can package the program, recognize champions, and identify ways to motivate other staff to be involved. Other ideas related to staff recognition include lunch with the CEO, providing opportunities for listening, and monthly town halls for improved communication. This is a recommendation supporting staff retention; however, focused attention was not given to this particular program during the consultative visit.

Training and Orientation

Hospitals across the country are welcoming recently graduated nurses to their units and hoping to turn them into competent, confident nurses as quickly as possible. New nurses have a difficult time bridging the gap from nursing school to practice and hospitals must recognize this difficult transition if they hope to keep the nurses for the long term. Here are five strategies that help new graduates through the transition and ensure that they are engaged, long-term employees.

Orientation programs vary greatly in range from 6-12 weeks however; research evidence strongly supports nurse residency programs as a key strategy to retention of new nurses or graduates. Findings have been extremely positive with clear changes in the nurse's perceptions of their competence, ability to communicate, and satisfaction with their work. A unique and very important outcome has been the retention rates up to 95% according to the American College of Nursing Education. This is in contrast with published reports indicating turnover rates of 30% in the first year of employment with many graduate nurses. New grads hired into residency programs are full-time employees who are eased into the role of professional nurse through didactic sessions and hands-on clinical training, all under the supervision and support of trained nursing staff and educators. A few weeks into floor orientation, nurse residents return to the classroom for education on a broad array of important topics, predominantly addressing areas that are high-risk for patient safety.

Residency programs are longer than traditional orientation programs, ranging from 6 to 12 months. The success of any orientation or residency program can be measured in nurse and new graduate retention.

Key evidence-based elements of residency programs include:

- clinical coaching by a preceptor matched for compatibility with a new nurse residents
- Preceptors and nurse residents are on the same schedules as much as possible.
- evidence-based classroom curriculum with case studies and direct linkage to clinical experiences
- hands-on learning of skills in a clinical setting
- participation in a support group of other nurse residents and peers
- high visibility of nurse leaders
- Professional socialization and opportunities for development.

A frequently cited barrier to residency programs is the cost in nurses' time. Yet the cost of not retaining one new graduate can fund a large portion of a residency program. If a residency program is not feasible, hospitals can capture many elements of the residencies in a well-designed, traditional orientation.

Evidence indicates that preceptors provide incredible support when new graduates enter the workplace. The preceptor is the first nurse who invests in the graduate, planning assignments, nurturing confidence and competence, and overseeing the development of their skills and clinical judgment. Preceptors responsibly transition new

graduates into their new roles, unit processes, and workplace norms. The preceptor and graduate works together for a variable length of time from weeks to months.

Mentoring programs are also known to improve new graduate retention. Mentors differ from preceptors in that mentors invest in the new graduates for years, rather than weeks or months. Some mentoring programs do not begin until the preceptorship ends to avoid overlap between mentors and preceptors. Mentors often provide professional development advice and serve as consultants for complex patient issues and workplace challenges.

Preceptors and mentors should not only be experienced nurses but should have the ability to communicate, easily develop relationships, have a positive attitude toward nursing and, the organization.

During residencies or traditional orientations, staff development personnel should make frequent contact with graduates and new nurses and schedule structured interviews at 30, 60, and 90 days and at 6 months. The interviews provide opportunities for individualized feedback and time to identify problems leading to resignations.

There are no proscribed numbers of hours for orientation for seasoned or new nursing graduates. Special care, time and attention must be given to new graduates and also with nurses who have not been in psychiatric services. If nursing leadership is committed to success with graduate nurses it is not a matter of how long will they remain on orientation and essentially not counted in the staffing mix. It is individualized. New graduate nurses require a structured program where they receive continuous support and intermittent structured education. Graduates generally stay on an extended orientation few weeks on their shift working with a nurse to become acquainted with the flow of the day and the parameters of true responsibility and decision making. Graduates are not lingering and left out of the staff mix. Graduates are capable but require supervision and assistance with some decision making. As graduates begin to expand their role, their comfort rises but they need to be treated for what they are, graduates, right out of school. They frighten easily as they transition from student to their professional role. Throughout the orientation period a nurses' comfort, confidence and competence should be continually assessed. Graduate nurses are not licensed until they successfully pass their board examination so, technically, in a graduate status, they are working under the CNO's license.

Regardless of how the orientation or residency program is structured, graduate nurses do best and stay longer when given the tools and attention they require. If graduate nurses will be hired, strong consideration should be given to preparation and on-going support. As stated earlier, this is not a new role in nursing. Many hospitals have tried graduates but failed because they were not prepared to provide the graduate nurse what they require. There is a huge body of peer reviewed literature and evidence demonstrating the benefits reaped when graduate nurses are welcomed in and hospitals remain committed to their success.

