

STATE OF CALIFORNIA  
**Budget Change Proposal - Cover Sheet**  
 DF-46 (REV 08/17)

Fiscal Year 2019-20	Business Unit 4440	Department Department of State Hospitals	Priority No.
Budget Request Name 4440-068-BCP-2019-GB		Program 4410-STATE HOSPITALS	Subprogram 4410010-ATASCADERO 4410020-COALINGA 4410030-METROPOLITAN 4410040-NAPA 4410050-PATTON

Budget Request Description  
 Direct Care Nursing

**Budget Request Summary**

The Department of State Hospitals (DSH) requests a total of 379.5 positions and \$46 million General Fund, phased in across a three-year period, to support the workload of providing 24-hour care nursing services. This phase-in requests 117.3 permanent full-time positions and \$15 million in fiscal year (FY) 2019-20; an additional 157.2 permanent full-time positions and \$19 million in FY 2020-21, and the remaining 105.0 permanent full-time positions and \$12 million in FY 2021-22. DSH also requests position authority only for 254.0 temporary help positions and 50.0 administrative positions to implement a staffing standard consistent with the findings of the Clinical Staffing Study of 24-hour care nursing services.

Requires Legislation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Code Section(s) to be Added/Amended/Repealed	
Does this BCP contain information technology (IT) components? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, departmental Chief Information Officer must sign.</i>	Department CIO	Date

For IT requests, specify the project number, the most recent project approval document (FSR, SPR, S1BA, S2AA, S3SD, S4PRA), and the approval date.

Project No.                      Project Approval Document:                      Approval Date:

If proposal affects another department, does other department concur with proposal? ☐ Yes      ☒ No  
*Attach comments of affected department, signed and dated by the department director or designee.*

Prepared By Janna Lowder, Chief Fiscal and Program Research Natalie Crank, RPS II	Date	Reviewed By George Maynard, Deputy Directory – Administrative Services (A)	Date
Department Director (A) Stephanie Clendenin	Date	Agency Secretary Kris Kent	Date

**Department of Finance Use Only**

Additional Review: ☐ Capital Outlay    ☐ ITCU    ☐ FSCU    ☐ OSAE    ☐ CALSTARS    ☐ Dept. of Technology

PPBA	Original Signed By: Kris Cook	Date submitted to the Legislature  <b>JAN 10 2019</b>
------	----------------------------------	---



## Analysis of Problem

### A. Budget Request Summary

The Department of State Hospitals (DSH) requests a total of 379.5 positions and \$46 million General Fund, phased in across a three-year period, to support the workload of providing 24-hour care nursing services. This phase-in requests 117.3 permanent full-time positions and \$15 million in fiscal year (FY) 2019-20; an additional 157.2 permanent full-time positions and \$19 million in FY 2020-21, and the remaining 105.0 permanent full-time positions and \$12 million in FY 2021-22. DSH also requests position authority only for 254.0 temporary help positions and 50.0 administrative positions to implement a staffing standard consistent with the findings of the Clinical Staffing Study of 24-hour care nursing services. The staffing standard was developed through research conducted within DSH's Clinical Staffing Study and in collaboration with the Department of Finance Research and Analysis Unit through a Mission-Based Review. The proposal examines nurse-to-patient ratios for providing 24-hour nursing care and the components available to achieve these ratios including internal registries, overtime, and position movements among facilities. The proposal additionally presents staffing methodologies for the administration of medication and the afterhours nursing supervisory structure. All methodologies can be re-assessed annually with updates provided within the annual DSH Caseload Estimate.

### B. Background/History

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals and employs nearly 11,000 staff. Additionally, DSH provides services through jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the state. In fiscal year (FY) 2017-18, DSH served 11,961 patients within state hospitals and jail-based facilities, with average daily censuses of 5,897 and 227 respectively. The CONREP program maintains an average daily census of approximately 654. DSH's five state hospitals are Atascadero, Coalinga, Metropolitan – Los Angeles, Napa and Patton. DSH continues to designate 336 beds at three of its state hospitals, Atascadero, Coalinga, and Patton for the treatment of mentally-ill prisoners, as required by *Coleman v. Brown*.

#### Clinical Staffing Study Overview

In 2013, the DSH initiated a comprehensive effort to evaluate staffing practices among the five state hospitals. This study, identified as DSH's Clinical Staffing Study, was assembled to ensure past practices and staffing methodologies continue to be both adequate and appropriate for the department's growing and evolving populations, and consistent among all DSH facilities. DSH's population served has grown by 25 percent since FY 2007-08. In addition to this growth, the composition of the population has changed becoming increasingly forensic and increasingly more geriatric. These dynamics along with the application of new treatment modalities over time necessitate the review and analysis of current staffing models.

The Clinical Staffing Study is comprised of four components: Hospital Forensic Departments, 24-Hour Care Nursing Services, Protective Services, and Treatment Planning and Delivery. Each of these components involve a comprehensive examination into current staffing practices and development of staffing methodologies. These four components each provide critical and required services to DSH patients through statutorily required forensic evaluations for the courts, 24-hour housing and nursing care, safety to patients and treatment providers, and delivery of psychiatric treatment. As part of each component's assessment, the Clinical Staffing Study will review current staffing standards and practices, propose new data-driven staffing methodologies to adequately support the current populations served, assess relief factor coverage needs and review current staffing levels within core clinical and safety functions.



## Analysis of Problem

### Scope of Nursing Services

This proposal provides a detailed summary for the second component of the Clinical Staffing Study, 24-Hour Care Nursing Services. Nursing services provides the essential 24-hour care necessary to treat and house patients with psychiatric needs. Nursing services involves observation and recording duties, medication and treatment delivery, identification of and response to emergency situations, safety and security roles and assisting in the implementation of individualized patient treatment and recovery plans. These roles consist of administration of medications, assessing patient behaviors and physical conditions utilizing provisions of care standards, supervising patient activities and providing escort services within and outside of the facility and implementing appropriate interventions identified by each patient's treatment and recovery plan. The primary nursing classifications utilized within DSH hospitals consist of registered nurses, supervising registered nurses, psychiatric technicians, senior psychiatric technicians and unit supervisors.

### Current Staffing Standards

The nursing staffing standards of California state hospitals have been a legislative and public concern for over seven decades. One of the first staffing studies dates back to 1947 when the Department of Mental Hygiene (DMH), subsequently the Department of Mental Health<sup>1</sup>, assessed nursing functions within state hospitals in an effort to improve unit overcrowding. Since the 1947 study, the changing role of psychiatric hospitals and the evolving concepts of care and treatment delivery have impacted and redefined adequate staffing standards for nursing staff; this is a theme that has been reiterated in every subsequent study conducted over the years. From 1947 to about 1980 a series of staffing studies were conducted by the Department; all with varying methodologies and outcomes. A description and timeline for these studies is provided in **Appendix A**.

### *Sapunor's Court Order*

Despite the many staffing study efforts, the identification of a staffing methodology did not directly translate into the timely delivery of actual staff on the units of the state hospitals. This issue came into fruition in 1981 when the Communications Workers of America (CWA) Psychiatric Technician Union filed a petition in the Superior Court of California, County of Sacramento, commanding the Department of Developmental Services (DDS) and the DMH to increase staffing at state hospitals to legal requirements by June 12, 1981, or to show cause as to why they have not been able to comply with mandated levels. A settlement was negotiated, and in August 1981, Superior Court Judge John M. Sapunor issued a court order directing the DDS and the DMH to meet the licensing requirements governing minimum level-of-care nursing staff at state hospitals.

The order also mandated that these minimum staffing requirements be posted on each unit and that each state hospital track and report on any shifts which fall below the minimum levels. The terminology of Sapunor's Court Order has since been updated to reflect the requirements of California Code of Regulations (CCR) Title 22 licensing. The full documentation of Sapunor's Court Order and accompanying DMH memorandum can be found in **Appendix B**.

### *CCR Title 22*

DSH hospitals are licensed and regulated under CCR Title 22: Social Security, Division 5: Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies. DSH hospitals contain beds licensed under Chapter 2 - Acute Psychiatric Hospital, Chapter 3 - Skilled Nursing Facilities and Chapter 4 - Intermediate Care Facilities. DSH is not licensed under Chapter 1 - General Acute Care Hospitals; which is the commonly cited CCR Title 22 chapter that defines minimum staffing ratios. The following sections provide a summary of the aforementioned chapters.

---

<sup>1</sup> The Department of Mental Hygiene transitioned to the Department of Mental Health in 1977 (Chapter 1252, Statutes of 1977).



## Analysis of Problem

- Chapter 2 – Acute Psychiatric Hospital

Acute psychiatric hospitals provide intensive 24-hour inpatient care to mentally ill patients. Twenty-four-hour inpatient care involves basic medical, nursing, rehabilitative, pharmacy and dietary services, including an emphasis on psychiatric nursing services and individual therapeutic programs developed by a mental health treatment team. Psychiatric nursing requirements state that there shall be a method for determining staffing requirements based on an assessment of patient needs and that it shall take into consideration: the patient's ability to care for oneself, the patient's degree of illness, the patient's requirements for special nursing activities, the skill level of personnel required to care for each patient and appropriateness of placement of the patient on an acute level-of-care unit. Sufficient nursing personnel shall be employed to provide adequate nursing care and treatment and to ensure the safety of all patients.

- Chapter 3 – Skilled Nursing Facilities

Skilled Nursing Facilities (SNF) are defined as health facilities, or a distinct part of a hospital, which provide continuous skilled nursing care and supportive care to patients whose primary need is for the availability of skilled nursing care on an extended basis. It provides 24-hour inpatient care and, as a minimum, includes physician, skilled nursing, dietary and pharmaceutical services along with a defined activity program.

Pursuant to CCR Title 22, nursing staff ratios shall be based on the anticipated individual patient needs for the activities of each shift and shall be distributed throughout the day to achieve a minimum of 3.2 nursing hours per patient day. The SNF shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant staffing requirements.

- Chapter 4 – Intermediate Care Facilities

Intermediate Care Facilities (ICF) and ICF designated beds are defined as providing inpatient care to patients who have a need for skilled nursing supervision and need supportive care, but not on a continuous basis. For nursing services, each facility shall employ sufficient staff to provide a minimum average of 1.1 nursing hours per patient day. Nursing care shall also be provided at a level that allows each patient to achieve and maintain their highest level of self-care, maximum functioning and independence. The development of an individual care plan for each patient based upon initial and continuing assessments are also a requirement of ICF licensure.

See **Appendix C** for CCR Title 22 sections relevant to nursing services.

Staffing standards established by the task force of hospital Executive Directors in FY 1980-81, the Sapunor Court Order, and CCR Title 22 serve as the foundation for the minimum ratios currently utilized by DSH. The Sapunor Court Order and CCR Title 22 staffing requirements represent the leanest staffing permitted to maintain regulatory compliance. Currently the minimum ratios utilized by DSH for nursing staffing allocations are: 1:6 on day and evening shifts and 1:12 on night shifts for units licensed as acute and SNF; and 1:8 on day and evening shifts and 1:16 on night shifts for units licensed as ICF.

### *Assembly Bill (AB) 394*

Chapter 945, Statutes of 1999 (AB 394) required the California Department of Health Services (CDHS) to establish mandated numerical licensed staff-to-patient ratios for General Acute Care Hospitals licensed under CCR Title 22, Chapter 1. As a result, various studies were conducted by stakeholders to develop and propose their own staff-to-patient ratios; however, variations in their ratio proposals and an overall lack of empirical research on the number of patients nurses can safely and effectively handle, prompted the CDHS to partner with the University of California (UC) Davis Center for Health Services



## Analysis of Problem

Research and the UC Davis Center for Nursing Research to conduct their own study<sup>2</sup>. Even though DSH is not licensed as a General Acute Care Hospital under CCR Title 22 Chapter 1 and would not be regulated by the ratios, the research findings, specifically for psychiatric units, provides an important point of reference for hospital staffing levels throughout California. Of California's 495 hospitals, a sample size of 90 hospitals was selected. Of the 90 hospitals, 20 reported staffing data for psychiatric units. Specific to those psychiatric units, 979 shifts were analyzed resulting in the following staff-to-patient ratios utilized on psychiatric units within General Acute Care Hospitals. The ratios below demonstrate how psychiatric units in the community are staffed and illustrates that the majority are operating at ratios significantly richer than DSH's budgeted ratios.

**Figure 1.1: Hospital Nursing Staff Ratios and Quality of Care Final Report— Survey Findings**

5 <sup>th</sup> Percentile	10 <sup>th</sup> Percentile	25 <sup>th</sup> Percentile	Median	75 <sup>th</sup> Percentile	90 <sup>th</sup> Percentile	95 <sup>th</sup> Percentile
1:2	1:2.5	1:3.5	1:4.5	1:6	1:11	1:15

See **Appendix D** for a one-page summary of the CDHS and UC Davis study, and **Appendix E** for the CDHS's Final Statement of Reasons regarding implementation of AB 394.

### DSH Patient Populations

In addition to the multiple attempts to identify staffing standards, which ultimately only resulted in required minimum levels, the DSH has also experienced significant changes among its patient populations. These changes include an aging population requiring enhanced medical care and a growing forensic population requiring different treatment programs and nursing staff to provide a safeguarding presence in addition to their regular nursing duties.

DSH provides treatment to both forensic and civil commitment types. Major forensic commitments include Incompetent to Stand Trial (IST), Mentally Disordered Offender (MDO), Not Guilty by Reason of Insanity (NGI), Sexually Violent Predator (SVP) and California Department of Corrections and Rehabilitation (CDCR) Inmate-Patient Transfers (Coleman Patients). Lanterman-Petris-Short (LPS) Patients make up DSH's civil commitments. A list of all DSH legal commitment types are provided in **Appendix F.1**. A full description of each commitment type is presented in DSH's Report on Measures of Patient Outcomes, **Appendix F.2**.

Over the last three decades the DSH's patient population has experienced a reduction in the number of patients committed through the civil court process with an offsetting increase in the number of forensic patients, who are committed to DSH through the criminal court process. Currently, more than 90 percent of DSH's patient population is classified as forensic. This shift in patient commitment type resulted in evolving challenges for the DSH nursing staff. Forensic patients create an additional documentation workload, due to statutory reporting requirements and periodic evaluations of their legal status. Nursing staff, because they are around the patients 24-hours 7-days per week are relied on to document changes in patient behavior and response to treatment in the patient's medical chart to inform other clinicians treating the patient who are not physically around the patient every hour of the day. Furthermore, the combination of severe mental health conditions and criminality in the forensic population, including the potential for elevated levels of aggression, now requires a different treatment approach than civil commitments, sometimes including a custodial element. Having a largely forensic patient population necessitated a critical shift in treatment methodology to address the increased aggression and changing treatment goals of these individuals. Rather than generalizing a community-based recovery model for the all commitment types in a one-size-fits-all approach, DSH clinicians are improving treatment delivery by applying targeted methods along treatment pathways for each commitment type. This paradigm shift directly impacts nursing duties. DSH's current staffing standards pre-date this shift to an increasingly forensic patient population. As the forensic population was

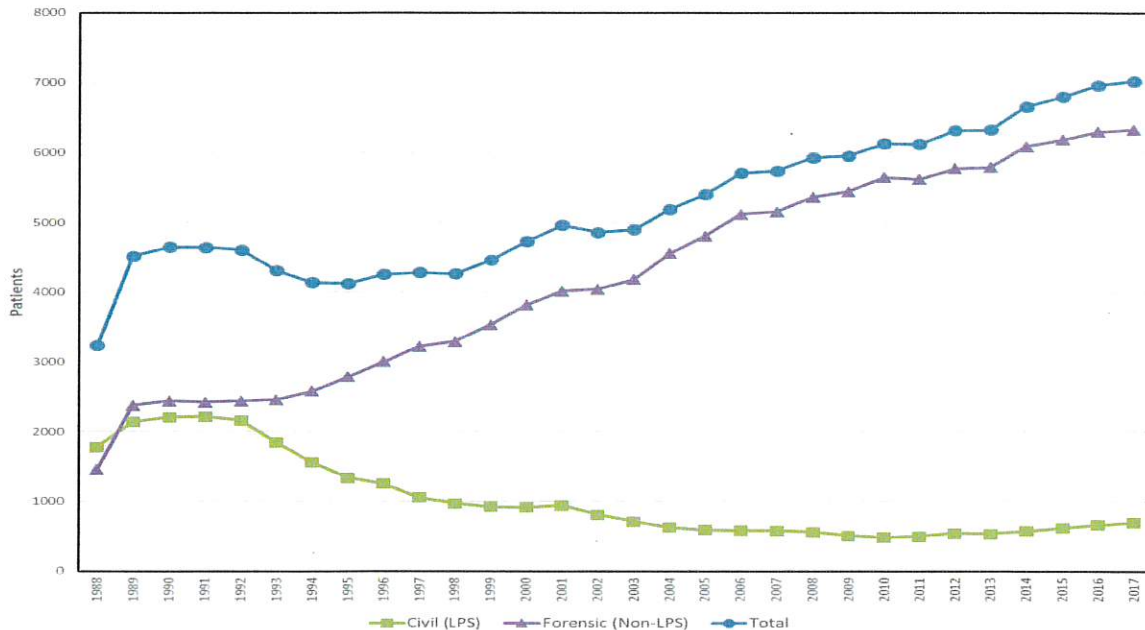
<sup>2</sup> Final May 2002 research findings are documented in the Hospital Nursing Staff Ratios and Quality of Care Final Report on Evidence, Administrative Data, an Expert Panel Process, and a Hospital Staffing Survey as prepared by the UC Davis Center for Health Services Research in Primary Care and the UC Davis Center for Nursing Research in partnership with CDHS.



## Analysis of Problem

increasing, specific capital outlay projects were completed to provide more secure treatment areas to house forensic patients. Additional efforts were pursued to provide Grounds Presence Psychiatric Technician Teams to patrol hospital grounds and assist with escorts and hospital police officers have taken on more responsibilities to ensure the safety and security of patients, staff, and the public given the DSH's antiquated facilities and growing forensic population. Figure 1.2 below displays the shift in DSH's patient population.

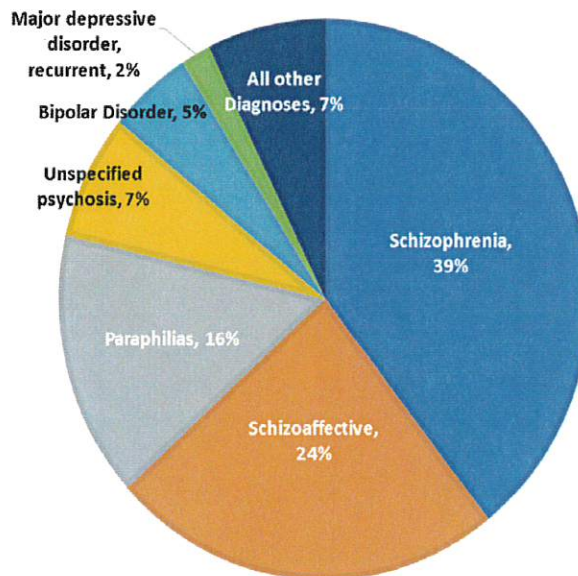
**Figure 1.2 Forensic and Civil Populations at DSH: 1988 though 2017**



### Major Diagnoses

Across all facilities and commitment types, the DSH patient population is characterized by the prevalence of acute mental health conditions. Figure 1.3 displays the breakdown of major diagnoses among the DSH patient population. In total, 39 percent of DSH patients have received a schizophrenia diagnosis, while 24 percent of patients have received a schizoaffective disorder diagnosis. Paraphilia affects 16 percent of all DSH patients while unspecified psychosis disorder affects seven percent. Bipolar disorder and major depressive disorder each account for five and two percent respectively. All remaining diagnoses encompass 22 additional diagnosis groupings including anxiety disorders, dissociative disorders, personality disorders, and mood disorders not considered bipolar or depressive.

**Figure 1.3: Major Diagnosis for Residents on Unit**



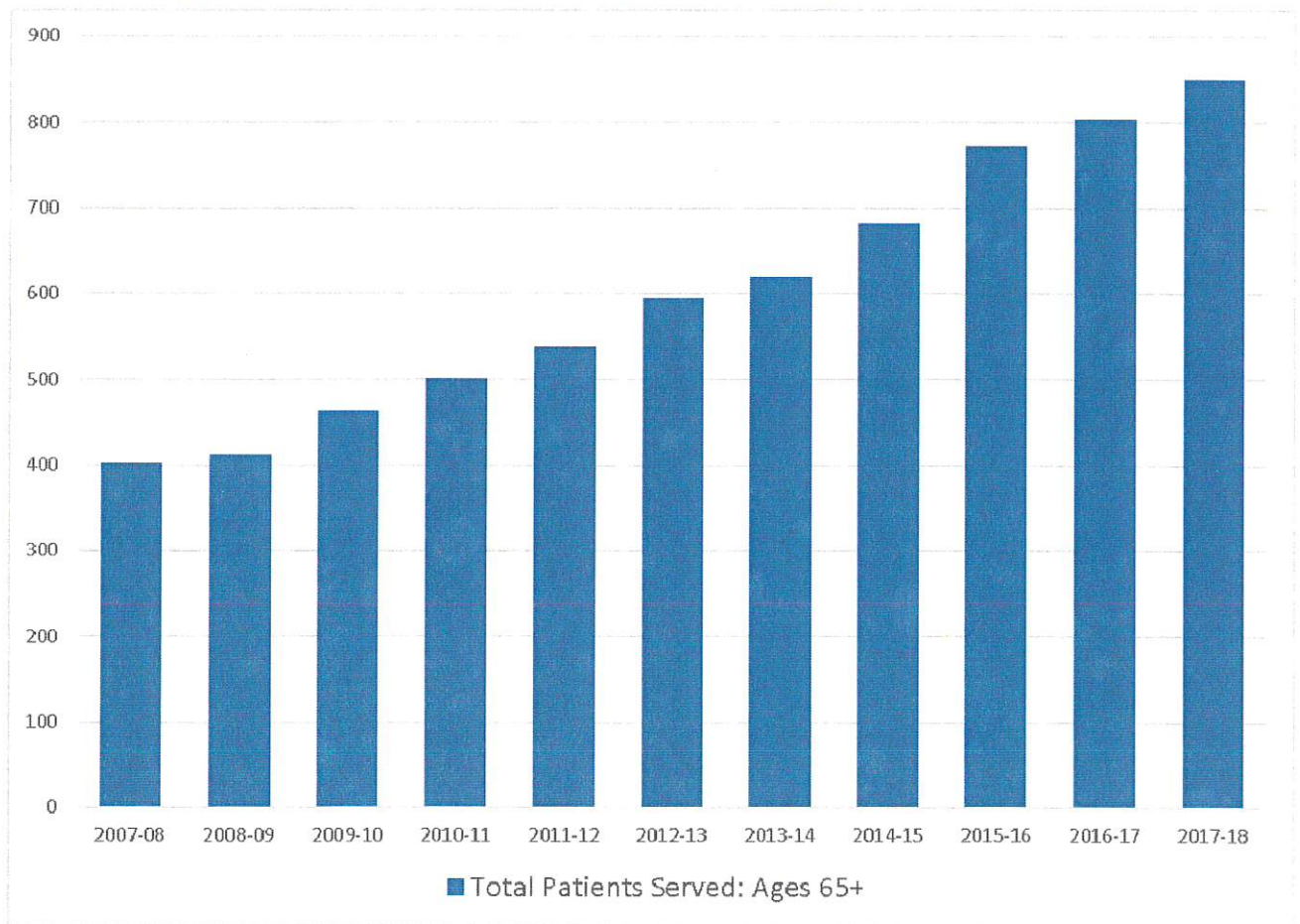


## Analysis of Problem

### *Aging Population*

DSH provides treatment to an aging patient population, including a growing number of older patients with restricted mobility and enhanced medical needs. This population often requires additional care assistance from nursing staff to assist in basic daily activities such as grooming, showering, brushing teeth, shaving, eating, etc. This population also tends to have a greater fall risk and therefore require extra supervision and attention in order to prevent such fall situations and related injuries. From FY 2007-08 to FY 2017-18, the number of DSH patients served age 65 and over increased by 111.4 percent (see Figure 1.4).

**Figure 1.4: Total Patients Served Age 65 and Older, FY 2007-08 to 2017-18<sup>3</sup>**



### *High Aggression*

Nursing staff at DSH facilities encounter high levels of patient aggression due to the unique forensic and mental health challenges of the population. DSH fulfills an essential role in patient care, treating patients whose significant mental health needs and often forensic status prevents them from receiving treatment in psychiatric hospitals within the community, as well as patients whose mental health status is too acute to receive treatment in a prison setting. Each year, DSH releases the DSH Violence Report which provides an analysis of patient-on-patient and patient-on-staff violence. The 2017 report<sup>4</sup> found that a steady proportion of DSH's patient population continue to present significantly high levels of

<sup>3</sup> Data reflects all patients who were 65 and older as of June 30th in each fiscal year. Patients Served is calculated by summing the June 30th census of the prior fiscal year and all admissions over the course of the respective fiscal year. Transfers are not included in this dataset.

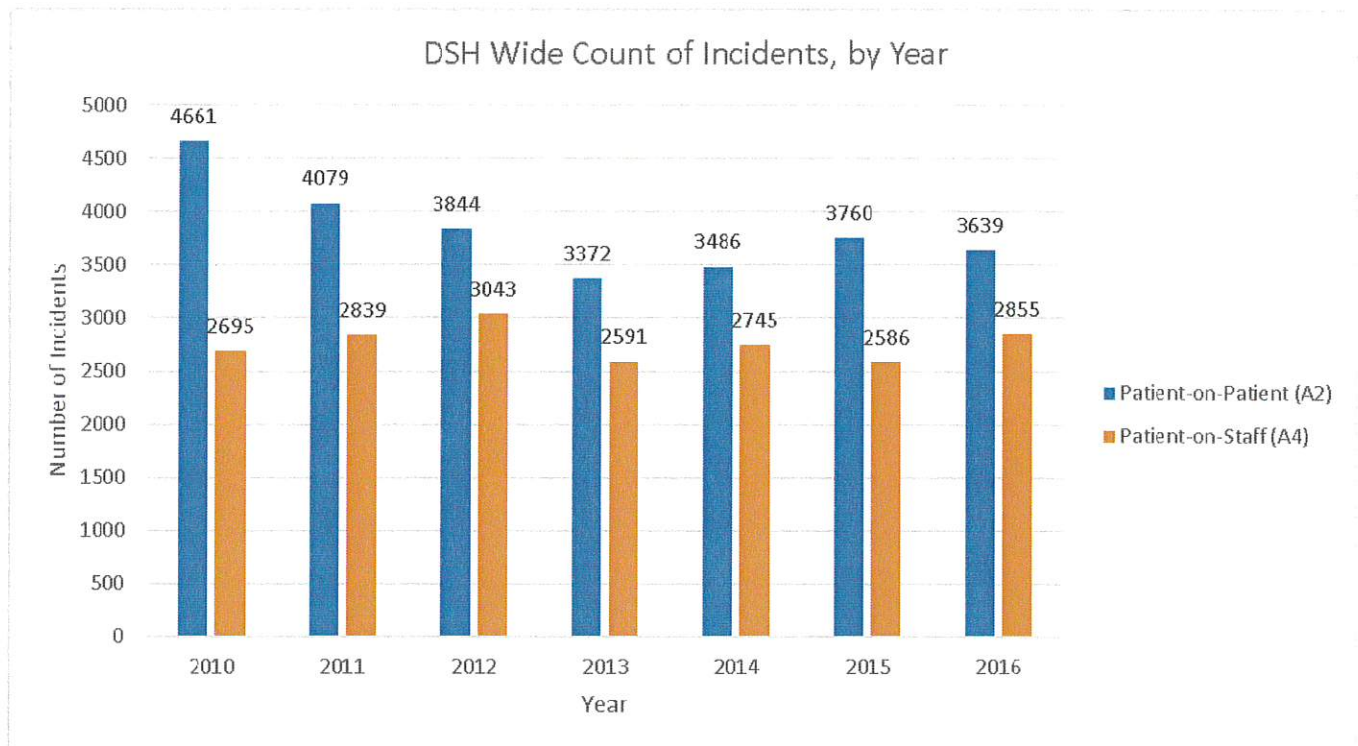
<sup>4</sup> The DSH Violence Report released in November 2017 is based on 2016 data.



## Analysis of Problem

repeat aggression, despite targeted treatment methods. Among the DSH patient population, LPS, IST and MDO patient types continue to display the highest rates of violence. The report also found that there has been an increase in patient violence among newly admitted patients, especially IST patients, and that the majority of violent incidents occur within 120 days of a patient's admission. In total, there were 3,639 patient-on-patient aggressive incidents and 2,855 patient-on-staff aggressive incidents recorded in 2016.

**Figure 1.5: DSH Incident Counts per Year**



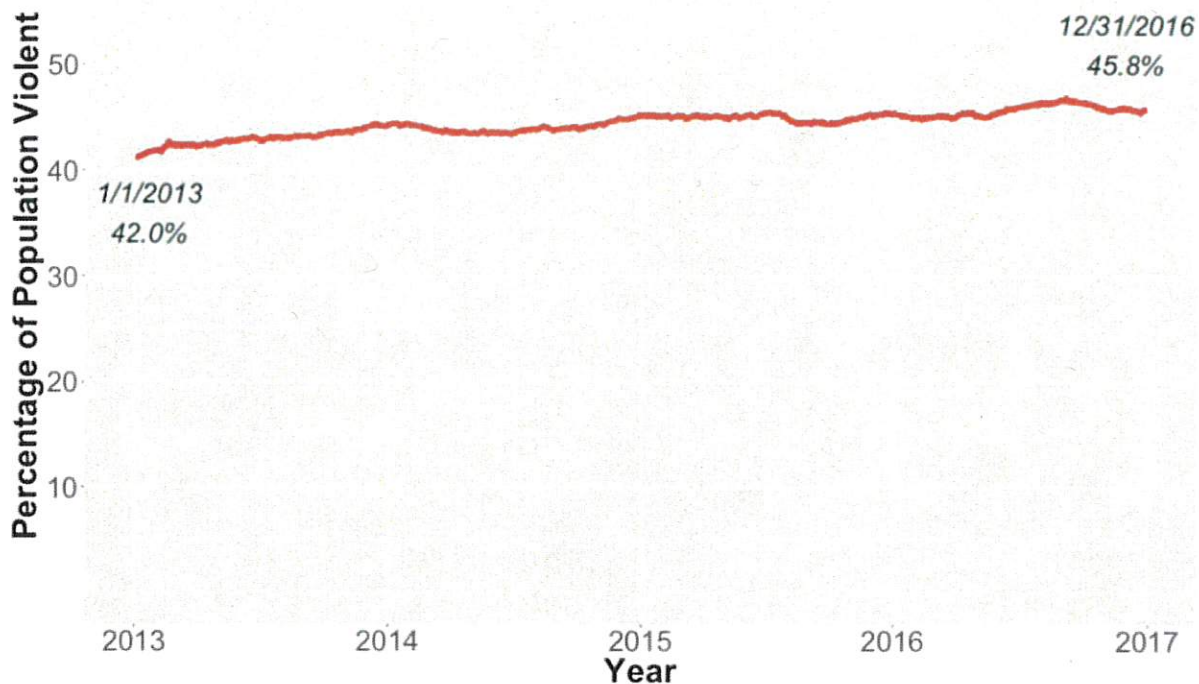
Additionally, the report found that in 2016, the median length of hospitalization for a patient with 10 or more violent acts is about three times that of a patient with no violent acts. The increased length of hospitalization for more violent patients results in a higher percentage of these dangerous patients residing in the hospitals. As displayed in Figure 1.6, the percentage of patients residing in DSH who were violent in a DSH hospital during their treatment stay has been increasing from 42 percent in January 2013 to 45.8 percent in December 2016<sup>5</sup>.

<sup>5</sup> DSH Violence Report, DSH Hospital Violence 2016, published November 2017.



## Analysis of Problem

**Figure 1.6: DSH Hospitals 2013-2016 Daily Percentage of In-Hospital Assaultive Patients Residing in Hospitals**



### Changes in Nursing Services

DSH's current staffing standards and resources continue to be limited by the minimum court-ordered staffing levels even though throughout the years actual nursing services required to be provided, and the tasks involved in providing them, have become increasingly more complex and time-intensive. An example provided during subject matter expert interviews was the steps involved in treating a simple scrape today versus twenty years ago. Twenty years ago, a nurse cleaned and bandaged the scrape and made a note in the patient's chart. Today, an appointment must be made, forms must be filled out, a full write-up on the injury must be completed and documented in the patient's chart along with a scheduled follow-up and documentation of the follow-up must be completed. The additional tasks and documentation requirements stem from the need to standardize on evidence-based practices to improve patient outcomes, as well as the added benefit of ensuring accountability that can inform an audit, lawsuit or other action pursued by oversight agencies and stakeholders such as The Joint Commission, collective bargaining units, and Patient's Rights Advocates. Moreover, the Civil Rights of Institutionalized Persons Act (CRIPA), a federal law intended to protect the rights of people in state or local correctional facilities, nursing homes and mental health facilities, increased documentation requirements as enacted under the DSH-Enhancement Plan. The need for timely, thorough and informative nursing notes is also driven by the fact that they are used to inform clinicians when writing required forensic court reports for forensic patients. In addition, basic standards of care, such as administering medication have become more heavily regulated in recent years and require additional processes, documentation and staff time.

### **C. State Level Considerations**

This proposal is consistent with DSH's Vision, Mission, Goals and Objectives as set forth in the 2018 - 2023 DSH Strategic Plan. Specifically, this proposal supports DSH's vision "Caring today for a Safe and Healthy Tomorrow" and its mission "to provide evaluation and treatment in a safe and responsible manner, by leading innovation and excellence across a continuum of care and settings."



## Analysis of Problem

This proposal also aligns with The Division of Occupational Safety and Health (Cal/OSHA) on understanding and implementing safety standards in healthcare facilities. In accordance with SB1299 adopted September 29, 2014, the Cal/OSHA was mandated to implement standards for state hospitals and other health facilities regarding the implementation of workplace violence prevention plans no later than July 1, 2016. California Code of Regulations Title 8, section 3342 - Violence Prevention in Health Care was adopted on December 8, 2016 and became effective April 1, 2017.

This provision of state law mandates a significant number of violence prevention measures including "Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift." As 37.7 percent of the DSH workforce with 1,496 authorized positions, nursing care staff are the primary responders to incidents of workplace violence within DSH facilities as well as the first line of defense in de-escalating situations that can become violent. Ensuring that adequate nursing care staffing can be maintained and reducing staff fatigue caused by mandatory overtime are primary measures to reduce the risk of violent incidents occurring and potential for Cal/OSHA citations and fines.

Additionally, this proposal is consistent with recommendations from the Little Hoover Commission developed in 2016, to conduct an assessment of patient health needs, staff leave time and overtime and to seek adequate nursing staff to achieve overtime reduction. The analysis of this proposal meets this recommendation as nursing level, overtime and internal nursing registries were assessed for how to achieve the patient health needs as it relates to nursing services. Additional position authority is also requested to support the functions of administering medications and nursing supervision.

### D. Justification

#### DSH Nursing Services Staffing Study

The 24-Hour Care Nursing Services component of DSH's Clinical Staffing Study was initiated in May 2015 with a focus on the following key elements:

- Documentation of all current staffing practices within each of the five hospitals
- Identification of the commonalities and difference among treatment and housing units
- Development of a classification system for grouping/categorizing units with similar staffing needs
- Identification of proposed staff-to-patient ratios for each grouped category
- Documentation of all nursing duties within each hospital including unit-based duties and off-unit based duties
- Assessment of the relief factor needed to ensure adequate coverage across all shifts for 7-day and 5-day per week unit-based posts
- Identification of the necessary staff resources based on the proposed methodology and ratios

To address the above elements, multiple interviews, conference calls and data collection surveys were necessary. Key collaborators consisting of central staffing offices, nursing coordinators, coordinators of nursing services, clinical administrators and program directors, provided extensive data and regular feedback on the calculations and findings. The Clinical Operations Advisory Council (COAC) provided additional feedback on the proposed methodologies.

#### *Data Collection*

The data collection and analysis process during the staffing study involved the following efforts, each of which informing the next step in the analysis process.

- Collection and use of staff delivered data,
- Categorization and grouping of hospital units,

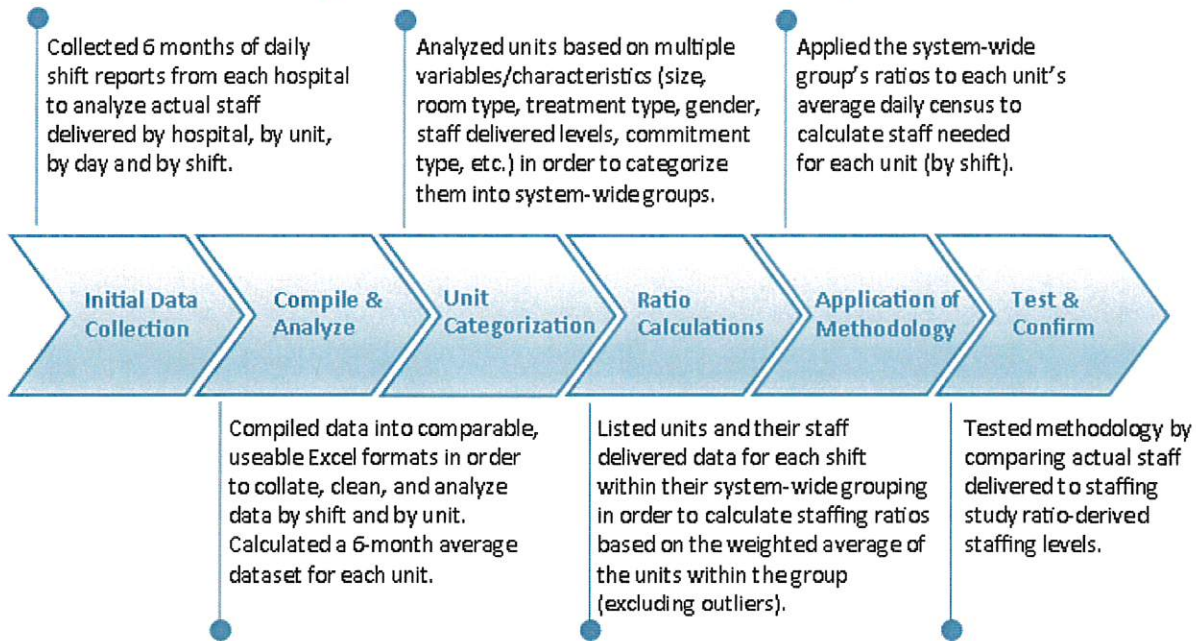


## Analysis of Problem

- Development of staff-to-patient ratios,
- Documentation of additional unit-based functions and
- Data collection to re-assess the nursing relief factor

Figure 2.1 displays the full process for how DSH collected, compiled, cleaned, analyzed, and calculated staffing data from all five hospitals in order to make the data consistent and comparable across facilities

**Figure 2.1: DSH Data Collection and Analysis Process**



### *Staff Delivered Data*

Staffing practices at each hospital vary due to the population they serve, the services they offer and their unique location specific limitations. Historically, each hospital has operated independently of one another and while all maintain compliance with licensure and regulatory staffing minimums, they have each developed their own method for determining nursing staffing requirements based on patient needs. Additional information regarding current hospital staffing practices can be found in **Appendix G**.

The differences in each hospital's process for determining staffing levels also leads to different processes for documenting their staffing practices and staffing levels. While hospitals consistently document staffing levels for licensing compliance and day-to-day operations, the method for tracking this data is often through hand written documentation and not easily compiled for hospital-to-hospital analysis. However, this day-to-day documentation of actual staff delivered was identified as the most reliable data metric for assessing hospital nursing staff needs and staff delivered. For the 24-Hour Care Nursing Services Staffing Study, staff delivered means nursing staff physically present and working on or for a unit including regularly scheduled staff, overtime (voluntary and mandated) staff, registry staff and floated staff from other units. It does not include staff allocated to the unit but not present due to regular days off, unplanned absences, training, etc. Actual staff delivered is an important variable because it reflects changes in patient acuity resulting in enhanced observations, one-to-one staffing (due to aggression, self-harm, suicide risk, etc.) and escalated behavioral situations impacting the whole unit. Additionally, staff delivered data is a reliable metric because hospitals are required by licensing to document staff delivered by unit and by shift, ensuring it is regularly tracked and available for significant time periods.



## Analysis of Problem

To obtain the data each hospital was requested to provide six months of daily staffing reports inclusive of all three shifts to ensure an adequate sample size for an analysis. Six-month averages were calculated for all relevant variables across all units and shifts. This allowed for inter-hospital and system-wide comparisons to be conducted with the intent of categorizing units into like groups based on variables that drive staffing levels versus units grouped based on California Department of Public Health (CDPH) unit licensure. These unit categories, along with staff delivered data, would serve as the basis for developing ratios more in-line with patients and treatment needs of the units.

### *Categorization of Units*

Multiple data elements were assessed to develop a grouping system and way to categorize units. These groupings were then analyzed across all five hospitals to compile an itemized system-wide list of units and their staff delivered data by category. Ultimately, a system-wide classification of hospital units was developed that groups units of similar staffing needs and similar functionalities together. Additional information on the unit categorization process and the descriptions of each unit type can be found in **Appendix H**. The final unit classifications include:

- Admissions
- Medical Treatment
- Specialized Services Treatment
- Incompetent to Stand Trial Treatment
- Mentally Disordered Offender Treatment
- Multi-Commitment Treatment
- CDCR (Coleman) Treatment
- Sexually Violent Predator Treatment
- Lanterman-Petris-Short Treatment
- Discharge Preparation Treatment

Utilizing a system-wide classification system for hospital units that is based on treatment provided, staffing need and functionality in lieu of CDPH licensure and staffing minimums allows for staffing practices at all DSH hospitals to be consistently aligned with actual unit staffing needs. Essentially units at different hospitals with similar missions would be staffed using the same methodology which would create system-wide standardization of staffing practices within DSH.

### *Identification of Proposed System-Wide Nurse-to-Patient Ratios*

The methodology proposed for carrying out system-wide staffing practices is to apply standard system-wide staff-to-patient ratios developed for each unit grouping to all units categorized within each group. The system-wide staff-to-patient ratios were developed using a weighted average of unit census and staff delivered data for all units categorized within each group, resulting in the standard system-wide ratio for the entire group. To assess the accuracy of this methodology, the proposed system-wide standard ratios were populated into hospital staffing calculation sheets and applied to the average census. Accuracy was assessed by the range in variance of staff delivered to the units. The staffing requirements produced by the new standard ratios were also checked against staffing minimums and hospital staffing standards. Proposed ratios, by shift, for all groups within each category are identified in Figure 2.2.



## Analysis of Problem

**Figure 2.2: Proposed Standard System-Wide Unit Groupings and Staff-to-Patient Ratios**

Group	AM	PM	NOC	N <sup>†</sup>
<b>Admissions</b>				
PC Standard Admissions	1: 4.5	1: 5.0	1: 8.0	13
Hybrid Admissions	1: 5.5	1: 5.5	1: 9.5	10
<b>Medical Treatment</b>				
Medical Unit	1: 2.0	1: 2.0	1: 2.5	4
Skilled Nursing Facility	1: 2.5	1: 2.5	1: 4.0	3
Medically Fragile/Geropsych	1: 4.5	1: 5.0	1: 7.5	8
<b>Specialized Services Treatment</b>				
High Aggression/Enhance Treatment Unit/Program (ETU/ETP)	1: 1.5	1: 1.5	1: 3.0	2
PC Specialized Services: Polydipsia, DBT, Substance Abuse	1: 5.5	1: 5.5	1: 9.0	4
LPS Specialized Services: Polydipsia, DBT, Pre-DBT	1: 3.0	1: 3.0	1: 4.5	4
PC Specialized Services: Intermediate Care High Behavior Acuity	1: 4.5	1: 4.5	1: 7.5	2
Specialized Services: Sex Offender Treatment	1: 7.5	1: 7.5	1: 14	2
Specialized Services: Deaf, Hard of Hearing	1: 3.0	1: 3.0	1: 6.0	1
Specialized Services: Monolingual	1: 5.0	1: 5.5	1: 8.0	1
<b>Incompetent to Stand Trial (IST) Treatment</b>				
IST Admission to Discharge	1: 5.5	1: 5.5	1: 9.5	11
IST Permanent Housing-Single	1: 5.5	1: 6.5	1: 9.5	4
IST Permanent Housing-Dorm, Mixed	1: 6.5	1: 6.5	1: 12.0	8
<b>Mentally Disordered Offender (MDO) Treatment</b>				
MDO Permanent Housing-Single, Mixed	1: 5.0	1: 5.0	1: 10.0	9
<b>Multi-Commitment Treatment</b>				
MDO, NGI, LPS Permanent Housing-Dorm, Mixed	1: 6.5	1: 6.5	1: 11.5	27
MDO, NGI Permanent Housing-Single	1: 5.5	1: 6.5	1: 10.5	2
CDCR/MDO Permanent Housing	1: 7.5	1: 8.0	1: 12.5	4
<b>CDCR (Coleman) Treatment</b>				
CDCR Permanent Housing	1: 5.5	1: 6.0	1: 11.5	2
<b>Sexually Violent Predator (SVP) Treatment</b>				
SVP Permanent Housing	1: 6.0	1: 6.5	1: 13.5	7
SVP Residential Recovery Unit	1: 13.0	1: 17.0	1: 32.5	7
<b>Lanterman-Petris Short (LPS) Treatment</b>				
LPS Permanent Housing	1: 5.0	1: 5.0	1: 9.0	4
<b>Discharge Preparation Units</b>				
Discharge Ready	1: 7.0	1: 7.5	1: 12.5	3

<sup>†</sup> Total number of units used in calculating the system-wide group's ratio

**Appendix I.1 – I.5** provides a comparison of the actual staff delivered captured during the staffing study and the staffing levels that would result from applying the proposed system-wide grouping ratios (as displayed in Figure 2.2) for each hospital and unit.

The proposed standardized staff to patient ratios displayed in Figure 2.2, reflect the actual average staffing currently being delivered on the various units at state hospitals. For example, on units across the five state hospitals that are classified as 'LPS Permanent Housing' there is an average of one nursing staff delivered on the unit for approximately every five patients during both the AM and PM shifts. The staffing ratios reflected in the table above include all registered nurses, psychiatric technicians, licensed vocational nurses, and psychiatric technician assistants delivered to a unit,



## Analysis of Problem

including shift lead senior psychiatric technicians and the psychiatric technicians assigned to each unit's medication room. It does not include unit supervisors or supervising registered nurses.

These staffing ratios are the result of the hospitals' staffing practices, described in Appendix G. While each hospital has developed its own unique methodology for determining the necessary staffing to be delivered on a unit, the actual staffing delivered across the hospitals was consistent enough to be able to develop the categorizations shown in the figure above. In other words, the variance in the number of staff delivered on 'LPS Permanent Housing' units across the hospitals was not significant and therefore allowed for the development of one standard ratio for this unit category. It is also important to note that the needed staffing for a particular unit is not static; it is constantly being reassessed based on the patient needs for each shift and in accordance with the staffing methodologies developed by each of the hospitals. While the average on the LPS units is 1:5 there may be days or shifts when the ratio is lower or higher.

### Aligning Resources with Need

In looking at these staffing ratios, it is clear that the hospitals have been staffing units at a richer ratio than the historically funded ratios of 1:6 for Acute and 1:8 for ICF. Safety is the primary reason for these richer ratios, but even with these enhancements, DSH's staffing levels are still lower than those in community General Acute Care Hospital psychiatric units (see Appendix D) and violence continues to be a significant problem at DSH. Because the staff delivered ratios are richer than what has been historically funded, the hospitals do not have sufficient position authority to staff all the posts on all the units. The additional staff delivered to the units has been achieved through a combination of overtime and temporary help (e.g., permanent intermittent, retired annuitants). This, in combination with high vacancy rates in the nursing classifications, has been one of the main drivers behind the high use of overtime at the state hospitals, including the use of mandatory, or forced, overtime.

To better understand the drivers of overtime at each hospital and formulate ways in which it might be reduced, we examined the nursing staffing needs at each hospital. The ratios in the table above can be applied to the units at each hospital to determine the total number of nursing staff needed at each hospital (this also includes the application of a relief factor of 1.75 to account for weekends, holidays, and leave usage). **See Appendix J.1 – J.5** for a detailed display of how the proposed system-wide grouping ratios are applied to current units to calculate the level of nursing staff delivered to each unit for each hospital, assuming each unit is filled to operational capacity. **See Appendix K** for the total number of nursing staff, as calculated in appendix J.1-J.5, needed at each hospital with relief, by classification. We then compared the total need to the total number of authorized nursing positions at each hospital. The table below reflects the findings of this comparison and a resource shift to better align position authority with need.



## Analysis of Problem

**Figure 2.3. Alignment of Position Authority with Position Need by Hospital**

	DSH-Atascadero		DSH-Coalinga		DSH-Metro		DSH-Napa		DSH-Patton		Systemwide Change
	Positions	% of Need	Positions	% of Need	Positions	% of Need	Positions	% of Need	Positions	% of Need	
Staffing Study Identified Need	1,003.6		989.5		803.4		1,204.6		1,164.7		
Current Positions	1,032.6	103%	964.1	97%	563.2	70%	964.9	80%	1,110.9	95%	
Position Authority Shift	-132.0		-76.1		142.5		93.0		-27.4		0.0
Revised Position Authority	900.6	90%	888.0	90%	705.7	88%	1,057.9	88%	1,083.5	93%	
Added Temporary Help	30.1	3%	28.0	3%	67.2	8%	47.5	4%	81.2	7%	254.0
Added Overtime (Position Equivalent)	(72.9)	7%	(73.5)	7%	(30.5)	4%	(99.2)	8%	0.0	0%	(276.1)
Revised Staffing Total	1,003.6	100%	989.5	100%	803.4	100%	1,204.6	100%	1,164.7	100%	

**Staffing Study Identified Need:** Includes the total number of registered nurse, psychiatric technician, and senior psychiatric technician positions needed to staff the hospital units in accordance with the staffing ratios identified by the staff delivered data in the study and with a relief factor application of 1.75. Position detail can be found in Appendix J.1-J.5 and Appendix K.

**Current Positions:** Includes the total number of registered nurse, psychiatric technician, and senior psychiatric technician positions authorized at each hospital according to the Salaries and Wages galley and available to staff hospital units. These totals do not include nursing positions that have been staffed to off-unit assignments, which will be discussed in greater detail below.

**Current Positions Percentage:** This reflects the number of staff authorized at each hospital as a percentage of the need identified by the staffing study. For example, DSH-Metropolitan has only 70 percent of the positions it needs to staff its units.

**Position Authority Shift, Percentage, and Revised Position Authority:** This reflects the redistribution of nursing positions among the hospitals so that DSH-Metropolitan and DSH-Napa have authorized positions closer to the need identified by the study. This redistribution allows all hospitals to be between 88 percent to 93 percent of need compared to the current variance of 70 percent to 103 percent. This only redistributes position authority among the hospitals, not funding.

**Added Temporary Help:** In recognition that hospitals do not have sufficient position authority to meet the need, temporary help position authority is added in an amount consistent with the levels used during 2017-18. Across the five hospitals, a total of 254 temporary help positions were used to help meet the unit staffing needs in 2017-18. No additional funding is provided as the cost for these positions was absorbed by the department in 2017-18.

**Added Overtime (Position Equivalent):** This reflects the overtime, shown as a position equivalent, necessary to meet the staffing study identified need after accounting for resources available from authorized positions, including temporary help. From a recent evaluation of the relief factor, each nursing position works an average of 1,673 hours per year on the unit, after accounting for leave time and off-unit training (see **Appendix L** for additional information on the relief factor review). Each overtime position equivalent in the table above reflects a total of 1,673 hours of overtime worked. As with temporary help, no additional funding is included as the cost for this overtime was absorbed by the department in 2017-18. Note that this reflects *budgeted* overtime for each hospital. Actual overtime worked by unit staff will be higher than these totals due to vacancies, which results in salary savings, and leave that is not funded by the department (e.g. employees on dock leave who do not receive compensation).

Determining the feasibility of the budgeted overtime can be calculated as follows, using DSH-Napa as an example:



## Analysis of Problem

Regular, ongoing positions:	1,057.9			
Filled positions with 5% vacancy rate:	1,005.0	165,961.6	=	165.1 annual hours of overtime per filled position
Overtime position equivalent need:	99.2	1,005.0		(13.8 hours per month)
Overtime hours need:	165,961.6			

Based on the current rates of voluntary overtime among the nursing classifications, an average of 165.1 annual hours of overtime per position appears to be reasonable. Note that actual overtime worked will be higher when the vacancy rate exceeds five percent. Recognizing that some of the hospitals struggle with high vacancy rates in the nursing classifications, a separate BCP has proposed nurse instructor positions to expand the pipeline for psychiatric technician training programs at specified community colleges.

**Revised Staffing Total:** The revised staffing total per hospital meets 100 percent of the need identified by the Staffing Study through a combination of budgeted permanent, ongoing positions, temporary help, and overtime.

The adjustments in the table above do not result in additional funding for DSH nor in a net change in the total funding budgeted for each hospital. The funding for the additional need for temporary help and overtime now being recognized has been shifted from each hospital's operating expenses and equipment budget to the personnel services budget to accurately reflect where the expenditures are occurring. The position shift and the additional temporary help position authority and overtime funding will be reflected in the 2021-22 Salaries and Wages galley. This BCP requests an additional 254.0 temporary help positions, but not the associated funding, as this level of temporary help was absorbed by the department in 2017-18.

### *Off-Unit Positions*

To determine the number of positions available to staff units, as reflected in the table above, DSH surveyed each hospital to identify all the off-unit positions filled with registered nurses or psychiatric technicians and their function. There are a number of off-unit functions that are appropriate to be staffed by nurses, including medical clinics (similar to an urgent care), off-unit patient treatment programs (such as art/music therapy), and admission suites (where patients first arrive and are processed as part of the hospital admission process). However, upon closer examination of the off-unit positions filled with nursing staff, it was determined that some of these duties may be more appropriate for administrative positions, such as staff services analysts (SSA). As a result of the Workforce Cap and other reductions, DSH had insufficient position authority for administrative positions, which is why it has been filling some of these positions with psychiatric technicians and registered nurses, which were unaffected by the various reductions.

Fifty jobs across the five hospitals that are currently performed by a nursing classification were found to be more appropriate for an administrative classification. These 50 positions are accounted for in the 'Current Positions' total in the above table (Figure 2.3) and this BCP proposes additional authority for 50 administrative positions, the bulk of which are SSAs. This proposal does not include funding because shifting these nursing positions back to the units will reduce overtime expenditures. The overtime savings would then be used to fund the additional administrative positions. Over the next year, there will be a closer examination of these off-unit positions to determine if there are additional positions, beyond the 50, that can be shifted back to the units.

### *Future Adjustments*

DSH will continue to evaluate the following areas:

- **Staff Delivered Data:** Staff delivered data will be re-evaluated periodically to assess any changes or impacts to nursing delivery. The re-assessments will involve review of staff delivery across all shifts and all units and compared to previous results. Adjustments to staff-to-patient ratios and delivered staffing levels will be presented through the caseload estimate process.



## Analysis of Problem

Additionally, if units shift to serving a different patient classification or providing a different type of treatment, staffing would need to be adjusted accordingly through the estimate process. Future adjustments of authority may be needed.

- **Nursing Overtime:** Overtime (mandatory and voluntary) will continue to be assessed quarterly. Overtime will also be assessed in comparison to vacancy rates and internal registry usage as all impact the total staff delivered calculation presented in Figure 2.3. Updates will be presented through the caseload estimate process.
- **Vacancy Rates:** Ongoing recruitment efforts and vacancy rate impacts will continue to be assessed. Updates regarding these efforts and the impact to staff delivery will be provided through the caseload estimate process.
- **Internal Registry Usage (Temporary Help):** Monthly and annual registry usage will be assessed for its impact to staff delivery. As noted above, increased usage of an internal registry will directly impact overtime need. If higher registry usage can be achieved, additional temporary help authority will be pursued through the caseload estimate process.
- **Off-Unit Nursing Positions:** DSH has identified approximately 50 nursing positions which can be redirected from administrative functions back to providing nursing services on the units. The successful redirection of these positions will be evaluated along with the potential for additional position redirections. Redirections can only occur if the functions can be fulfilled by an administrative classification such as an SSA.

### Additional Unit-Based Staffing

In addition to the ratio-driven nursing staff, there are also two unit-based functions which require staffing; the functions of administering medication (medication pass) and unit supervision. Each of these functions are examined further in the sections below. Data and information gathered by The University of California, Irvine (UCI) during the validation process of DSH's staffing study, has been included to provide more robust depictions of each function.

#### *Medication Pass*

The function of medication pass is to prepare, administer, document and ultimately manage the medication administration process within each unit. Medication pass occurs four times a day, typically at 8am, 12noon, 4pm and 8pm or 9pm; and may last up to two hours per pass. Specific medications may also be administered at different times during the days such as after meal times or prior to sleep. Medications are stored, managed and administered from a medication room on each unit or brought patient to patient using a medication cart. This process varies depending on the mobility and acuity of the patients within the unit.

Each hospital staffs their medication rooms with a licensed psychiatric technician on both AM and PM shifts. This staff member must be fully dedicated to this function to maintain compliance with medication pass procedures, controlled substance handling requirements, and to complete meticulous documentation requirements regarding medication inventory, patient medication compliance, and pharmacy medication records reconciliation. In addition to the one dedicated staff member, additional floor staff are pulled to assist during all medication passes as medication pass requires two staff. One staff member to ensure the security of the medication and to provide medication and one staff member to ensure the medication was taken and to help prevent disruptions as patients are awaiting their medications. Some units with a larger patient census and high volumes of medication utilize two medication carts to administer all medications within the two-hour window. Units which use two medication carts for medication pass will use an additional staff member for each cart. A full list of duties for the medication room staff is documented below in Figure 2.4



## Analysis of Problem

**Figure 2.4: Tasks of Medication Room Staff (Table developed by UCI)**

- ✧ Transcribe new orders to the medication administration record (MAR) and other forms as appropriate (e.g., Daily Care Flow Sheet, Medication Identification Index Card, Laboratory Testing Tracking Log, Medical Referral and Diagnostic Tests Tracking Log, Infection Reporting Worksheet)
- ✧ Fax orders to the pharmacy
- ✧ File pharmacy approval notices/faxes
- ✧ Update MARs with all PRNs, emergency orders, hold orders, order modifications (minor), order discontinuations
- ✧ Stamp and sign orders that have been faxed and place original order on patient's chart
- ✧ Follow procedures for taking telephone/verbal orders including documentation requirements (noting in Medical/Psychiatric Appointment Log, entering into MARs)
- ✧ Review physician's order for recent changes
- ✧ Compare physician's orders to MARs
- ✧ Ensure physician's orders comply with policies for completeness (e.g., date, time, name of medication, form of medication, dose etc.), diagnosis/indication, and prescriber's signature/badge number
- ✧ Clarify any orders as required, particularly if dosages are higher than guidelines or if required to be crushed per protocol
- ✧ Sign copy of physician's orders
- ✧ Review all charts at the beginning of a shift
- ✧ Obtain new medications from pharmacy and store correctly
- ✧ Be knowledgeable about all medications/treatments and any special precautions or contraindications
- ✧ Have knowledge of the patient including diagnosis, allergies, etc.
- ✧ Evaluate the patient prior to administration of medication for signs and symptoms of adverse reactions
- ✧ Be aware of required vital signs associated with medications/treatments
- ✧ Ensure medications are administered within one hour before or within one hour after the scheduled time
- ✧ Check expiration dates on medications and supplies
- ✧ Document multi-use medications when first used
- ✧ Conduct weekly check for expired floor stock
- ✧ Follow correct procedures for infection control
- ✧ Follow correct procedures for storing medications
- ✧ Report medication variances
- ✧ Assemble necessary equipment
- ✧ Prepare medications when the patient is present
- ✧ Visually inspect medications for contamination
- ✧ Check drug preparation with MAR three times prior to administration
- ✧ Identify the patient while maintaining patient confidentiality
- ✧ Conduct patient education
- ✧ Observe the patient until the medication is swallowed and check mouth if necessary
- ✧ Chart medications immediately after administration
- ✧ Administer PRN medications as required, complying with policy
- ✧ Administer emergency medications as required, complying with policy
- ✧ Report any unusual circumstance to the registered nurse (e.g., toxic signs, refusal)
- ✧ Notify shift lead of PRN administrations
- ✧ Replace all equipment
- ✧ Clean medication drawer, cart and equipment



## Analysis of Problem

- ✧ Follow correct procedures to dispose of pharmaceutical waste
- ✧ Conduct monthly review of orders and carry forward to next month's MARs
- ✧ Conduct audit of recent orders (if on NOC shift)
- ✧ Supervise trainee staff who are completing medication certification training

In addition to needing a medication room psychiatric technician during the actual medication pass, an assistant (also a licensed psychiatric technician), is also used to assist the medication room nurse throughout the shift. This may include co-signing for medication or picking up medication from the pharmacy, taking vital signs requested by the physician prior to medication, clarifying medication orders, assisting in ensuring patients report to the medication room and providing medication education to patients. The dedicated medication room staff and medication room assistant must go through a formal medication certification course annually.

### *Medication Pass: Research on Risk*

Some issues to consider in assessing the administration of medication involve any factors which can increase the risk of medication errors or increase the risk of patient or staff safety. This may include:

- High volume of psychiatric medication: Virtually all DSH patients are prescribed psychiatric medication
- Growing volume of non-psychiatric medication: Due to an aging population, the volume of non-psychiatric medication needs may continue to grow
- Current medication rooms may not be physically ideal for their current function
- Medication orders and notes may often be handwritten until an electronic health record system is implemented

Medication errors are defined as the preventable inappropriate use of medications whereby a medication is administered differently than as ordered. Medication errors can occur when medications are ordered, transcribed, dispensed, administered, or taken by the patient. Errors may be of omission, in which a patient failed to receive a medication. Or errors may be of commission, in which a patient received the wrong drug, the wrong dose, the wrong drug form, at the wrong time, via the wrong route of administration, or with/without the necessary accompanying treatment. Medication errors are common, estimated to occur at a rate of between one in five and one in twenty doses, even though nurses intercept around 85 percent of potential errors. Prevalence is difficult to measure, due to low rates of detection and reporting. In one anonymous self-report study, one-third of nurses reported making an error (or near error) in medication administration during the 28-day study period (Balas, Scott & Rogers, 2004; Bates et al., 1995a; Bates et al., 1995b; Brady et al., 2009; Hughes & Ortiz, 2005)<sup>6</sup>.

Medication errors may or may not result in patient injury. Patient injuries resulting from adverse drug events (ADEs) are the most frequent cause of adverse events in hospitals. Serious ADEs may result in patient disability or death; less serious drug injuries may increase length of stay. The majority of ADEs

---

<sup>6</sup> Balas, M. C., Scott, L. D., & Rogers, A. E. (2004). The prevalence and nature of errors and near errors reported by hospital staff nurses. *Applied Nursing Research*, 17(4), 224-230.

Bates, D. W., Boyle, D. L., Vander Vliet, M. B., Schneider, J., & Leape, L. (1995). Relationship between medication errors and adverse drug events. *Journal of General Internal Medicine*, 10(4), 199-205.

Bates, D. W., Cullen, D. J., Laird, N., Petersen, L. A., Small, S. D., Servi, D., ... & Vander Vliet, M. (1995). Incidence of adverse drug events and potential adverse drug events: Implications for prevention. *Journal of the American Medical Association*, 274(1), 29-34.

Brady, A., Malone, A., & Fleming, S. (2009). A literature review of the individual and systems factors that contribute to medication errors in nursing practice. *Journal of Nursing Management*, 17, 679-697.

Hughes, R. G., & Ortiz, E. (2005). Medication errors: Why they happen, and how they can be prevented. *Journal of Infusion Nursing*, 28, 14-24.



## Analysis of Problem

are caused by system errors, rather than human error from individual pharmacists, nurses or patients. The following system design and organizational failures have been linked to medication errors (Balas et al., 2004; Kohn, Corrigan, & Donaldson, 2000; Leape, et al., 1991; Brady et al, 2009)<sup>7</sup>:

- Lack of information about the patient due to patient information being inaccessible
- Lack of knowledge about the drug being administered
- Reliance on manual documentation, handwritten orders and poorly coordinated information systems
- A poorly designed, small room for medication management
- Information overload, work distractions and interruptions
- Lack of experience, staff shortages, overwork, overtime and fatigue
- Inadequacy of “checks and balances”
- Poor medication delivery system from the pharmacy (e.g., late deliveries, loss of orders or lack of 24-hour coverage)
- Drug administration systems that are not standardized (e.g., that follow different procedures during the week as on weekends)
- Poor quality/damaged medication packaging or similar packaging/labeling

To summarize, research has demonstrated that—at typical hospitals—the potential for medication error is high.

### *Medication Pass: Staffing*

The psychiatric technicians currently assigned to the medication rooms are included in the staff delivered ratios compiled by the Staffing Study (See Figure 2.2). This BCP proposes that these positions be pulled out of the ratio-driven nursing staffing levels and added as a stand-alone position in the majority of the units. Due to the significant responsibilities of the medication room psychiatric technician, this position is unavailable to assist with direct patient care on the unit floor. To again use an LPS unit as an example, the effect of this proposal would be as follows:

**Figure 2.5: Example of Unit Staffing with Medication Room**

<b>35 Bed Unit with a 1:5 Nurse to Patient Staffing Ratio (LPS Unit)</b>				
	<u>Patients</u>	<u>Floor Staff</u>	<u>Med Room</u>	<u>Total Staff</u>
Current:	35	6	1	7
Proposed:	35	7	1	8

Note that the resulting overall nurse to patient ratio for LPS units resulting from this proposal is 1:4.4, which is nearly identical to the median nurse to patient ratio identified by UC Davis's survey of General Acute Care Hospital psychiatric units.

This proposal adds this medication room psychiatric technician post to 128 units across the five hospitals. Some units are excluded because (1) they already have high nurse to patient staffing ratios

<sup>7</sup> Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). (2000). *To err is human: Building a safer health system* (Vol. 6). National Academies Press.

Leape, L. L., Brennan, T. A., Laird, N., Lawthers, A. G., Localio, A. R., Barnes, B. A., ... & Hiatt, H. (1991). The nature of adverse events in hospitalized patients: Results of the Harvard Medical Practice Study II. *New England Journal of Medicine*, 324(6), 377-384.



## Analysis of Problem

and additional staff are not needed (medical and skilled nursing facility units), (2) the patient acuity is low enough to not require additional staffing (residential recovery and discharge ready units), and (3) they were activated since 2015-16 and were already budgeted to provide a higher staffing ratio. Additionally, these added posts are budgeted as 12-hour shifts, whereas currently the medication room is staffed with a psychiatric technician for the AM and PM shifts (total of 16 hours). As a result, the proposed staffing ratios displayed in Figure 2.5 above will apply to 6 hours during AM shift and 6 hours during PM shift. DSH is continuing to evaluate the feasibility of these 12-hour posts for the medication room.

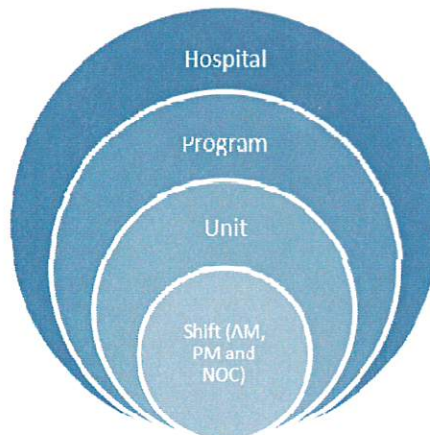
The additional 12-hour medication room posts for 128 units requires 335 additional psychiatric technician positions to account for relief. These positions will be phased in over the course of three years, with 185 added in 2019-20 (95 partial-year, equating to 185 in the full-year), 90 added in 2020-21 (45 partial-year, equating to 90 in the full-year), and then the remaining 60 in 2021-22 (60 full-year). The phase-in accounts for the time necessary to hire for this significant number of positions. It additionally recognizes that DSH cannot immediately begin staffing these additional posts until additional psychiatric technicians are hired. A phased-in approach is necessary since the vast majority of these new posts will be filled by existing staff, however, implementing the full proposal in 2019-20 before additional psychiatric technicians can be hired would pull available staff away from the ratio-driven staffing on the units, thus increasing the overtime required for the remaining nursing staff.

It is anticipated that providing this additional staff to DSH units will decrease patient violence and other disruptions, thus increasing staff and patient safety. In 2016, there was a total of 6,494 aggressive incidents in the five hospitals, with 2,855 aggressive incidents against staff and 3,639 aggressive incidents against patients. This translates into approximately 18 aggressive incidents per day. The use of Family Medical Leave Act (FMLA) and workers' compensation leave among nurses at DSH is nearly double the rate used by correctional officers at CDCR. With additional staffing, DSH nurses will be able to better address patient needs in a timely manner and reduce aggressive incidents.

### *Unit Supervision*

The organizational and supervisory structure of each hospital relevant to nursing services provided on the units follows the general layout depicted in Figure 2.6 in which each housing unit resides within the programmatic oversight of a treatment program managed by a program director. Additionally, nursing oversight and management at the programmatic level is performed by a nursing coordinator. Nursing coordinators are generally allocated one or two per program depending on the number of units within a program. Furthermore, at the unit level nursing oversight and management is performed by either a unit supervisor or supervising registered nurse depending on the need and medical acuity of the unit. Unit supervisory positions are overseen by the nursing coordinator and to some extent the program director of the program their unit is assigned to.

**Figure 2.6: DSH Hospital Supervisory Organizational Structure**





## Analysis of Problem

Unit supervisors and supervising registered nurses are the first-line supervisors on the units. Current hospital staffing practices for unit supervisory positions allocate one-unit supervisor or supervising registered nurse to each unit. These supervisors work five days per week during the day shift; however, they are responsible for the continuous management and supervision of their unit on a 24-hour basis. They schedule and direct the activities of nursing service personnel on the unit; work as a liaison between unit staff on different shifts; are responsible for the implementation of habilitation, rehabilitation, and nursing plans of care for each patient; supervise the administration of treatments, medicines, and the preparation of accurate descriptive records; orient, teach, counsel, and evaluate the performance of unit nursing personnel including unit shift leads; promote individual staff development; investigate and adjust or recommend solutions to complaints from patients, visitors, or unit staff; and prepare or direct the preparation of records and reports.

The next level of oversight for nursing services on the units is at the shift level and is provided by shift leads which are staffed one per shift (three per unit). However, shift leads are not supervisory level positions and are generally staffed with senior psychiatric technicians or registered nurses and are sometimes staffed by psychiatric technicians acting in the senior role. To ensure a supervisory level position is available during times when the unit supervisor is not present such as on PM and NOC shifts, hospitals use an offsite on-call program officer of the day (POD) to provide unit supervision coverage. The program officer of the day assignment rotates between supervisory level positions such as unit supervisors, program directors, nursing coordinators and supervising registered nurses. The current practice of one unit supervisor during the day and a rotating offsite POD during afterhours makes it difficult to provide an adequate level of supervision on PM and NOC shifts. Based on interviews of staff that are assigned POD duty, they are called throughout the night several times to address staff issues. Additionally, the need to establish supervisory positions overnight was identified for the following reasons:

- To ensure the same supervisor is overseeing the same units and staff so they can be familiar with the individuals and patients they are supervising and vice versa.
- To monitor delivery of care and make sure it is compliant with licensing and hospital standards.
- To ensure effective communication between units during staffing shortages, emergencies, shift change, etc.
- To carry out personnel actions when necessary.

In addition to the current practice of one unit supervisor or supervising registered nurse per unit on the AM shift; one 12-hour post is proposed to address supervision coverage during the PM and NOC shifts. The expanded supervisory coverage allows for 20-hour oversight (additional 12-hour shift and existing 8-hour shift) of staff and patient activities and is necessary to ensure such things as escorts, shift changes, and break times are appropriately managed while maintaining safe unit staffing levels. Additionally, a supervisory presence can aid in addressing unit acuity changes in an expedited manner especially during unit and hospital-wide emergencies that may require coordination across units. While AM shift coverage is one unit supervisor per unit; coverage for PM/NOC does not need to be at AM levels given the decrease in patient activity and administrative workload on these shifts.

The proposed PM/NOC shift supervising registered nurses range from three to four supervisors per hospital for a total of 17 per night and will oversee multiple programs and units with a staff to supervisor ratio of approximately 1:40. Due to the breadth of this coverage, a 7-day per week relief is necessary to ensure a supervisory presence is available (see Appendix L for detail pertaining to the 7-day/12-hour relief). This is an initial, conservative estimate of the overnight supervisory need. This staffing allotment may need to be adjusted as these positions are filled and overnight workload for these supervisors can begin to be measured.

The 17 additional 12-hour posts require 44.5 supervising registered nurse positions after accounting for relief. These positions are phased-in over a two-year period with the assumption that these additional posts are activated in January 2020. These additional supervisory positions will mostly be filled through



## Analysis of Problem

existing staff, so DSH will need time to be able to backfill the positions. It should be noted that DSH may experience difficulties in filling these overnight supervising registered nurse positions. Unlike supervising registered nurse positions at CDCR, DSH supervising registered nurses cannot earn overtime compensation. Therefore, the primary incentive for accepting a supervising registered nurse position is the predictable Monday through Friday 8am to 5pm schedule, so registered nurses may be reluctant to promote into these overnight positions. DSH will monitor the vacancy rates and implementation of these positions in order to assess if alternative solutions will need to be pursued.

### Recommendations and Findings

The DSH initiated the Clinical Staffing Study to ensure staffing practices and methodologies continue to be adequate and appropriate for the department's growing and evolving populations. DSH's population served has become increasingly forensic and elderly, with compliance requirements further impacting the hospital system. These changes to DSH necessitated the review and analysis of current staffing models to develop staff-to-patient ratios which provide adequate staffing to the hospitals. Implementing the proposed staffing ratios will ensure state hospitals have the adequate staffing necessary to reduce the high levels of overtime experienced among the 24-hour care nursing operations.

### *Proposed Staff Resources*

The table on the following page, Figure 2.7, displays the staffing needs based on the proposed ratios, medication pass, and unit supervision methodologies, as well as incorporation of the updated relief factor. The ratio-driven unit staffing will be met through the combination of permanent positions, temporary help (internal registry usage) and overtime. Each of these categories have been evaluated and temporary help was updated to reflect 2017-18 usage. These categories will continue to be assessed annually with updates included through the caseload estimate process. Additionally, both the medication pass and unit supervision proposals are based on conservative methodologies utilizing 12-hour shifts to provide cross shift coverage. These methodologies will be evaluated through implementation to ensure the 12-hour shifts are adequate.

**Figure 2.7: 24-Hour Care Nursing Services: Staffing Need (Proposed Methodology)**

Hospital	Ratio-Driven Unit Staffing						Medication Pass			Afterhours Supervision			Total
	AM	PM	NOC	Sub-Total	8-hr Relief @ 0.75	Total w/ Relief	Med Pass PT	12-hr Relief @ 1.62	Total w/ Relief	SRN	12-hr Relief @ 1.62	Total w/ Relief	
Atascadero	232.1	215.9	127.1	575.1	428.5	1,003.6	31.0	50.1	81.1	3.0	4.9	7.9	1,092.6
Coalinga	229.7	215.2	122.1	567.0	422.5	989.5	17.0	27.5	44.5	3.0	4.9	7.9	1,041.9
Metropolitan	178.4	177.7	104.4	460.4	343.0	803.4	16.0	25.9	41.9	3.0	4.9	7.9	853.2
Napa	268.3	259.6	162.3	690.3	514.3	1,204.6	31.0	50.1	81.1	4.0	6.5	10.5	1,296.1
Patton	260.4	257.7	149.3	667.4	497.3	1,164.7	33.0	53.4	86.4	4.0	6.5	10.5	1,261.6
<b>DSH-Total</b>	<b>1,168.8</b>	<b>1,126.1</b>	<b>665.3</b>	<b>2,960.2</b>	<b>2,205.6</b>	<b>5,165.8</b>	<b>128.0</b>	<b>207.0</b>	<b>335.0</b>	<b>17.0</b>	<b>27.5</b>	<b>44.5</b>	<b>5,545.4</b>

Figure 2.8 displays the new resources to be requested as part of this proposal. This includes 335 psychiatric technicians and 44.5 supervising registered nurses for a total of 379.5 new positions and \$46 million to be phased-in across three years. It also includes position authority only for 254.0 temporary help positions and 50.0 administrative positions.



## Analysis of Problem

**Figure 2.8: Additional Resource Request 2019-20 through 2021-22 (Positions and Dollars)**

	Total	Salaries	Benefits	OE&E	Positions
<b>Medication Pass Positions - Psychiatric Technicians</b>					
2019-20	\$ 10,669,000	\$ 6,070,000	\$ 3,079,000	\$ 1,520,000	95.0
2020-21	\$ 25,754,000	\$ 14,714,000	\$ 7,455,000	\$ 3,585,000	230.0
2021-22	\$ 37,418,000	\$ 21,431,000	\$ 10,857,000	\$ 5,130,000	335.0
2022-23+	\$ 37,313,000	\$ 21,431,000	\$ 10,857,000	\$ 5,025,000	335.0
<b>Afterhours Supervision Positions - Supervising Registered Nurses</b>					
2019-20	\$ 4,301,000	\$ 2,400,000	\$ 1,546,000	\$ 355,000	22.3
2020-21	\$ 8,566,000	\$ 4,792,000	\$ 3,084,000	\$ 690,000	44.5
2021-22	\$ 8,545,000	\$ 4,792,000	\$ 3,084,000	\$ 669,000	44.5
2022-23+	\$ 8,545,000	\$ 4,792,000	\$ 3,084,000	\$ 669,000	44.5
<b>Temporary Help Positions<sup>1</sup></b>					
2019-20	\$ -	\$ -	\$ -	\$ -	254.0
2020-21	\$ -	\$ -	\$ -	\$ -	254.0
2021-22	\$ -	\$ -	\$ -	\$ -	254.0
2022-23+	\$ -	\$ -	\$ -	\$ -	254.0
<b>Administrative Positions<sup>1</sup></b>					
2019-20	\$ -	\$ -	\$ -	\$ -	50.0
2020-21	\$ -	\$ -	\$ -	\$ -	50.0
2021-22	\$ -	\$ -	\$ -	\$ -	50.0
2022-23+	\$ -	\$ -	\$ -	\$ -	50.0
<b>Total (2022-23+)</b>	<b>\$ 45,858,000</b>	<b>\$ 26,223,000</b>	<b>\$ 13,941,000</b>	<b>\$ 5,694,000</b>	<b>683.5</b>

<sup>1</sup> Net-Zero funding achieved through movement of dollars from OE&E to Salaries

### Future Issues for Consideration

The following highlights the items which may require future considerations.

- This proposal aligns nursing position authority with need. However, significant overtime, including mandatory overtime, will continue to be a reality at DSH unless the vacancy rates in the nursing classifications can be reduced. The 2019-20 Governor's Budget includes a proposal to increase the capacity of psychiatric technician training programs and it will take some time for this to make an impact on the vacancy rates. DSH needs to continue to evaluate how it can better attract and retain nursing staff and consideration of such proposals will need to be given in future budgets.
- This proposal includes additional position authority for temporary help in an amount consistent with 2017-18 usage. Should DSH be able to increase the use of temporary help positions, future budgets should likewise increase the authority as increased use of temporary help will reduce overtime.
- A more thorough evaluation of the off-unit functions currently staffed with nursing classifications needs to be completed. There were 50 of these functions that were found to be appropriate for administrative classifications and as a result 50 nursing positions (Eight registered nurses, 38 psychiatric technicians, two licensed vocational nurses and two psychiatric technician assistants) can be returned to staffing the units, and thus reducing overtime. It should be determined if there are additional hospital functions where this shift can occur.



## Analysis of Problem

- This proposal includes 12-hour posts for medication pass psychiatric technicians, whereas this function has traditionally been staffed with one 8-hour post on AM shift and one 8-hour post on PM shift. DSH is continuing to assess the feasibility of this new approach, however should it be determined that a 12-hour shift is insufficient to meet this need, the staffing for medication pass will need to be increased by 25 percent (shift from 12 hours of coverage to 16).
- The proposed 17 posts for overnight supervision is a conservative estimate of the need. This provides for a relatively high supervisor to staff ratio of 1:40. Depending on the workload experience of these added overnight supervisors, the total number of positions may need to be adjusted.

### E. Outcomes and Accountability

The positions requested within this proposal will be phased in across a three-year period. It is intended that full implementation of positions for each function will occur by July 1, 2021.

#### Projected Outcomes

Workload Measure	BY	BY+1	BY+2	BY+3
Implement the medication pass psychiatric technician across all 128 identified units.	Begin implementing medication pass positions. Establish 185 positions.	Continue tracking the implementation and recruitment efforts for filling positions. Establish remaining 90 positions.	Continue tracking the implementation and recruitment efforts for filling positions. Establish remaining 60 positions. Assess the effectiveness of the 12-hour shift.	Continue tracking the implementation and recruitment efforts for filling positions. Assess the effectiveness of the 12-hour shift.
Implement the afterhours supervision.	Begin implementing afterhours supervision positions. Establish 44.5 positions throughout the year.	Continue tracking the implementation and recruitment efforts for filling positions. Assess the effectiveness of the supervision ratio.	Continue tracking the implementation and recruitment efforts for filling positions. Assess the effectiveness of the supervision ratio.	Continue tracking the implementation and recruitment efforts for filling positions. Assess the effectiveness of the supervision ratio.
Track and assess overtime usage quarterly; evaluate impact of methodologies.	Continue tracking overtime (mandatory and voluntary) quarterly. Compare to vacancy rates and temporary help. Provide updates within the caseload estimate.	Continue tracking overtime (mandatory and voluntary) quarterly. Compare to vacancy rates and temporary help. Provide updates within the caseload estimate.	Continue tracking overtime (mandatory and voluntary) quarterly. Compare to vacancy rates and temporary help. Provide updates within the caseload estimate.	Continue tracking overtime (mandatory and voluntary) quarterly. Compare to vacancy rates and temporary help. Provide updates within the caseload estimate.
Track and assess temporary help (internal nursing registries); evaluate impact of methodologies.	Continue tracking the use of temporary help to support internal nursing registries. Compare to vacancy rates and overtime. Provide	Continue tracking the use of temporary help to support internal nursing registries. Compare to vacancy rates and overtime. Provide	Continue tracking the use of temporary help to support internal nursing registries. Compare to vacancy rates and overtime. Provide	Continue tracking the use of temporary help to support internal nursing registries. Compare to vacancy rates and overtime. Provide



## Analysis of Problem

	updates within the caseload estimate.	updates within the caseload estimate	updates within the caseload estimate	updates within the caseload estimate
Evaluate the redirection of 50 nursing positions back to the units. Survey and evaluate the appropriateness of additional redirections.	Implement the redirection of 50 nursing positions back to the units. Establish 50 administrative positions to fulfil these roles. Collaborate with hospitals in the evaluation and appropriateness of additional redirections.	Collaborate with hospitals in the evaluation and appropriateness of additional redirections. Provide an update on additional redirections within the caseload estimate.		
Track and assess registered nurse and psychiatric technician vacancy rates. Identify effectiveness of recruitment efforts and assess the necessity for additional recruitment solutions.	Continue tracking vacancy rates and begin tracking impact of recruitment efforts. Assess the need for additional recruitment solutions.	Continue tracking vacancy rates and begin tracking impact of recruitment efforts. Assess the need for additional recruitment solutions. Present additional solutions in the caseload estimate or budgetary process.	Continue tracking vacancy rates and begin tracking impact of recruitment efforts. Assess the need for additional recruitment solutions. Present additional solutions in the caseload estimate or budgetary process.	Continue tracking vacancy rates and begin tracking impact of recruitment efforts. Assess the need for additional recruitment solutions. Present additional solutions in the caseload estimate or budgetary process.

## F. Analysis of All Feasible Alternatives

**Alternative 1:** Approve all components of the DSH nursing services staffing proposal. This proposal includes realignment of staffing resources to meet the staffing levels identified by the DSH nursing services staffing study. Realignment involves balancing all authorized positions across hospitals, increasing temporary help to the 2017-18 usage levels and establishing 50 analyst positions in order to redirect 50 nursing positions back to the units. Additionally, this proposal requests additional position authority for the functions of medication pass, and afterhours nursing supervision.

This alternative provides DSH with the opportunity to align its budget to accurately reflect all personal services costs within the personal services budgetary-line item; while balancing resources among DSH facilities and providing the staffing resources for medication pass and afterhours nursing supervision. The additional position authority, requested in this proposal will be phased-in across a three-year period.

### Pros:

- Aligns staffing resources among the categories of authorized positions, temporary help (internal registry) and overtime, to achieve the staffing levels identified through the DSH staffing study. No funds are requested to achieve this. Funds currently being used to support personal services costs from the operating expenses and equipment budgetary line items, will be transferred to the personal services budgetary line items.
- Provides resources to support the administration of medication (medication pass). Increased support for this function will decrease the reliance on floor nursing staff and allow for dedicated medication management during 12-hours of each day.



## Analysis of Problem

- Provides the resources to support afterhours nursing supervision. Increasing supervision provides more support to address any issues which arise during the evening and night hours such as scheduling concerns, patient needs and incidents requiring immediate action.

### Cons:

- Requires an increase in General Fund expenditures.

**Alternative 2:** Partially approve the DSH nursing services proposal. Approve the realignment of resources to meet the staffing levels identified by the DSH nursing services staffing study. Realignment involves balancing all authorized positions across hospitals, increasing temporary help to the 2017-18 usage levels and establishing 50 analyst positions in order to redirect 50 nursing positions back to the units.

### Pros:

- Aligns staffing resources among the categories of authorized positions, temporary help (internal registry) and overtime, to achieve the staffing levels identified through the DSH staffing study. No funds are requested to achieve this. Funds currently being used to support personal services costs from the operating expenses and equipment budgetary line items, will be transferred to the personal services budgetary line items.
- No impact to the General Fund.

### Cons:

- Does not provide the resources to support the administration of medication (medication pass). Without these additional resources floor staff will continue to be pulled to provide the dedicated medication management which ultimately decreases available nursing staff to ensure patients receive the attention and services necessary.
- Does not provide the resources to support afterhours nursing supervision. Without these resources there is no on-sight supervision during the evening and night shifts requiring full reliance on the offsite Program Officer of the Day.

**Alternative 3:** Maintain the *status quo*; do not approve new positions or additional funding. This alternative provides no solutions for DSH nursing services. This alternative does not provide any additional resources for the administration of medications or for afterhours nursing supervision. This alternative also does not provide for any realignment of resources to achieve the identified nursing services staffing levels.

### Pros:

- Does not require a General Fund augmentation

### Cons:

- Does not provide solutions to align staffing resources among the categories of authorized positions, temporary help (internal registry) and overtime, to achieve the staffing levels identified through the DSH staffing study.
- Does not provide the resources to support the administration of medication (medication pass). Without these additional resources floor staff will continue to be pulled to provide the dedicated medication management which ultimately decreases available nursing staff to ensure patients receive the attention and services necessary.
- Does not provide the resources to support afterhours nursing supervision. Without these resources there is no on-sight supervision during the evening and night shifts requiring full reliance on the off-site Program Officer of the Day.



## Analysis of Problem

### G. Implementation Plan

The requested positions are proposed to be phased in across a three-year period. The current estimated phase-in plan for the medication pass psychiatric technicians and the supervising registered nurses providing afterhours nursing supervision is displayed in **Appendix M.1 and M.2**. Note that this is an initial estimate of a phase-in and its primary purpose is for the appropriate budgeting of resources across fiscal years. Some hospitals may fill these positions more quickly than the schedule provided, while others may take longer. The actual implementation schedule will be evaluated each fall and may result in budgeting adjustments.

DSH will work with each hospital to prioritize how the units will activate the additional posts for medication pass. The goal is to activate these posts in all 128 units by July 1, 2021.

### H. Supplemental Information

N/A.

### I. Recommendation

Approve all components of the DSH nursing services staffing proposal. This allows for the realignment of staffing resources to meet the staffing levels identified by the DSH nursing services staffing study. Realignment involves balancing all authorized positions across hospitals, increasing temporary help to the 2017-18 usage levels and establishing 50 administrative positions in order to redirect 50 nursing positions back to the units. Additionally, this provides the additional position authority for the functions of medication pass and afterhours nursing supervision.



## Appendix A

### Department of State Hospitals

#### 24-Hour Care Nursing Services Staffing Study

#### Previous Nursing Staffing Studies – Summary and Timeline

- A 1953 study, submitted to the California State Legislature, proposed a methodology that was based on experiential<sup>1</sup> nursing staffing ratios and consensus. These staffing standards were adopted as goals and used for budgetary planning until fiscal year 1967-68.
- A five-year follow-up study to the 1953 study used a “need-time survey” methodology that involved time/work measurements and a detailed task analysis of actual nursing functions by unit type (patient categories). This study focused on the hours of nursing care needed to give the patients in the hospitals an “adequate” level of care.
- In 1965, DMH, the California Medical Association, the American Psychiatric Association, and other professional organizations formed the California Commission of Staffing Standards. The Commission’s methodology focused on minimum acceptable levels of care and included the implementation of the Staffing Care of Patients Effectively (SCOPE) System which utilized a computerized application of sets of fixed workload allowances related to a survey of characteristics of actual in-hospital patients to determine nursing staffing requirements. The SCOPE System was formally adopted and implemented in the fiscal year 1968-69 budget, with the commitment to achieve full compliance within five years.
- In the 1970s, changes in mental health legislation, including the passage of Chapter 1202, Statutes of 1973 (SB 413), subjecting state hospitals to the same licensing regulations as private sector hospitals, coupled with a major restructuring of state hospital clinical services into program based treatment modalities, prompted DMH to initiate a new staffing study known as Program Review Unit Number 72 (Project 72). Project 72 shifted the staffing study focus back to “adequate” levels of care and away from the SCOPE standards that were based on minimum acceptable levels of care. Project 72 utilized a broad range of industrial engineering and numerical analysis techniques and was approved within Chapter 72, Statutes of 1977 (SB 18).
- In fiscal year 1976-77, a survey conducted by the Department of Health Services (DHS) found numerous deficiencies in the DMH’s staffing and program compliance. The findings persisted even after the full implementation of Project 72 staffing standards in July 1977. In an effort to maintain certification for the hospitals, DMH and DHS negotiated the augmentation of staffing for selected functions on a hospital-by-hospital basis. These negotiated augmentations and the related funding were subsequently signed by the Governor as emergency legislation (Chapter 71, Statutes of 1978), providing the budgeting and allocation of treatment unit staffing in state

---

<sup>1</sup> Experiential staffing ratios are based in empirical and observational findings.



## Appendix A

hospitals. This staffing was based partially on the Project 72 staffing standards and partially on the staffing ratios negotiated by DMH and DHS.

- During fiscal year 1980-81, DMH assembled a panel of experts and stakeholders, and after a thorough review of prior studies on staffing requirements, current staffing allocations and staffing patterns utilized in comparable psychiatric inpatient settings outside of the state hospital system; the panel developed conceptual staffing standard models. The Panel's models included greatly enhanced clinical staffing and significant expansion of patient programming. Subsequently, DMH assembled a task force of State Hospital Executive Directors, directed to propose viable staffing alternatives in light of feasible levels of treatment services and fiscal constraints facing the state. The Task Force considered the 1980-81 panel findings, and produced staffing recommendations based on operational experience and actual staffing patterns of selected programs certified by review agencies. The Task Force's staffing proposal was adopted and submitted to the Legislature.



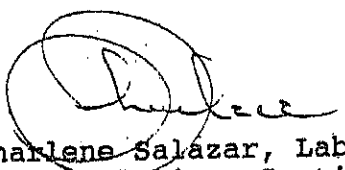
State of California

C. J. JONES  
Department of Mental Health

MEMORANDUM

To : Labor Relations Coordinators  
State Hospitals and CMF/Vacaville

Date: November 22, 1991

From :  Charlene Salazar, Labor Relations Analyst  
Labor Relations Section

Telephone: (916) 654-2590

Subject: JUDGE SAPUNOR'S DECISION.

Enclosed is a copy of the Judge Sapunor decision as we discussed at the meeting on Thursday, November 21, 1991. I only enclosed one so you may want to provide one to your Personnel Officer also, if he/she is interested.

I enjoyed seeing you all yesterday. Hope your Thanksgiving is wonderful!

Enclosure

RECEIVED

AUG 10 1993

PERSONNEL OFFICE  
ATASCADERO STATE HOSPITAL



## JUDGE SAPUNOR'S COURT ORDER

### BACKGROUND

1. On August 7, 1981, pursuant to a negotiated settlement, Superior Court Judge J.M. Sapunor issued a court order directing the Departments of Developmental Services and Mental Health to meet, post, and tabulate staffing requirements (see attached order).
2. On August 10, 1981, a copy of Judge Sapunor's order was sent to the Hospital Executive Directors by Clyde Murrey, Chief, Division of State Hospital Programs. Also, cover memo stated that instructions on how compliance will be met would be sent at a later date (see attached).
3. Between August 14, 1981 and September 28, 1981, request for suggestions on style and content of the form to be posted flowed between the hospitals and Headquarters.
4. On October 2, 1981, the form and instructions for completing and posting the form were mailed to all state hospitals (see attached).
5. On October 23, 1981, additions to the October 2, 1981 memo were made regarding unlicensed staff which may be counted in minimums (see attached).
6. On October 16, 1981, CWA petitioned the court for an order to show cause why the Departments should not be held in contempt.
7. On November 5, 1981, the Deputy Attorney General, Dennis Eckhart, responded to the court. In his response, Mr. Eckhart outlined the past events that had taken place with regards to Judge Sapunor's order of August 7, 1981. Mr. Eckhart stated that all the hospitals had complied with the order by October 30, 1981 (see attached).
8. On November 6, 1981, a memo from Dennis Eckhart was sent to both Departments' Legal staff. Mr. Eckhart stated that the petitioner requested the order to show cause be dismissed in light of the declaration filed by Mr. Eckhart on November 5, 1981 (see attached).
9. In the Department of Mental Health, it does not appear that Labor Relations staff has been involved in the litigation.



## I. STATE HOSPITAL STAFFING STANDARDS BACKGROUND

The staffing of California state psychiatric facilities has been the subject of legislative concern and periodic study by the Department of Mental Health over the past three decades. A review of the file of these prior studies presents a rich history and some interesting insights into the changing mix and numbers of patients under care; the changing role of state hospitals; the evolving concepts of care, treatment, and methods of delivery; improvements in quantifying the relationship between patient needs and staff workload; and an increase in sophistication in projecting hospital staffing requirements.

### A. The 1947 Nursing Staffing Goals

The first such study of record within the Department of Mental Hygiene was transmitted to the Legislature in 1947 and concerned the nursing function in state hospitals. The report set forth guides for the classification of wards by type of treatment service, established the nursing complements for such wards expressed in patient:staff ratios, and attempted to accommodate the problems of overcrowding patients in excess of the rated ward capacities. The staffing ratios proposed in this report were formally adopted as goals and served as the bases for budgetary justification until 86% of these standards were achieved in Fiscal Year 1951-52.

### B. The 1952 Nursing Staffing Standards

During the Fiscal Year 1952-53 budget hearings before the Senate Finance Committee, "The Department of Mental Hygiene was requested to make a further study concerning the ratio of nursing personnel to total inmate population in mental institutions, to assist in determining a desirable goal for the State of California."

The response to this request was contained in the subsequent November 1953 report to the Legislature. In its statement of the problem, the report noted that "Standards change particularly with changing concepts of treatment", a theme which has been reiterated in every subsequent study. The report went on to note that since the 1947 study, there had been an increase in hospital admissions and turnover, an increase in the amount of intensive treatment for the acutely mentally ill, and an increase in the numbers of senile patients needing medical care and needing bed care. The study outlined the factors and rationale supporting the nursing staffing proposals. It is interesting to note that the staffing projections in this report were based on a total hospital population of 30,459 mentally ill patients.

The nursing staffing ratios proposed in this report were adopted as goals and used for budgetary planning until the 1967-68 fiscal year.



### C. The 1958 Nursing Staffing Survey

In accord with the 1953 report recommendation to reexamine the nursing staffing standards within five years, the Department of Mental Hygiene initiated another such study in 1958. The stated objective of the study was "...to determine how many hours of nursing care are needed to give the patients in the hospitals of the California Department of Mental Hygiene an adequate level of care." (Emphasis added.)

Whereas the previous such study efforts and staffing ratios were experiential and based on consensus, the 1958 study design was much more ambitious. The methodology was described as a "need-time survey" and involved observers' time/work measurement of actual nursing functions. Since the measurements were intended to document the "adequate" level of care desired and "not the measure of care as presently rendered", the situations to be measured were "set up with a sufficient number of personnel and sufficient time to perform the functions in a desirable manner."

The report of this study documented a detailed task analysis of the time and frequency for a comprehensive listing of nursing functions, synthesized into the "Number of Hours Needed Per Patient" for each of eleven representative types of units (patient categories). The application of these time requirements indicated the need to more than double the nursing staff allowed for by the 1952 staffing standards. The 1958 report is a matter of record, but there is no indication on file whether it was ever endorsed by the Department or sent to the Legislature.

### D. The 1967 Report by the California Commission on Staffing Standards

In 1965, Senate Resolution Number 166 urged the Department of Mental Hygiene to request the California Medical Association, the American Psychiatric Association, and other such professional organizations or persons as the Department considered appropriate to jointly evaluate the staff needs of the state hospitals. This resolution was in response to a finding which resulted from an eighteen-month study by the California Medical Association that an outstanding deficiency of state hospitals was "the lack of adequate professional staff to meet reasonable medical standards for care and treatment of patients."

The appointment of the above requested Commission represented a significant venture in the development of staffing standards for the California state hospitals. It was the first time that such efforts were conducted under the auspices of representatives of the various professional associations and by individuals from outside the State civil service system. It was also the first time that the study efforts extended beyond nursing and included a comprehensive and coordinated study of all treatment disciplines. Finally, it was the first time that industrial engineering techniques were applied on a large scale in the documentation of patient services and workload measurement in psychiatric programs.



After an eighteen-month study, the California Commission on Staffing Standards presented its recommendations to the State Senate in a two-volume report dated February 1967. The Commission's recommendations related to staffing represented a departure from the former patient:staff ratio head-count method, since they were expressed in terms of times and tasks. They were recommended as "...the minimum staff requirements necessary to give the basic level of medical care to which anyone ill enough to enter a California state hospital is entitled."

The system of nursing standards, known by the acronym "SCOPE" (Staffing Care of Patients Effectively), involved the determination of nursing staffing requirements based on a computerized application of sets of fixed workload allowances related to a survey of characteristics of actual inhospital patients. The SCOPE System was formally adopted and implemented in the Fiscal Year 1968-69 budget, with the commitment to achieve 100% of these standards within five years.

The SCOPE System was utilized during a period of significant changes in the California mental health system. The continued expansion of county mental health programs and the introduction of the Lanterman-Petris-Short Act had profound effects upon the role and size of state psychiatric facilities. At the time of the implementation of the SCOPE System, there were approximately 18,000 patients in the Department of Mental Hygiene hospitals for the mentally ill, excluding Atascadero State Hospital. Five years later, in 1973, the inhospital population had declined to less than 6,000 patients and had changed dramatically in its composition. The SCOPE System of nursing staffing greatly facilitated the orderly budgeting of staff during this period of rapidly changing conditions.

#### E. The 1973 Staffing Standards System

The achievement of 100% of the SCOPE nursing staffing standards ahead of the 1973 schedule and the effects of the changes in mental health legislation, coupled with a major restructuring of state hospital clinical services into program organizations, prompted the Director of the Department of Mental Hygiene to authorize a new study of staffing requirements. This study was formally entitled "Program Review Unit Number 72 (Project 72)", with the multiple objectives of (a) updating the staffing standards for ward nursing personnel, (b) expanding the SCOPE concept to include all members of the multidisciplinary treatment teams, and (c) providing staffing standards specific to each of the eight types of treatment programs.

The project was carried out in collaboration with an interdisciplinary Departmental task force and an advisory council similar in makeup to the earlier California Commission on Staffing Standards.

Whereas the 1967 staffing standards were based on minimum acceptable levels of care, the Project 72 study focused on selected ward programs which were judged by peer review to be effective models of interdisciplinary treatment team operations.



Comprehensive work measurement studies were conducted involving all disciplines using a broad range of industrial engineering and numerical analysis techniques. The resulting standards promised a significant advance in the state-of-the-art by the segregation of fixed time requirements from variable workloads, the provision for allowances for management of unacceptable behavior of patients, and the quantification of staff hours for scheduled face-to-face interactions with patients to meet individualized treatment plan objectives.

The results of this project were documented in a report published in 1974, whereupon the Department authorized a pilot test of the Project 72 System to evaluate the impacts and benefits of implementing these standards. A two-year study, which culminated in July 1977, was conducted in three "experimental" programs and was matched with three "control" programs which were staffed in accordance with the old staffing standards. Based on preliminary favorable findings, the Governor signed into statute Senate Bill 18 which made the commitment to implement incrementally the Project 72 staffing standards (sometimes called 1973 Staffing Standards) starting with the Fiscal Year 1977-78 budget, with full implementation scheduled for June 30, 1980.

F. Assembly Concurrent Resolution Number 103

(ACR 103)

Prior to 1973, state hospitals had been traditionally exempt from licensure by the State Department of Health. The passage of SB 413, however, required that state hospitals were to be subject to the same licensing regulations as any health facility operated in the private sector. As a consequence, surveys of state hospitals conducted in 1976-77 by the Licensing and Certification Division of the Department of Health found numerous deficiencies in staffing and the failure to conform to current program standards in certain areas. This finding persisted even after the initial implementation of the Project 72 staffing standards in July 1977.

In an effort to maintain certification for the hospitals, a team of Departmental staff and Licensing and Certification Division staff negotiated the augmentation of staffing for selected functions on a hospital-by-hospital basis. These negotiated augmentations and the related funding were subsequently approved by the Legislature in AB 2481 (Torres) and signed by the Governor as emergency legislation (Chapter 71, Statutes of 1978), whereupon this legislation provided the pattern for subsequent budgeting and allocation of treatment unit staffing in state hospitals -- based partially on the Project 72 staffing standards and partially on the staffing ratios negotiated during the above-described process.

As a consequence of the crisis atmosphere in which these staffing augmentations were negotiated and funded, the Legislature added supplemental language to the Fiscal Year 1978-79 Budget Act and also passed Assembly Concurrent Resolution Number 103, requiring clarification of the bases for staffing determination and the resolution of other staffing-related issues.



In an endeavor to capitalize on the work measurement data previously collected during the Project 72 study and to also resolve the previously identified areas of program deficiency, the Department of Mental Health introduced a new approach to workload assessment, namely "prescriptive programming". Whereas all previous staffing studies focused on the manner in which the clinical staff spent its time, this study effort concentrated on how the patient should spend his/her time. Based on a sampling of 152 patients, multidisciplinary teams of specially selected clinicians designed individual treatment plans which were to provide a level of planned therapeutic activity adequate to attain the treatment goals for the subject patients. The diagnostic reassessment and treatment planning for this sampling of patients were compiled and synthesized into seven prescriptive treatment programming models. These models, after translation into workload statistics, were consolidated with the earlier work measurement findings of the Project 72 study and converted into new sets of staffing formulae.

The above formulae and supporting rationale were documented in the April 1979 report submitted to the Legislature in partial response to ACR 103 of 1978 and the 1978 Supplemental Budget Language to Item 262. Inasmuch as these staffing proposals represented a substantial departure from past methods, as well as a further increase in treatment unit staffing, the Department proposed a partial implementation of these standards on a pilot basis.

Along with the proposal for the pilot study, a comprehensive evaluation study was also proposed to measure the process and outcome benefits of implementing the enhanced treatment program models. The intent of the evaluation study was to provide Departmental management, the Governor, and the Legislature with a quantitative and qualitative assessment of the anticipated benefits and to provide, at predetermined milestones, points of decision as to the need for adjustment of the prescriptive programming models and/or whether the evaluation findings justified proceeding to further stages of implementation.

The proposals to pilot-test a first-stage implementation of the ACR 103 prescriptive programming models at one state hospital along with the concomitant evaluation study were submitted for review by the Legislature during the 1979 budget hearings for the Department, and again in 1980, but were not approved for implementation.

#### G. Supplemental Item 302, Paragraph 3

The essence of the legislative reaction and follow-up to the Department of Mental Health's ACR 103 proposal is reflected in paragraph 3 of Item 302 Supplemental Language to the Budget Act of Fiscal Year 1980-81, which reads as follows:

By 2/1/81, the department shall submit to the Legislature a proposal for staffing state hospitals that is consonant with the three-year plan for state hospitals to be completed



by 10/1/80. Staffing standards shall be related to the specific population state hospitals are designated to serve in the three-year plan, including the various types of mentally disordered offenders. The standards shall be developed in cooperation with the conference of local mental health directors and with a blue ribbon panel of consultants from professional schools in psychiatry, social work, psychology, nursing, vocational rehabilitation, education, pharmacy, and hospital administration. This panel shall also include former consumers of state hospital services.

In accordance with the above request, the Department of Mental Health assembled a panel of distinguished representatives of professional schools, the Conference of Local Mental Health Directors, and former consumers. This Panel, in a series of workshop meetings, reviewed the Department of Mental Health's prior work studies of staffing requirements, the current treatment team staffing allocations, and the staffing patterns in comparable psychiatric inpatient settings outside of the state hospital system. Based on the professional judgments of the panel members and in consideration of the above described inputs, the Panel developed conceptual models and staffing standard proposals. The Panel's recommendations and supporting rationale were documented in a December 1980 report entitled Treatment Unit Staffing Proposals for California State Hospital Mental Health Programs which was submitted for consideration by the Director of the Department of Mental Health.

In summary, the Panel recommended greatly enhanced clinical staffing and the expansion of patient programming to seven hours per day, seven days per week, which, at the current level of patient population, would have entailed the addition of 1,800 professional staff and an annual expenditure of 40 million dollars, plus an undetermined amount for related support personnel. In addition to the fiscal considerations, the Department of Mental Health was unable to endorse the Panel's staffing proposals for clinical and logistical reasons; however, it did subscribe to the prescriptive programming approach to treatment team staffing.

#### H. DMH Staffing Proposal - Three Year Plan

Since the Legislature's perceived need to update the staffing standards for treatment unit personnel was justified and required an appropriate response, a task force consisting of State Hospital Executive Directors was assembled. This Task Force was directed to review and evaluate the recommendations of the Staffing Standards Panel, in the light of feasible levels of treatment services and fiscal constraints facing the State and to propose some viable alternatives. The Task Force met in working sessions, considered the Staffing Standards Panel's input, and produced staffing recommendations based on its professional judgment and operational experience using as models, whenever possible, the actual staffing



patterns of selected programs which have been certified or deemed certifiable by the review agencies. The product of this second stage of development, after subsequent administrative review and refinement, was adopted by the Department as its staffing proposal for state hospitals and submitted to the Legislature as part of the Department's Three Year Plan for State Hospitals.

This manual has been amended since it was submitted to the Legislature in 1981. The terminology has been changed to be more in line with the requirements of Title 22 - Licensing. The coverage/relief allowance has also been changed to reflect the level approved on July 1, 1983.

Exhibit 1, which follows this page, provides an overview of the Department's staffing proposals for Level of Care personnel, expressed in full-time-equivalent positions per 100 patients, by type of program and by discipline. Exhibit 2, which also follows, provides a decision network for the programmatic classification of such patients.

The balance of this report provides more detailed description of the patient characteristics within each program category and the types of services and time allowances supporting the staffing standards, which are based upon the work measurement findings of the Project 72 Study from which the 1973 Staffing Standards System was originally derived.



<u>Client/PT Population</u>	<u>A.M. Shift</u>	<u>P.M. Shift</u>	<u>NOC Shift</u>	<u>Total Staff 24 hour Shift</u>
8 - 19	2	2	2	6
20 - 27	3	3	2	8
28 - 35	4	4	2	10
36 - 39	5	5	2	12
40 - 43	5	5	3	13
44 - 51	6	6	3	15
52 - 55	7	7	3	17
56 - 59	7	7	4	18
60 - 67	8	8	4	20
68 - 71	9	9	4	22

The above staffing table should be used as a guide in setting the staffing minimums on each unit.

Alternate staffing minimums approved for a unit by licensing are to be entered on the form posted on the unit.

Categories of personnel who may be counted in minimum staffing:

- Licensed Nursing Personnel: D.S., L.V.N., N.T.S., P.L.P.T. (with current L.V.N. License), Pre-registered Nurse (with current L.V.N. or P.T. license), P.T.I., P.T., R.N.I., R.N.II. Pre-Registered Nurse with interim permit may be counted as licensed, if supervised by a R.N.
- Unlicensed Personnel: S.A., G.S.A., H.W., P.T.A., P.T.S., P.T.T., P.T.T.C., Pre-licensed P.T., S.S.A.
- Rehabilitation Therapists assigned to Habilitation Units have licensing approval to be included in the minimum staffing ratio.

10/1/81.

# Memorandum

To : Douglas G. Arnold  
Interim Director

Date : January 7, 1983

Subject: CWA v. Loeb, Loberg,  
et al.

Telephone: ATSS ( )  
( ) 3-8193

*Dennis H. Mahoney*  
From : Dennis H. Mahoney  
Office of Legal Services

Attached please find a copy of the order relating to the above-captioned case which was agreed upon by both sides and by the court. Judge Sapunor signed this order on January 5, 1983.

The Office of Legal Services is available at your convenience to provide assistance in interpreting and carrying out this order.

DHM:cw  
Attachment

cc: Steven Shon, M.D.  
Delmar Gregory, M.D.  
Eugenia Mosier  
James Moore



1 HOWARD L. DICKSTEIN  
2 MARK E. MERIN  
3 KANTER, WILLIAMS, MERIN & DICKSTEIN  
4 Attorneys at Law  
5 1014 9th Street  
6 Sacramento, CA 95814  
7 Tele: 916/443-6911  
8  
9 Attorneys for Petitioners

10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO

10 CWA PSYCH TECH UNION, LOCAL  
11 11555, on behalf of its Members,  
12 All Psychiatric Technicians in  
13 The 11 State Hospitals and All  
14 Patients in Said Hospitals, vs.

NO. 295803

ALTERNATIVE WRIT OF  
MANDAMUS

Petitioners,

vs.

15 DAVID LOBERG, DIRECTOR OF THE  
16 STATE DEPARTMENT OF DEVELOP-  
17 MENTAL SERVICES AND AL M. LOEB,  
18 DIRECTOR OF THE DEPARTMENT OF  
19 MENTAL HEALTH, in their official  
capacities,

Respondents,

20 THE PEOPLE OF THE STATE OF CALIFORNIA TO RESPONDENTS DAVID  
21 LOBERG, DIRECTOR OF THE STATE DEPARTMENT OF DEVELOPMENTAL  
22 SERVICES AND AL M. LOEB, DIRECTOR OF THE DEPARTMENT OF MENTAL  
23 HEALTH:

24 It appears from the verified petition on file in this  
25 action that, in exercising judicial functions in the action  
26 now pending before you entitled CWA PSYCH TECH UNION, LOCAL  
27 11555, on behalf of its Members, All Psychiatric Technicians  
28 in The 11 State Hospitals and All Patients in Said Hospitals vs.

1 DAVID LOBERG, Director of the State Department of Developmental  
2 Services and AL M. LOEB, Director of the Department of Mental  
3 Health, in their official capacities, No. 295803, you have  
4 made orders that are in excess of your jurisdiction and  
5 in abuse of your discretion, and that you continue to abuse  
6 your discretion, and that you continue to abuse your discretion, and that Petitioner,  
7 the party herein, is entitled to a writ of appeal  
8 nor any other plain speedy, and plain remedy in the ordinary  
9 course of law.

10 THEREFORE, you are commanded, immediately on receipt  
11 of this writ, to comply with staffing at State Hospitals to  
12 legal requirements by June 12, 1981, or

13 IN THE ALTERNATIVE, to show cause before this Court  
14 on June 12, 1981, as to why you have not done so  
15 and why this Court should not issue a pre-emptory writ of  
16 mandate ordering you to comply with the law.

17 Date: June 12, 1981

18  
19  
20 J. M. SIMPSON, Clerk of the Court  
21  
22  
23  
24  
25  
26  
27  
28



ENDORSED:

AUG 7 1981

J. A. SIMPSON, CLERK  
By M. MERRITT, Deputy

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF SACRAMENTO

CWA PSYCH TECH UNION, LOCAL 11555, ) NO. 295803 DEPT. 18  
on behalf of its Members, all )  
Psychiatric Technicians in the )  
11 State Hospitals and All Patients )  
in Said Hospitals, )  
Petitioner, ) COURT'S ORDER  
AND JUDGMENT

vs.

DAVID LOBERG, DIRECTOR OF THE STATE  
DEPARTMENT OF DEVELOPMENTAL  
SERVICES and AL M. LOEB, DIRECTOR  
OF THE DEPARTMENT OF MENTAL HEALTH,  
in their official capacities,

Respondents.

The above-entitled matter having come on regularly for  
hearing on the 4th day of August, 1981, and evidence having  
been adduced on August 4, 5 and 6, 1981; the petitioners herein  
being represented by Mark Merin, Esq., and respondents David  
Loberg, Director of the State Department of Developmental  
Services, and Al M. Loeb, Director of the Department of Mental  
Health, being represented by Dennis Eckhart, Deputy Attorney  
General of the State of California; at the suggestion of the  
Court, and the parties having assembled in chambers to conduct

1 negotiations seeking a settlement of the litigation, the  
2 parties having come to an agreement, and having stated the  
3 terms of their agreement on the record in open Court,

4 IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

5 Respondents, David Loberg and Al M. Loeb, Directors of  
6 their respective State Departments, Department of Developmental  
7 Services and Department of Mental Health, shall:

8 1. Continue to meet the relevant licensing requirements  
9 governing staffing minimums for nursing care of patients in  
10 State Hospitals under their direction;

11 2. Assure that on each unit and ward in each State  
12 Hospital, in a place visible to level of care staff, there  
13 is posted the minimum staffing requirements for each shift,  
14 indicating the minimum number of licensed level of care  
15 personnel required and the number and category of unlicensed  
16 level of care personnel which may be counted to make up the  
17 minimums; and

18 3. Each month prepare a tabulation showing by shift  
19 for each ward or unit of each State Hospital the number of  
20 persons, if any, by which each such shift fell below posted  
21 minimums. Quarterly, said tabulations will be aggregated and  
22 forwarded to the headquarters of each respondent. Said  
23 aggregations and tabulations and the underlying documents on  
24 which they are based shall be public documents.

25 DATED: August 7, 1981.

26  
27 J. A. [unclear] CLERK  
28 By M. [unclear]  
DEPUTY CLERK

SEAL

J. M. SAPUNOR

JUDGE OF THE SUPERIOR COURT



1 KANTER, WILLIAMS, MERIN & DICKSTEIN  
2 MARK E. MERIN  
3 1014 9th Street  
4 Sacramento, CA 95814  
5 Tele: 916/443-6911

ENDORSED:

JAN 5 1983

6 Attorneys for Petitioner  
7 CWA PSYCH TECH UNION, LOCAL 11555, AFL-CIO

J. A. SIMPSON, CLERK  
By M. MERLIN, Deputy

8 SUPERIOR COURT OF CALIFORNIA, COUNTY OF SACRAMENTO

9 CWA PSYCH TECH UNION, Local 11555,  
10 on behalf of its Members, all  
11 Psychiatric Technicians in the  
12 11 State Hospitals and All Patients  
13 in Said Hospitals,

No. 295803

Dept. 7

DECISION AND ORDER  
OF THE COURT RE  
CONTEMPT

Petitioner,

13 vs

14 DAVID LOBERG, DIRECTOR OF THE STATE  
15 DEPARTMENT OF DEVELOPMENTAL SERVICES  
16 and KENNETH WAGSTAFF, DIRECTOR OF THE  
17 DEPARTMENT OF MENTAL HEALTH, in their  
18 official capacities,

Respondents.

19 On December 28 and 29, 1982, the days scheduled for hearing  
20 Respondent Kenneth Wagstaff's Return To The Order to Show Cause Re  
21 Contempt, the court met in chambers with Petitioner CWA Psych Tech  
22 Local 11555, AFL-CIO, represented by Kanter, Williams, Merin &  
23 Dickstein and Mark E. Merin and Howard L. Dickstein, and  
24 Respondent represented by the Attorney General of the State of  
25 California, Deputy Attorney General Dennis Eckhart, together with  
26 principals of Petitioner and Respondent, considered the  
27 affidavits, exhibits, and memoranda filed by the respective  
28 parties and the arguments of said parties and makes the following

1 findings and issues the following order:

2 FINDINGS

3 On August 7, 1981, after hearing in the above-entitled  
4 matter, this Court issued its Order and Judgment directing, inter  
5 alia, the Department of Mental Health to meet the relevant  
6 licensing requirements governing minimum level of care nursing  
7 staff at State Hospitals under its jurisdiction, to monitor  
8 instances of below-minimum staffing and quarterly to tabulate and  
9 to prepare a report of instances of below minimum staffing.  
10 Based on reports issued by the Department of Mental Health  
11 and provided to this Court, it is apparent that despite this  
12 Court's order staffing minimums have not been met at Atascadero,  
13 Patton and Metropolitan State Hospitals. The most recent  
14 quarterly report for the period from and including July through  
15 September, 1982, shows that minimum staffing was not provided at  
16 Atascadero State Hospital on 35% of the shifts, at Patton State  
17 Hospital on 57% of the shifts and at Metropolitan State Hospital  
18 on 13% of the shifts. A total of 213 additional full time level  
19 of care nursing staff were required to staff the subject hospitals  
20 at the minimum level posted in accordance with the Court's Order  
21 of August 7, 1981 and evaluated and enforced by the Licensing and  
22 Certification Division of the Department of Health Services.

23 The Court recognizes that Patton, Atascadero, and  
24 Metropolitan State Hospitals care for violent and dangerous  
25 mentally ill patients. Accordingly, employees responsible for  
26 patient care have dangerous and demanding jobs and staff shortages  
27 may increase the risks of assault and injury to both staff and  
28 patients.



1 Working under the conditions set out above has the potential  
2 to demoralize the level of care nursing staff, contribute to  
3 high turn-over rates, increase Workers' Compensation outlays,  
4 result in the deterioration of patient care and interfere with  
5 effective programming.

6 Meeting licensing requirements for numbers of level of care  
7 nursing staff is a high priority and present shortages of level of  
8 care nursing staff is a serious problem. Therefore, if funds  
9 cannot be obtained through the executive and legislative budget  
10 processes to meet level of care nursing staff minimums while  
11 maintaining other programs and activities at current levels,  
12 choices must be made and hospital programs, services and staff,  
13 curtailed, reorganized or eliminated to support the minimum level  
14 of care staffing levels.

15 Accordingly, it is hereby ORDERED:

16 1. The Director of the Department of Mental Health and his  
17 successor and such representatives as he may designate shall  
18 forthwith:

19 a. Examine the Department of Mental Health budget for  
20 Fiscal Year 82-83 and identify and list any programs, functions,  
21 activities and staff which, if required by Court order, could be  
22 curtailed, reorganized or eliminated to provide funds for more  
23 essential services; stating as to each such item the amount of  
24 funds which could be redirected. Said list shall include  
25 alternatives other than the reorganization of level of care  
26 nursing services; and

27 b. Present a proposal indicating how, anticipating a  
28 Court order, subject to contest before issuance, the number of

1 level of care staff at the three Department of Mental Health  
2 Hospitals will be increased until the minimum staffing levels are  
3 reached; and

4 c. Inform in writing the Secretary of the Health and  
5 Welfare Agency and the Director of Finance of the current shortage  
6 of level of care nursing staff under the jurisdiction of the  
7 Department of Mental Health and seek from the Department of  
8 Finance additional funding and/or authorization to expend funds  
9 already appropriated to meet level of care nursing staff  
10 minimums.

11 2. The Director of the Department of Mental Health and his  
12 successor and such representatives as he may designate shall  
13 within 90 days hence and at such other additional times as this  
14 Court may hereafter require, provide to the Court the information  
15 required by this order with copies to counsel for Petitioner. The  
16 information so provided shall be solely for the use of the Court  
17 and the parties to this litigation and shall be sealed by the  
18 Court to be opened only upon subsequent order of a Court of  
19 competent jurisdiction.

20 3. This matter is hereby set for further proceedings on  
21 April 11, 1983 in a Department to be assigned by the Presiding  
22 Judge.

23 Dated: JAN 5 1983

24  
25 J. M. SAPUNOR

26 JUDGE OF THE SUPERIOR COURT  
27  
28



1. MARK E. MERIN  
2. KANTER, WILLIAMS, MERIN & DICKSTEIN  
3. 1014 9th Street  
4. Sacramento, CA 95814  
5. Tele: 916/443-6911

6. Attorneys for Petitioner

7. SUPERIOR COURT, COUNTY OF SACRAMENTO

8. CWA PSYCH TECH UNION, et al.,  
9. Plaintiffs,

NO. 295803

PROOF OF SERVICE BY MAIL

vs

LOBERG, et al.,

Defendants.

I, RAMONA CARLOS, declare as follows:

I am over the age of 18 years, and not a party to the within  
action; my place of employment and business address is 1014 9th  
Street, Sacramento, CA 95814.

On January 5, 1983, I served the within

DECISION AND ORDER OF THE COURT RE CONTEMPT

on the parties in said action, by placing a true copy thereof en-  
closed in a sealed envelope with postage thereon fully prepaid  
in the United States post office box, Sacramento, CA addressed  
as follows:

Dennis Eckhart  
Deputy Attorney General  
555 Capitol Mall, Ste. 350  
Sacramento, CA 95814

Executed on January 5, 1983 at Sacramento, CA, I declare  
under penalty of perjury that the foregoing is true and correct.

Ramona Carlos

POST ON EA UNIT WHERE VISIBLE TO LOC ST

Atascadero State Hospital

Guide for Minimum Staffing

L O C NURSING

Client/Pt. Population	AM SHIFT	PM SHIFT	NOC SHIFT	TOTAL STAFF 24 HOUR SHIFT
8 - 19	2	2	2	6
20 - 27	3	3	2	8
28 - 35	4	4	2	10
36 - 39	5	5	2	12
40 - 43	5	5	3	13
44 - 51	6	6	3	15
52 - 55	7	7	3	17
56 - 59	7	7	4	18
60 - 67	8	8	4	20
68 - 71	9	9	4	22

Licensing regulations require a minimum of one licensed nursing staff member on duty per shift. However, a minimum of 2 licensed staff per shift is established at Atascadero State Hospital. Alternate Staffing Minimums approved by Licensing (specify).

Staffing requirements are adjusted to client/patient population changes on each shift on each unit. Staffing adjustments may be made for those periods of time when clients/patients are under the care and supervision of staff other than nursing - for example when clients/patients are at school, workshops, rehab activities, etc.

Unlicensed Staff Categories which may be counted in minimums.

SA - Student Assistant	PTS - Psychiatric Technician Student
GSA - Graduate Student Assistant	PTT - Psychiatric Technician Trainee
HW - Hospital Worker	PTTC - Psychiatric Technician Trainee
PTA - Psychiatric Technician Apprentice	Candidate
SSA - Social Service Assistant	PLPT - Pre-licensed Psychiatric Tech

Rehabilitation Therapists assigned to Habilitation Units have licensing approval to be included in the minimum staffing ratio.

Posted on Unit By: \_\_\_\_\_

Date: \_\_\_\_\_

10/1/81



POST ON EACH UNIT WHERE VISIBLE TO LOC STAFF

METROPOLITAN STATE HOSPITAL

Guide for Minimum Staffing

LOC Nursing

Patient Population	AM Shift	PM Shift	NOC Shift	Total Staff 24 Hour Shift
8 - 19	2	2	2	6
20 - 27	3	3	2	8
28 - 35	4	4	2	10
36 - 39	5	5	2	12
40 - 43	5	5	3	13
44 - 51	6	6	3	15
52 - 55	7	7	3	17

Staffing requirements are adjusted to patient population changes on each shift on each unit. Staffing adjustments may be made for those periods of time when patients are under the care and supervision of staff other than nursing - for example when patients are in groups or in individual therapy, rehab activities, at school or workshops, on grounds or day pass, etc.

Unlicensed Staff Categories:

SA - Student Assistant	PTS - Psychiatric Technician Student
GSA - Graduate Student Assistant	PTT - Psychiatric Technician Trainee
HW - Hospital Worker	PTTC - Psychiatric Technician Trainee Candidate
PTA - Psychiatric Technician Apprentice	PLPT - Pre-Licensed Psychiatric Technician
SSA - Social Service Assistant	

Posted on Unit By: \_\_\_\_\_

Date: \_\_\_\_\_

10/1/81

POST ON EACH UNIT WHERE VISIBLE TO LOC STAFF

METROPOLITAN STATE HOSPITAL

## Guide for Minimum Staffing

L O C      Nursing

UNIT: 101

[illegible]

Staffing requirements are adjusted to patient population changes on each shift on each unit. Staffing adjustments may be made for those periods of time when patients are under the care and supervision of staff other than nursing - for example when patients are in groups or in individual therapy, rehab activities, at school or workshops, on grounds or day pass, etc.

Unlicensed Staff Categories:

SA - Student Assistant  
GSA - Graduate Student Assistant  
HW - Hospital Worker  
PTA - Psychiatric Technician App  
SSA - Social Service Assistant

PTS - Psychiatric Technician Student  
PTT - Psychiatric Technician Trainee  
PTTC - Psychiatric Technician Trainee  
Candidate  
PLPT - Pre-Licensed Psychiatric Technician

Posted on Unit By: \_\_\_\_\_

Date:

10/1/81



POST ON EACH UNIT WHERE VISIBLE TO LOC STAFF

METROPOLITAN STATE HOSPITAL

Guide for Minimum Staffing

L O C     Nursing

UNIT: 102

Patient Population	AM Shift	PM Shift	NOC Shift	Total Staff 24 Hour Shift
8 - 19	3	3	2	8
20 - 32	4	4	2	10

Staffing requirements are adjusted to patient population changes on each shift on each unit. Staffing adjustments may be made for those periods of time when patients are under the care and supervision of staff other than nursing - for example when patients are in groups or in individual therapy, rehab activities, at school or workshops, on grounds or day pass, etc.

Unlicensed Staff Categories:

SA - Student Assistant	PTS - Psychiatric Technician Student
GSA - Graduate Student Assistant	PTT - Psychiatric Technician Trainee
HW - Hospital Worker	PTTC - Psychiatric Technician Trainee
PTA - Psychiatric Technician Apprentice	Candidate
SSA - Social Service Assistant	PLPT - Pre-Licensed Psychiatric Technician

Posted on Unit By: \_\_\_\_\_

Date: \_\_\_\_\_

10/1/81

POST ON EACH UNIT WHERE VISIBLE TO LOC STAFF

METROPOLITAN STATE HOSPITAL

Guide for Minimum Staffing

LOC Nursing

UNIT: 105

Patient Population	AM Shift	PM Shift	NOC Shift	Total Staff 24 Hour Shift
8 - 19	3	3	2	8
20 - 32	4	4	2	10

Staffing requirements are adjusted to patient population changes on each shift on each unit. Staffing adjustments may be made for those periods of time when patients are under the care and supervision of staff other than nursing - for example when patients are in groups or in individual therapy, rehab activities, at school or workshops, on grounds or day pass, etc.

Unlicensed Staff Categories:

SA - Student Assistant  
GSA - Graduate Student Assistant  
HW - Hospital Worker  
PTA - Psychiatric Technician Apprentice  
SSA - Social Service Assistant

PTS - Psychiatric Technician Student  
PTT - Psychiatric Technician Trainee  
PTTC - Psychiatric Technician Trainee  
Candidate  
PLPT - Pre-Licensed Psychiatric Technician

Posted on Unit By: \_\_\_\_\_

Date: \_\_\_\_\_

10/1/81



METROPOLITAN STATE HOSPITAL

L O C      Nursing

[illegible]

10/1/81

10/1/81





22 CCR § 71004

**§ 71004. Acute Psychiatric Care Bed Classification.**

Acute psychiatric care bed classification means beds designated for acute psychiatric, developmentally disabled or drug abuse patients receiving 24-hour medical care.

Note: Authority cited: Sections 208, 1250, 1250.1, 1251, 1255, and 1268, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

**HISTORY**

1. New section filed 10-5-76 as an emergency; effective upon filing (Register 76, No. 41).
2. Amendment filed 11-12-76 as an emergency; effective upon filing (Register 76, No. 46).
3. Certificate of Compliance as to filing of 10-5-76 filed 1-31-77 (Register 77, No. 6).
4. Certificate of Compliance as to filing of 11-12-76 filed 3-8-77 (Register 77, No. 11).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71004, 22 CA ADC § 71004



22 CCR § 71005

**§ 71005. Acute Psychiatric Hospital.**

(a) Acute psychiatric hospital means a hospital having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care for mentally disordered, incompetent or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services.

(b) An acute psychiatric hospital shall not include separate buildings which are used exclusively to house personnel or provide activities not related to hospital patients.

Note: Authority cited: Section 1250.1(e), Health and Safety Code. Reference: Section 1250(b), Health and Safety Code.

**HISTORY**

1. Change without regulatory effect pursuant to section 100(b)(3), Title 1, California Code of Regulations, repealing subsection (c), filed 4-2-90 (Register 90, No. 17).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71005, 22 CA ADC § 71005

22 CCR § 71211

**§ 71211. Psychiatric Nursing Service Definition.**

Psychiatric nursing service means the performance of those services directed toward meeting the objectives of an individual planned therapeutic program supervised and coordinated by a registered nurse in conjunction with the treatment plan, nursing care and other health professional care.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71211, 22 CA ADC § 71211



22 CCR § 71213

**§ 71213. Psychiatric Nursing Service General Requirements.**

(a) Written policies and procedures shall be developed and maintained by the director of nursing in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.

(b) The responsibility and the accountability of the nursing service to the medical staff and hospital administration shall be defined.

(c) There shall be a written organized staff education program which shall include orientation and in-service education and training.

(1) There shall be written objectives, plans for implementation and an evaluation mechanism.

(d) There shall be a written patient care plan developed for each patient in coordination with the total mental health team. This plan shall include goals, problems/needs and approach and shall be available to all members of the mental health team.

(e) There shall be a written nursing audit procedure and evidence that audit procedures are in effect.

(f) There shall be a method for determining staffing requirements based on assessment of patient needs. This assessment shall take into consideration at least the following:

(1) The ability of the patient to care for himself.

(2) His degree of illness.

(3) Requirements for special nursing activities.

(4) Skill level of personnel required in his care.

(5) Placement of the patient in the nursing unit.

(g) There shall be documentation of the methodology used in making staffing determinations. Such documentation shall be part of the records of the nursing service and be available for review.

(h) There shall be a written staffing pattern which shall show:

(1) Total numbers of staff including full-time and full-time equivalents.

(2) The available nursing care hours for each nursing unit.

(3) The categories of staff available for patient care.

(i) There shall be a record retained for six months of the written staffing pattern available for review by the Department at any given time.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71213, 22 CA ADC § 71213

22 CCR § 71215

**§ 71215. Psychiatric Nursing Service Staff.**

(a) The psychiatric nursing service shall be under the direction of a registered nurse who shall meet at least the following qualifications:

- (1) Master's degree in psychiatric nursing or related field with experience in administration; or
- (2) Baccalaureate degree in nursing or related field with experience in psychiatric nursing and two years of experience in nursing administration; or
- (3) Four years of experience in nursing administration or supervision and with experience in psychiatric nursing.

(b) The director of nurses shall not be designated to serve as charge nurse.

(c) Sufficient registered nursing personnel shall be provided to:

(1) Assist the director of nurses for evening and night services and when necessary for day services.

(2) Give direct nursing care based on patient need.

(3) Have a registered nurse on duty at all times.

(4) Plan, supervise and coordinate care given by licensed vocational nurses, psychiatric technicians and other mental health workers.

(d) Each nursing unit shall have a registered nurse, licensed vocational nurse or psychiatric technician on duty at all times.

(e) Licensed vocational nurses and psychiatric technicians may be utilized as needed to assist registered nurses in ratios appropriate to patient needs.

(f) Mental health workers may be utilized as needed to assist with nursing procedures.

Note: Authority cited: Sections 1275 and 131200, Health and Safety Code. Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**HISTORY**

1. Change without regulatory effect amending subsections (c)(4)-(e) and adding new Note filed 3-12-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 11).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71215, 22 CA ADC § 71215



22 CCR § 71217

**§ 71217. Psychiatric Nursing Service Equipment and Supplies.**

There shall be adequate and appropriate equipment and supplies related to the scope and nature of the needs anticipated and the services offered.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71217, 22 CA ADC § 71217

22 CCR § 71219

**§ 71219. Psychiatric Nursing Service Space.**

Office space shall be provided for the director of nurses.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 71219, 22 CA ADC § 71219

22 CCR § 72101

**§ 72101. Skilled Nursing Care Bed Classification.**

Skilled nursing care bed classification means beds designated for patients requiring skilled nursing care on a continuous and extended basis.

Note: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Sections 1250 and 1250.1, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72101, 22 CA ADC § 72101



22 CCR § 72103

**§ 72103. Skilled Nursing Facility.**

Skilled nursing facility means a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. It provides 24-hour inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1250 and 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72103, 22 CA ADC § 72103

22 CCR § 72301

**§ 72301. Required Services.**

- (a) Skilled nursing facilities shall provide, but shall not be limited to, the following required services: physician, skilled nursing, dietary, pharmaceutical and an activity program.
- (b) Skilled nursing facilities caring for patients who are mentally disordered and whose needs for a special treatment program are identified shall also meet the requirements for a special treatment program service.
- (c) Skilled nursing facilities providing intermediate care services shall do so in a distinct part separately approved by the Department and shall be in conformity with the licensing regulations for the type of service provided in that distinct part. The facility license shall indicate approval of the distinct part by the Department.
- (d) Written arrangements shall be made for obtaining all necessary diagnostic and therapeutic services prescribed by the attending physician, podiatrist, dentist, or clinical psychologist subject to the scope of licensure and the policies of the facility. If the service cannot be brought into the facility, the facility shall assist the patient in arranging for transportation to and from the service location.
- (e) Arrangements shall be made for an advisory dentist to participate at least annually in the staff development program for all patient care personnel and to approve oral hygiene policies and practices for the care of patients.
- (f) The facility shall ensure that all orders, written by a person lawfully authorized to prescribe, shall be carried out unless contraindicated.
- (g) The facility shall make arrangements for a physician or physicians to be available to furnish emergency medical care if the attending physician, or designee, is unavailable. The telephone numbers of those physicians shall be posted in a conspicuous place in the facility.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1252, 1276, 1315, 1316 and 1316.5, Health and Safety Code.

**HISTORY**

1. Amendment filed 2-8-83; designated effective 3-2-83 (Register 83, No. 7).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72301, 22 CA ADC § 72301

**22 CCR § 72309**  
**§ 72309. Nursing Service.**

Nursing service means a service staffed, organized and equipped to provide skilled nursing care to patients on a continuous basis.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40  
22 CCR § 72309, 22 CA ADC § 72309



22 CCR § 72311

**§ 72311. Nursing Service - General.**

(a) Nursing service shall include, but not be limited to, the following:

(1) Planning of patient care, which shall include at least the following:

(A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission.

(B) Development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited.

(C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition.

(2) Implementing of each patient's care plan according to the methods indicated. Each patient's care shall be based on this plan.

(3) Notifying the attending licensed healthcare practitioner acting within the scope of his or her professional licensure promptly of:

(A) The admission of a patient.

(B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient.

(C) An unusual occurrence, as provided in Section 72541, involving a patient.

(D) A change in weight of five pounds or more within a 30-day period unless a different stipulation has been stated in writing by the patient's licensed healthcare practitioner acting within the scope of his or her professional licensure.

(E) Any untoward response or reaction by a patient to a medication or treatment.

(F) Any error in the administration of a medication or treatment to a patient which is life threatening and presents a risk to the patient.

(G) The facility's inability to obtain or administer, on a prompt and timely basis, drugs, equipment, supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient.

(b) All attempts to notify licensed healthcare practitioners acting within the scope of his or her professional licensure shall be noted in the patient's health record including the time and method of communication and the name of the person acknowledging contact, if any. If the attending licensed healthcare practitioner acting within the scope of his or her professional licensure or his or her designee is not readily available, emergency medical care shall be provided as outlined in Section 72301(g).

(c) Licensed nursing personnel shall ensure that patients are served the diets as ordered by the attending licensed healthcare practitioner acting within the scope of his or her professional licensure.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code.

Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

## **HISTORY**

1. Amendment of subsections (a)(3), (a)(3)(C)-(D) and (b)-(c) and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72311, 22 CA ADC § 72311

22 CCR § 72313

**§ 72313. Nursing Service -Administration of Medications and Treatments.**

(a) Medications and treatments shall be administered as follows:

(1) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such order.

(2) Medications and treatments shall be administered as prescribed.

(3) Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded.

(4) Preparation of doses for more than one scheduled administration time shall not be permitted.

(5) All medications and treatments shall be administered only by licensed medical or licensed nursing personnel with the following exceptions:

(A) Students in the healing arts professions may administer medications and treatments only when the administration of medications and treatments is incidental to their course of study as approved by the professional board or organization legally authorized to give such approval.

(B) Unlicensed persons may, under the direct supervision of licensed nursing or licensed medical personnel, during training or after completion of training and demonstrated evidence of competence, administer the following:

1. Medicinal shampoos and baths.

2. Laxative suppositories and laxative enemas.

3. Nonlegend topical ointments, creams, lotions and solutions when applied to intact skin surfaces. Unlicensed persons shall not administer any medication associated with treatment of eyes, ears, nose, mouth, or genitourinary tract.

(6) Medications shall be administered as soon as possible, but no more than two hours after doses are prepared, and shall be administered by the same person who prepares the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.

(7) Patients shall be identified prior to administration of a drug or treatment.

(8) Drugs may be administered in the absence of a specific duration of therapy on a licensed prescriber's new drug order if the facility applies its stop-order policy for such drugs. The prescriber shall be contacted prior to discontinuing therapy as established by stop-order policy.

(b) No medication shall be used for any patient other than the patient for whom it was prescribed.

(c) The time and dose of the drug or treatment administered to the patient shall be recorded in the patient's individual medication record by the person who administers the drug or treatment. Recording shall include the date, the time and the dosage of the medication or type of the treatment. Initials may be used, provided that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.

(d) Oxygen equipment shall be maintained as follows:



(1) Humidifier bottles on oxygen equipment shall be changed and sterilized at least every 24 hours.

(2) Only sterile distilled, demineralized or de-ionized water shall be used in humidifier bottles.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72313, 22 CA ADC § 72313

22 CCR § 72315

**§ 72315. Nursing Service - Patient Care.**

- (a) No patient shall be admitted or accepted for care by a skilled nursing facility except on the order of a physician.
- (b) Each patient shall be treated as individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.
- (c) Each patient, upon admission, shall be given orientation to the skilled nursing facility and the facility's services and staff.
- (d) Each patient shall be provided care which shows evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails. The patient shall be free of offensive odors.
- (e) Each patient shall be encouraged and/or assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep patients active, and out of bed for reasonable periods of time, except when contraindicated by orders of a licensed health care practitioner acting within the scope of his or her professional licensure.
- (f) Each patient shall be given care to prevent formation and progression of decubiti, contractures and deformities. Such care shall include:
  - (1) Changing position of bedfast and chairfast patients with preventive skin care in accordance with the needs of the patient.
  - (2) Encouraging, assisting and training in self-care and activities of daily living.
  - (3) Maintaining proper body alignment and joint movement to prevent contractures and deformities.
  - (4) Using pressure-reducing devices where indicated.
  - (5) Providing care to maintain clean, dry skin free from feces and urine.
  - (6) Changing of linens and other items in contact with the patient, as necessary, to maintain a clean, dry skin free from feces and urine.
  - (7) Carrying out of physician's orders for treatment of decubitus ulcers. The facility shall notify the physician, when a decubitus ulcer first occurs, as well as when treatment is not effective, and shall document such notification as required in Section 72311(b).
- (g) Each patient requiring help in eating shall be provided with assistance when served, and shall be provided with training or adaptive equipment in accordance with identified needs, based upon patient assessment, to encourage independence in eating.
- (h) Each patient shall be provided with good nutrition and with necessary fluids for hydration.
- (i) Measures shall be implemented to prevent and reduce incontinence for each patient and shall include:
  - (1) Written assessment by a licensed nurse to determine the patient's ability to participate in a bowel and/or bladder management program. This is to be initiated within two weeks after admission of an incontinent patient.
  - (2) An individualized plan, in addition to the patient care plan, for each patient in a bowel and/or bladder management program.

(3) A weekly written evaluation in the progress notes by a licensed nurse of the patient's performance in the bowel and/or bladder management program.

(j) Fluid intake and output shall be recorded for each patient as follows:

(1) If ordered by the physician.

(2) For each patient with an indwelling catheter:

(A) Intake and output records shall be evaluated at least weekly and each evaluation shall be included in the licensed nurses' progress notes.

(B ) After 30 days the patient shall be reevaluated by the licensed nurse to determine further need for the recording of intake and output.

(k) The weight and length of each patient shall be taken and recorded in the patient's health record upon admission, and the weight shall be taken and recorded once a month thereafter.

(l) Each patient shall be provided visual privacy during treatments and personal care.

(m) Patient call signals shall be answered promptly.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code.

Reference: Sections 1262.7, 1275, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

### **HISTORY**

1. Amendment of subsection (e) and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72315, 22 CA ADC § 72315



22 CCR § 72317

**§ 72317. Nursing Service -Standing Orders.**

Standing orders shall not be used in skilled nursing facilities.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72317, 22 CA ADC § 72317

22 CCR § 72319

**§ 72319. Nursing Service - Restraints and Postural Supports.**

- (a) Written policies and procedures concerning the use of restraints and postural supports shall be followed.
- (b) Restraints shall only be used with a written order of a licensed healthcare practitioner acting within the scope of his or her professional licensure. The order must specify the duration and circumstances under which the restraints are to be used. Orders must be specific to individual patients. In accordance with Section 72317, there shall be no standing orders and in accordance with Section 72319(i)(2)(A), there shall be no P.R.N. orders for physical restraints.
- (c) The only acceptable forms of physical restraints shall be cloth vests, soft ties, soft cloth mittens, seat belts and trays with spring release devices. Soft ties means soft cloth which does not cause abrasion and which does not restrict blood circulation.
- (d) Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff.
- (e) No restraints with locking devices shall be used or available for use in a skilled nursing facility.
- (f) Seclusion, which is defined as the placement of a patient alone in a room, shall not be employed.
- (g) Restraints shall be used in such a way as not to cause physical injury to the patient and to insure the least possible discomfort to the patient.
- (h) Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency.
- (i) The requirements for the use of physical restraints are:
  - (1) Treatment restraints may be used for the protection of the patient during treatment and diagnostic procedures such as, but not limited to, intravenous therapy or catheterization procedures. Treatment restraints shall be applied for no longer than the time required to complete the treatment.
  - (2) Physical restraints for behavior control shall only be used on the signed order of a physician, or unless the provisions of section 1180.4(e) of the Health and Safety Code apply to the patient, a psychologist, or other person lawfully authorized to prescribe care, except in an emergency which threatens to bring immediate injury to the patient or others. In such an emergency an order may be received by telephone, and shall be signed within 5 days. Full documentation of the episode leading to the use of the physical restraint, the type of the physical restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient's health record.
- (A) Physical restraints for behavioral control shall only be used with a written order designed to lead to a less restrictive way of managing, and ultimately to the elimination of, the behavior for which the restraint is applied. There shall be no PRN orders for behavioral restraints.
- (B) Each patient care plan which includes the use of physical restraint for behavior control shall specify the behavior to be eliminated, the method to be used and the time limit for the use of the method.

(C) Patients shall be restrained only in an area that is under supervision of staff and shall be afforded protection from other patients who may be in the area.

(j) When drugs are used to restrain or control behavior or to treat a disordered thought process, the following shall apply:

(1) The specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the patient's health record.

(2) The plan of care for each patient specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions.

(3) The data collected shall be made available to the prescriber in a consolidated manner at least monthly.

(4) PRN orders for such drugs shall be subject to the requirements of this section.

(k) "Postural support" means a method other than orthopedic braces used to assist patients to achieve proper body position and balance. Postural supports may only include soft ties, seat belts, spring release trays or cloth vests and shall only be used to improve a patient's mobility and independent functioning, to prevent the patient from falling out of a bed or chair, or for positioning, rather than to restrict movement. These methods shall not be considered restraints.

(1) The use of postural support and the method of application shall be specified in the patient's care plan and approved in writing by the physician, psychologist, or other person lawfully authorized to provide care.

(2) Postural supports shall be applied:

(A) