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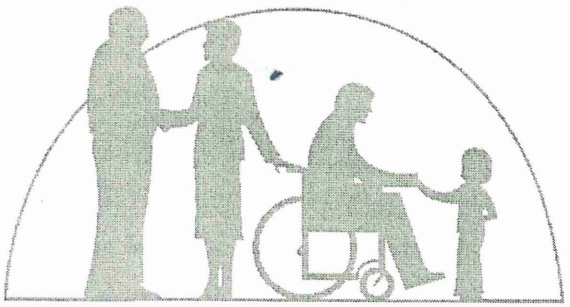

Minnesota Department of **Human Services**

1998 Legislative Report:

Mental Health Staffing Standards
for the
Regional Treatment Centers

Prepared by State-Operated Services Support

In accordance with Mn Stat 3.197 the cost of preparing this report was less than $1,000.

1997 Minn. Laws Chap. 203 Sec. 2
Subd. 7

BACKGROUND

Minnesota Laws of 1997, Chapter 203, directed the Commissioner to report staffing level standards for the regional treatment center mental health programs to the 1998 Legislature and gave the Commissioner discretion to recommend any changes in statute, rules, and appropriations needed to implement the recommendations.

PURPOSE

The purpose is to develop standards for staffing against which actual staffing levels may be compared for adequacy as the regional treatment center mental health programs evolve in the present day health care environment.

METHOD OF STUDY

Acute and Long Term Patient Staffing

Previous staffing level recommendations were reviewed against current staffing levels and population trends.

Adolescent Patient Staffing

Absent previous staffing level recommendations, data from similar programs and the American Academy of Child and Adolescent Psychiatry was collected and evaluated against the needs of the patients typically served by the Brainerd and Willmar adolescent treatment programs.

Mobile and Other Crisis Staffing; Transitional Services

No evaluation for the system was conducted. These are services determined in the regions served by the regional centers and by the local mental health planning authorities based on the unique needs of local patients, as individual crises arise.

FINDINGS

Acute and Long Term Patient Staffing

Clinical staffing standards have been systematically reviewed for the regional treatment center adult mental health programs since the early 1980's when the facility programs directors developed an evaluation process based on patient acuity measures. In 1987 the Sheppard Pratt Health System, Inc. was engaged to similarly review clinical staffing standards. The review recommended an overall staff to patient ratio of 1.24:1; at that time the regional treatment center mental health programs were staffed at 72% of the recommended standard with an overall staff to patient ratio of .9:1.

In 1989 and 1991, the Department contracted with Policy Research Associates, Inc. to conduct a clinical survey of all patients in the then six regional treatment center adult mental health programs. In 1992 and 1994 the Commissioner utilized this data base to rate patients' acuity and to group patients as in previous staffing models. The level of staff required to meet current program needs was reviewed and updated. The February, 1995 Biennial Staffing Recommendations, which also incorporated other state staffing models and professional consensus, resulted in an overall staff to patient recommended ratio of 1.20:1; at that time regional treatment center staff for mental health programs was at approximately 87% of the standard with an overall ratio of 1.06:1.

Fiscal year 1998 average staffing for the regional treatment center adult mental health programs represents an overall staff to patient ratio of 1.21:1.

RTC	FTE Staffing	Projected Average Daily Population	Overall Staff to Patient Ratios
AMRTC	271	235	1.15
BRHSC	118.1	97	1.22
FFRTC	93.3	82	1.14
SPRTC	140.8	123	1.14
WRTC	186.9	130	1.44
	810.1	667	1.21

There has not been an attempt to apply the standards for each of the four level of acuity groupings in this report owing to the current changes occurring in the regional treatment center mental health programs. However, the overall staff to patient ratio clearly compares more favorably than in previous reports. The five regional treatment center adult mental health programs continue to be fully licensed, certified, and accredited. In addition, the actual staff mix must remain flexible enough to meet the needs of the patient population.

Adolescent Treatment Staffing

Benchmark staffing guidelines developed in this study (Attachment A) suggest and overall staff to patient ratio of 2:1 in the Brainerd and Willmar Adolescent Treatment Programs and 3.33:1 for the secure component at Willmar.

CONCLUSIONS

Acute and Long Term Patient Staffing

The overall staff to patient ratio and staffing guidelines suggested in the 1995 Biennial Staffing Guidelines (Attachment B) remain valid. The regional treatment center adult mental health programs are in the midst of systemic change. Foremost is the implementation of the Mental Health Initiatives, authorized by the 1995 Legislature, which enables the regional treatment centers to partner with local community-based services to expand and integrate a regionally-based continuum of services for person with serious and persistent mental illness. These partnerships allow for the creative deployment of regional treatment center staff resources to expand and strengthen community based service alternatives to clients and provides opportunities for state services to assume new roles. As state resources move into the community, the inpatient population declines. Implementation has occurred over the past two years with substantial implementation expected by the end of fiscal year 1998. Furthering this effort has been the reallocation of out-state resources to the metro area enabling the delivery of services in the patient's home region.

In addition, opportunities are arising in the regions served by the regional treatment center adult mental health programs for the provision of services in a managed care environment and Anoka is developing transition units in the community as well as preparing for the new psychiatric hospital currently under construction.

The rapidly changing health care environment presents the regional treatment center system with the opportunity to examine its future roles and functions. Systematic planning with stakeholder groups has begun in earnest in order to inform policy and budget proposals for the 2000-01 biennium. This planning effort is particularly important for regional treatment center mental health programs where treatment advances have led to greater control of symptoms and more flexible life options for

persons so affected. The trend to provide services to persons in their home communities, together with new and more effective medications, has led to decreasing lengths of stay for patients in all hospital settings, including regional treatment centers. Current policy planning will take into consideration this changing environment.

Adolescent Treatment Staffing

Current staffing levels indicate that the Brainerd Adolescent and the Willmar secure component of its adolescent programs approximate the benchmark staffing guidelines.

The Willmar Adolescent Program will have its overall staffing addressed in the allocation process for FY 99; a significant portion of its current staffing is "borrowed" from the adult program allocation.

RECOMMENDATIONS

Acute and Long Term Patient Staffing

Upon full implementation of the Mental Health Initiatives, re-evaluate all facilities both for patient acuity and staff mix, and revise FY 99 staffing allocations as necessary. Reassess staffing guidelines in light of the recommendations for revisions in the safety net, as part of the 2000-01 biennial budget planning.

Adolescent Patient Staffing

Adjust Willmar Adolescent Program staffing within current resources in the FY 99 allocation process. Reassess in conjunction with recommendations for revision in the safety net discussions as part of the 2000-01 biennial budget planning.

REPORT: ADOLESCENT STAFFING GUIDELINES

January 1998

I. Introduction

The role of Minnesota's state-operated adolescent treatment programs in the two regional treatment centers at Brainerd and Willmar has changed as it has throughout the country. This is the result of changes in public policy; in treatment approaches to adolescents with severe emotional disturbance; in the growth of community-based services; and in quality of care standards developed by regulating and accreditation agencies. The Department of Human Services adolescent inpatient programs remain an important part of the comprehensive children's mental health continuum of care and treatment.

The adolescent staffing guidelines are based on the unique nature of the two state operated programs which are inpatient psychiatric hospitals providing care to adolescents with severe emotional disturbance. As psychiatric hospitals they differ significantly from residential treatment centers, group and foster care settings in the level of services delivered to the highly dysfunctional adolescents with severe emotional disturbance who are admitted for treatment. The Brainerd and Willmar programs admit adolescents on a statewide basis following a screening process to determine mental health necessity and to rule out the ability of community based services to respond to the adolescent's needs. Staffing guidelines were developed to provide quality treatment to the adolescents with severe emotional disturbance in Minnesota's regional treatment centers at Brainerd and Willmar.

II. Methodology

The first step in the adolescent staffing study consisted of data collection from similar facilities throughout the country. A review was then conducted based on the staffing model of the American Academy of Child and Adolescent Psychiatry. Clinical staffing information was received from seven facilities: Fairview-University Hospitals, Minneapolis, Minnesota; Rochester Mayo Hospital, Rochester, Minnesota; Cherokee State Hospital, Cherokee, Iowa; Independence State Hospital, Independence, Iowa; Mendota Mental Health Institute, Madison, Wisconsin; Winnebago Mental Health institute, Winnebago, Wisconsin; and Oregon State Hospital, Salem, Oregon.

Telephone surveys and site visits to comparable programs suggest that there is a very good fit between the physical plant structure and the program components available at other public and private facilities that treat adolescents and children (see Table A: Program Comparisons - Physical Space and Program Components on last page). As these were the same programs contacted concerning their staffing patterns, it would be safe to assume that there should also be a corresponding similarity in the number of staff needed to effectively run the programs.

The clinical staff/patient ratios were calculated for: Registered Nurse, Licensed Practical Nurse, Psychologist, Social Worker, Rehabilitation Therapist, and ancillary nursing personnel.

The goal of the staffing guidelines study was to identify a standard of care for health care personnel needed in Minnesota's state operated adolescent programs in order to provide active treatment and meet psychiatric, medical, and legal standards of ethical care.

III. Clinical Profile of Adolescents in State Operated Adolescent Programs

Adolescents with severe emotional disturbance, who are admitted to the two facilities, present a clinical picture of severe dysfunction.

A snapshot picture of the adolescents currently in the programs indicates the typical adolescent, male and female, has been in multiple community placements--including inpatient psychiatric units in community hospitals for diagnosis and treatment. The number of prior placements in the past year for each adolescent ranges from 0 to 26, with an average of 8. Increasingly, the adolescent is admitted for hospital care as a lateral move from a psychiatric hospital unit for intermediate duration (i.e. more than 2 weeks and less than 3 months).

Immediate prior placement often includes a community Rule 5 facility, emergency foster homes, therapeutic foster homes, regional detention centers and requests from community court services for Rule 20 assessments.

The programs serve adolescents who demonstrate:

1. **Severe psychiatric symptoms**, including psychosis, depression, bipolar disorders, and post traumatic stress disorders due to significant abuse history.

2. **Severe behavioral symptoms** including: serious suicide attempts, violent rages, fire setting, use of weapons, and extreme mood swings--psychopathology

which community-based services are unable to handle due to the extreme severity and lengthy duration of emotional disturbance.

3. Complicating factors of these severely damaged adolescents include: severe anxiety, cognitive impairment with severe learning disability, self-injurious behaviors, sexual abuse, lack of natural supports, and chemical abuse.

During FY 1997 adolescents were admitted within several major diagnostic disorders.

	Brainerd	**Willmar**
Affective	22%	43%
Behavior	37%	25%
Adjustment	8.5%	14%
Psychosis	12%	9%
Chemical	-0-	6%
Organic/other	20.7%	3%

Information from comparison programs suggests great similarity in admitting diagnosis and presenting problems, with depression and suicidal behaving being fairly common and borderline tendencies being noted often. Behavior diagnoses are present between 25% and 33% of the time. When the diagnostic groupings for children are examined, a behavioral diagnosis is more common, with ADHD being a frequently noted category.

In FY1997 the median length of stay at Brainerd was 77 days and 111 days at Willmar. This is a dramatic change at Willmar when compared to FY1996 when the median length of stay was 225 days.

Brainerd
82 adolescents served
36.5% stayed less than 30 days
25.6% stayed 31 - 60 days

Willmar
90 adolescents served
10% stayed less than 30 days
16% stayed 31 - 60 days

IV. Program Services at the Adolescent Programs at Brainerd and Willmar

The two state-operated adolescent programs provide acute psychiatric services in a hospital setting with 24-hour psychiatrist and RN coverage as well as other full-time professional staff to deal with psychiatric and behavioral emergencies. They offer inpatient services over a short to medium duration: Brainerd -- 77 days; Willmar -- 111 days median length of stay. The two facilities have a total bed capacity of 67. Brainerd has a capacity of 25 beds, with an average daily census of 15 in FY 1997. Willmar has a capacity of 42 -- 36 nonsecure and 6 secure. During FY 1997 the program had an average daily census of 37.

Reimbursement for clients is through Medical Assistance, private insurance or through county or court funding. Referral sources include county social service agencies, mental health collaboratives, families, insurance companies, and the court system. Level VI special education services are provided on campus by the local school district. Adolescents with severe emotional disturbance are admitted only if they meet the hospital admission standards. Both programs meet applicable regulatory and accreditation licensure such as DHS Rule 5, JCAHO, and HCFA standards.

- **Brainerd**

The Timberland Child Adolescent Program at Brainerd provides four specialty services:

1. Child/Adolescent Psychiatry.
2. Pediatric Neurology.
3. Neuropsychology.
4. Subspecialty Track for Adolescents with Cognitive Impairment or Brain Injury.

- **Willmar**

The Adolescent Treatment Unit at Willmar has operated since 1965 as a specialized treatment program for SED adolescents and their families. A $2.5 million building renovation is nearing completion on the WRTC campus for the ATU. Completion is expected in the spring of 1998 and the adolescent mental health program services will move into the two remodeled buildings.

The Adolescent Treatment Unit has developed five program modules consisting of 8-9 beds to provide the following specialized services based on customer responses from a statewide survey and the facility's internal strategic planning:

1. Short-term Crisis Services. 72-hour treatment services for child experiencing an acute psychiatric behavioral crisis which necessitates professional management within a safe environment. Length of stay: 3 days.

2. Short-term Evaluation Services. Rapid assessment, diagnosis, evaluation, and triage services for timely appropriate interventions and placement decisions. Length of stay: 5 - 30 days.

3. Brief Intensive Treatment. Psychiatric treatment for adolescent in need of short-term treatment based on assessments and diagnosis. Includes family therapy as integral services. Length of stay: 7 - 30 days.

4. Intermediate Transitional Treatment. Highly structured multi disciplinary treatment program for adolescent with significant psychiatric and behavioral problems not treated in a community setting. Length of stay: more than 30 days.

5. Secure Treatment. Intensive treatment services within a locked setting with enhanced staffing level to treat the adolescent in a safe environment to prevent harm to self or others. Length of stay: 3 - 90 days.

V. Secure Treatment

The Protective Component Unit at Willmar is a secure treatment program of the Adolescent Treatment Unit. This secure unit, for SED adolescents who demonstrate violent behaviors, was designed at the request of the Department of Human Services in 1979 and 20 FTE were allocated by the department for a 6-bed unit. This was a staffing ratio of 3.33 to 1 for this unique service in Minnesota.

VI. Benchmark Adolescent Staffing Guidelines

Based on the information received, the following represents a composite standard of practice in the adolescent programs contacted and AACAP guidelines of a model for staffing at inpatient psychiatric adolescent programs:

Table 1

BENCHMARK ADOLESCENT STAFFING GUIDELINES

STAFF	STAFF/PATIENT RATIO
Psychiatrist	1 : 10
Social Worker	1 : 8
Psychologist	1 : 8
Rehab. Th.	1 : 10
RN/LPN	1 : 1.7
MHPA/HST	1 : 1
Overall Staff Ratio:	**2 : 1**

VII. Application of Staffing Guidelines to the State Operated Adolescent Programs

Based on review of information received from other facilities and the model from AACAP guidelines, the following represents the benchmark staffing guidelines for adolescents and a comparison with the Timberland Child Adolescent Unit (TACP) at Brainerd and the Adolescent Treatment Unit (ATU) at Willmar.

The staffing levels are current number of staff working in the programs and are based on FY 1997 average daily census (adc).

Table 2

ADOLESCENT STAFFING GUIDELINES TABLE

PROGRAM: FY1997 (adc)	BRAINERD 15 adc				WILLMAR 30 adc		
STAFF TOTAL	Benchmark 2 : 1	Ratio 2.16 : 1	Staff 32.45	Benchmark Difference + 2.45	Ratio 1.9 : 1	Staff 57	Benchmark Difference - 2.64
Psychiatrist/MD*	1 : 10	1 : 9	1.6	+ 0.1	1 : 21	1.5	-1.7
Social Worker	1 : 8	1 : 8	2	-0-	1 : 20	1.5	-2.25
Psychologist	1 : 8	1 : 25	0.6	-1.3	1 : 15	2	-1.75
Rehab. Th.	1 : 10	1 : 7.5	2	+0.5	1 : 10	3	-0-
RN/LPN	1 : 1.7	1 : 1.3	14	+5	1 : 1.9	16	-1.64
MHPA/HST/BA	1 : 1	1 : 2.2	11.25	-3.75	1 : 0.9	33	+ 3

***Note:** The number of psychiatrists and physicians was not included in staffing ratios at other facilities contacted. The number is based on AACAP guidelines.

- **Secure Treatment**.

Secure treatment services for adolescents are provided at Willmar's Protective Component Unit (PCU). This population of clients requires a more intense staffing beyond the benchmark guidelines for adolescents with severe emotional disturbance. Behavior management needs of this population frequently require 1 : 1 and/or other staff intense intervention. In recognition of these needs, 20 positions historically have been allocated to the PCU. The allocated staffing level for this program represents an overall staffing level of 3.33 : 1.

Demand for services has exceeded the 6-bed program capacity. This has required the utilization of Adolescent Treatment Unit resources for this program.

Table 3

ADOLESCENT STAFF ALLOCATIONS

	Benchmark Staff	Actual Staff	Allocated Staff
Brainerd Adolescent nonsecure (TACP)	**30**	**32.45**	**31.40**
Willmar Adolescent nonsecure (ATU)	**60**	**57**	**30**
Willmar Adolescent secure (PCU)*	**20**	**22**	**20**
Total FTE:	**110**	**111.45**	**81.4**

* Benchmark application plus additional resources for this special population.

VIII. Summary

Benchmark standards based on national professional standards of practice indicate a significant difference exists between the number of FTE allocated to the adolescent programs and the current operating number of staff. In order to meet the benchmark guidelines staff positions need to be added in the adolescent programs, particularly in the professional level of staffing.

Based on benchmark guidelines, using the average daily census of FY1997 in the two adolescent programs, the following can be concluded:

- **Brainerd:**

  Timberland Child Adolescent Program at Brainerd is allocated 31.40 positions and currently operates with 32.45 FTE. This meets the 2 : 1 benchmark guidelines; however, the program has a different staff mix from the benchmark guidelines and may need to adjust this to meet the guidelines.

- **Willmar:**

  The Adolescent Treatment Unit, nonsecure unit at Willmar has been allocated 30 FTE. It currently operates with 57 FTE assigned to the program, compared to 60 FTE benchmark guidelines.

  The Protective Component Unit, secure unit, at Willmar is allocated 20 FTE.

  The adolescent mental health program at Willmar needs to enhance its professional mix to meet the benchmark guidelines.

Adolescent staffing guidelines can indicate the level of staffing needed to deliver adequate treatment according to current best practices. As treatment practices change, the guidelines need to be reviewed, in order to serve as an accurate basis for deployment of staff resources.

Table A

PROGRAM COMPARISONS - PHYSICAL SPACE AND PROGRAM COMPONENTS

Physical Plant	S	S	M	M	M	M	S	S	S
(M=Multi Story)									
(S=Single Story)									
Program Components									
(Y=Services provided)									
(O=Occasionally provided)									
(n= Not Offered)									
Crisis	Y	Y	O	Y	Y	Y	Y	Y	Y
Short Term Evaluation	Y	Y	O	Y	Y	Y	Y	Y	Y
Brief Intensive Treatment	Y	Y	Y	Y	Y	Y	Y	Y	Y
Intermediate Length Treatment	Y	Y	Y	Y	Y	Y	Y	Y	n
Separate Locked / Secure Unit	n	Y	n	n	n	Y	n	n	n
Respite	Y	Y	n	n	n	O	O	n	n
Forensic Evaluation	Y	O	O	O	n	O	O	n	n
Forensic Treatment	n	n	n	n	n	n	n	n	n
Children's Evaluation	n	n	Y	Y	Y	Y	Y	Y	Y
Children's Treatment	n	n	Y	Y	Y	Y	Y	Y	Y
Facilities:	1	2	3	4	5	6	7	8	9

1 = Brainerd
2 = Willmar
3 = Oregon
4 = Independence, IA
5 = Cherokee, IA
6 = Winnebago, WI
7 = Mendota Mental Health, WI
8 = Rochester Mayo, MN
9 = Fairview, MN

C. Sta ng Standards

The staffing allocation recommended for each hospital was determined by applying the staffing standards to the patient data base from the most recent survey of hospital patients. In addition, each hospital receives eight program support positions to be used as follows: Program Director; Medical Director; Discipline Chiefs of Nursing, Social Work, Psychology, and Rehabilitation Services; Jarvis Coordinator; Infection Control Coordinator. The hospital's population is sorted into the identified patient groupings and multiplied by the associated staff required for each group.

Level 1 Admission and Diagnosis
Treatment Staffing Standards
25 Bed Unit

Total Treatment Staff 36.8

Staff/Patient Ratio 1.5:1

	* RATIO	FTE
Psychiatrist	1:15	1.7
Medical Doctor	1:50	.5
Registered Nurse	1:3	8.3
Psychologist	1:15	1.7
Social Worker	1:10	2.5
Rehab Professional	1:20	1.3
Other Direct Care	1:1.2	20.8

* Includes 24 hour coverage. Does not include program director, discipline chiefs or other program support staff.

Description of patient grouping
Level 1:

All patients regardless of psychiatric or physical level of care scores, who have been in the facility 21 days or less

Anticipated Behaviors: (Not all patients exhibit all behaviors/needs.)

High risk of suicidal behaviors
(admits suicidal ideation, recent suicide attempt)

Self-injurious behaviors(s)
(commits injurious acts upon self)

Actively assaultive/threatening behaviors
(risk of harming others is high)

Danger to the community
(dangerous behavior when in community)

Actively psychotic behaviors
(seeing or hearing things others don't see or hear)
(easily led into danger)
(any behavior which could be dangerous to self or others)

Confused and disoriented
(cannot care for personal needs)
(subject to exploitation/vulnerability)
(makes irresponsible decisions)

History of chemical dependency or serious and frequent substance abuse

Related Treatment Requirements:

Comprehensive assessment of client (and family as appropriate)

1:1 Observation
Seclusion
Restraint
Escort off unit
Control of contraband
Recreation (supervised)
Psychometric testing
Health education
Universal precautions
Individual treatment program
Supervision of activities of daily living
Medication- Voluntary and emergency
Daily psychiatric intervention
Secure unit
Neurological consultation
Individual and group therapy
Family therapy

Level 2 Stabilization and Rehabilitation
Treatment Staffing Standards
25-Bed Unit

Total Treatment Staff 24.8
Staff/Patient Ratio 1:1

	* RATIO	FTE
Psychiatrist	1:25	1
Medical Doctor	1:100	.3
Registered Nurse	1:4	6.3
Psychologist	1:25	1
Social Worker	1:20	1.3
Rehab. Professional	1:25	1
Other Direct Care	1:1.8	13.9

* Includes 24 hour coverage. Does not include program director, discipline chiefs or other program support.

Description of patient grouping
Level 2:

All patients whose length of current hospitalization is more than 21 days AND whose psychiatric symptom rating is less than 70. These patients are not dangerous to self or others and are the most likely candidates for a less restrictive environment.

Anticipated Behaviors: (Not all patients exhibit all behaviors/needs.)

- Social skills deprivation (some degree of isolation, few personal contacts, poor skills in relationships with others, skills do not meet normative community standards)
- Self-control deficits (difficulty with handling emotions, i.e.anger, frustration)
- May not assume total personal responsibility for self-care skills
- Needs a period of stabilization predischarge (should have period of time for integration of social, leisure and vocational skills)
- Acute symptoms of mental illness have been stabilized
- Usually compliant with treatment regimen, including use of medication
- Uses leisure time reasonably well/does not disrupt environment

Related Treatment Requirements:

- Therapeutic community structure
- Leisure time activities and access to community resources
- Available work programming in hospital
- Medication supervision
- Structure for maintaining independence in activities of daily living
- Health Education
- Universal precautions
- Chemical dependency treatment and aftercare
- Active community contacts for discharge planning
- Therapy programming in groups of 10-20
- Individual treatment plan and multidisciplinary review
- Individual Therapy
- Treated chemical dependency and related aftercare program

Level 3 Re-Evaluation and Intervention
Treatment Staffing Standards
25-Bed Unit

Total treatment Staff 30.5
Staff/Patient Ratio 1.2:1

	* RATIO	FTE
Psychiatrist	1:20	1.3
Medical Doctor	1:100	.3
Registered Nurse	1:4	6.3
Psychologist	1:30	.8
Social Worker	1:20	1.3
Rehab Professional	1:20	1.3
Other Direct Care	1:1.3	19.2

* Includes 24 hour coverage. Does not include program director, discipline chiefs or other program support.

Description of patient grouping
Level 3:

All patients whose length of current hospitalization is more than 21 days AND whose psychiatric symptom rating is greater than 70. Most of these patients are psychiatrically unstable and/or dangerous to self or others.

Anticipated Behaviors: (Not all patients exhibit all behaviors/needs.)

Disruptive behaviors
(frequently annoys others, fails to comply with hospital rules and expectations, socially and/or sexually inappropriate behaviors, requires frequent staff intervention, exploits others)

Chronically suicidal
(suicidal risk constantly present)

Elopement risk
(violates limitations of liberty status)

History of chemical dependency or serious chemical use or abuse (frequent chemical use or abuse, becomes intoxicated when given opportunity)

Requires protection from exploitation
(can be easily taken advantage of by others)

Assaultive and/or self injurious behavior

Physical problems requiring continual medication/nursing care and attention (i.e., seizure disorders, severe physical handicaps, etc.)

Chronic residual psychosis with frequent exacerbations

May have poor personal hygiene and other self-care deficits.

Related Treatment Requirements:

Seclusion
Restraint
Close observation/protection
Therapy programming in small group (2-8)
Individual therapy
Close supervision of activities of daily living (self-care skills)
Medication-Voluntary and emergency
Universal precautions
E.C.T.
Court testimony
Escort services - on and off campus
Individual treatment plan and multidisciplinary review
Recreation/leisure program
Health education
Legal reports - court ordered evaluations and quarterly reviews
Chemical dependency treatment and aftercare

Level 4 Active Treatment with Special Physical Care Needs
Treatment Staffing Standards
25-Bed Unit

Total Treatment Staff 30.7

Staff/Patient Ratio 1.2:1

	* RATIO	FTE
Psychiatrist	1:50	.5
Medical Doctor	1:50	.5
Registered Nurse	1:3	8.3
Psychologist	1:30	.8
Social Worker	1:25	1.
Rehab. Professional	1:15	1.7
Other Direct Care	1:1.4	17.9

* Includes 24 hour coverage. Does not include program director, discipline chiefs or other program support staff.

Description of patient grouping
Level 4:

All patients whose length of current hospitalization is more than 21 days AND who require a high level of skilled nursing care, regardless of psychiatric symptom rating.

Anticipated Behaviors: (Not all patients exhibit all behaviors/needs.)

- May physically assault others
- Physical deficits (impaired ambulation,sight, hearing, stamina, etc.)
- Physical problems requiring continuous medical/nursing care
- Poor to no reality contact (confusion and disorientation)
- Unable to perform, or needs assistance to perform activities of daily living (self-care skills)
- History of chemical abuse
- Memory loss- environmental disorientation (hallucinations, delusions, generally associated with dementia)
- Unable to or limited recognition of safety hazard
- May disrupt the environment
- Vulnerable to exploitation by others (potentially unable to report)
- Psychiatrically labile (hyperactivity versus hypoactivity, withdrawn, excitability)

Related Treatment Requirements:

- Intensive medical intervention
- Restraints
- Leisure time/group activities
- Flannel boards/Communication assist devices
- Skilled nursing care
- Universal precautions
- Locked/secure ward must be available
- Reality orientation/validation therapy
- Relaxation Therapy
- E.C.T.
- Chemical dependency treatment and aftercare
- Special equipment
- Brief directive psychotherapy
- Supervised nursing care including assistance with activities of daily living and rehabilitation
- Individualized treatment plan and multidisciplinary review
- Discharge plan with supportive services as necessary
- Escort services on and off campus