Following a review of the current orientation program, the following recommendations are offered:

1. Staffs are required to work one week of days, evenings and nights regardless of the shift they are hired for. The actual value of this exercise is in question and it may serve to discourage a candidate as it could be disruptive to the personal life schedule. It would seem the resources could be better utilized.
2. The orientation schedule runs through three weeks with the last few days beginning their on unit orientation. The content maybe interesting to some but staff in orientation needs to learn their job and the expectations of their position. Early on in orientation risk and safety issues need to be maximized such as precautions, observing patients and the importance of that task, the value of contraband checks, how to behave when a patient is psychotic or manic or won't get out of bed. What is the role when a patient is being admitted, how to respectfully take a person's valuables from them. They need to understand what to report to nurses, what an emergency looks like, how to call a code or for help, if told to do so. How should they behave when a patient starts screaming and getting angry. Alternatives to restraints should be a priority, suicidality and what to be aware of and how to stay safe. MHS staff or nurses for that matter may not benefit initially by having one half hour on borderline personality disorder, six core strategies etc. Orientation should be considered a valuable time and, it is a limited time the important information needs to be conveyed so staff will feel safe and act accordingly. Emphasis should be on what is required for the job not what would be nice to know and could be reviewed at a later time during the ongoing education calendar.

Recommendations:

In review of the current authorized minimum staff at the VPCH, it is evident there are opportunities for staff reduction in the future. The current minimum staffing, if all staff came to work, would provide coverage higher than typically observed in many hospitals, based on this writer's experience. Clinical indicators such as patient aggression on staff; restraint; 1:1 usage; overtime and staff absenteeism must be measured consistently in order to evaluate effectiveness of the staffing pattern.

1. Consider putting in place a time and attendance policy that can be administered and adhered too.
2. It could be beneficial to conduct a review of the patient to staff injury which occurs outside of emergency interventions. While some indicators show progress such as in restraints and 1:1's it would be interesting to understand more about why these aggressive acts occur. Literature reveals that often patients act out due to frustration created by staff. This is observed in ignoring patients requests, patients feeling belittled and insignificant and in general feeling their needs are not being addressed and, this could very well not be the case. Anytime staff are injured it is imperative to understand the circumstances. Review of video footage often provided many insights.

3. Leadership is aware and concerned about safety issues and staffing is tied to safety. Leadership took the initiative to have an outside consultant review proposed staffing before moving into the new hospital. The opinion of the consultant was essentially to evaluate the effects of staffing and re-evaluate in one year following the move. Leadership has followed through and has implemented some plans and training but, formally going about establishing and/or evaluating a culture of safety may still be required.
4. Leadership is strongly encouraged to review TJC manual chapters on Leadership and Patient Safety Systems as a foundation for further progress in the development of a person-centered, staff supportive culture of safety.
5. It is understood and acknowledged that leadership and staff have embraced the philosophy for restraint reduction in “Six Core Strategies” however, over the longer-term other suggestions are offered for consideration:
 - a. Raise the “visibility” of patient and staff safety by creating a new value or launching a new PI project targeted on safety OR a Combination of the above.
 - b. Emphasize an agency “Vision” of creating a violence and injury-free environment, with Trauma Informed Care as the initial step toward having an institution exemplifying a “Highly Reliable Culture” of care.
 - c. Establish a baseline of safety culture and periodically evaluate the staff and patients perspective on safety. Could use the Agency for Healthcare Research and Quality’s (AHRQ’s) Hospital Safety Culture Survey, LD 03.01.01 (E1).
 - d. Monitor the data being collected against the priorities chosen. Measure the effects of new actions taken by data analysis. (Don’t be afraid of a lack of success in some things) LD 03.01.01 (E2)
 - e. Ensure that all staff in all departments and programs participates in some way in the evaluation of the culture, selection of priorities and actions taken to improve the culture. Include patients and families as well, LD 03.01.01 (E3).
 - f. Ensure there is a “Code of Conduct” that addresses staff behaviors that work against establishing a culture of safety. (e.g., “I won’t tell on you if you won’t tell on me.” OR a staff member whose personality is such that other staff members won’t confront him/her regarding a safety issue.) and sends a message about expectations that are re-enforced through the HR process. - LD 03.01.01 (E4)
 - g. Create a safe environment for the discussion of safety related issues. - LD 03.01.01 (E5)
 - h. Beginning with the current Trauma Informed Care education and model, evaluate the staff’s receptiveness and re-educate some staff if necessary. In lieu of, or as part of discipline, re-educate staff on safety principles.

- Develop a strategic plan for ongoing training in safety and quality. - LD 03.01.01 (E6)
- i. Create multi-disciplinary PI teams to help assess and evaluate progress. Find the natural leaders and encourage their participation. - LD 03.01.01 (E7)
 - j. Create a safe environment through use of brainstorming tools (accepting all initial ideas), re-enforcing that all ideas and thoughts are welcome.- LD 03.01.01 (E8)
 - k. Identify culture of safety literature to share or make available to staff. Make some “Required readings” for key positions and include in performance evaluations. Allow staff to search for other literature to share. LD 03.01.01 (E9)
 - l. Establish patient participation expectations for improving the culture of safety. Consider using Peer Support Workers to help solicit patient and family feedback on the culture of safety. LD 03.01.01 (E10).
 - m. Training materials such as Preparing the Adult Mental Health Workforce to Succeed in a Transformed System of Care (NASMHPD).
 - n. Consider providing resource material in High Reliability in Health Care Organizations.

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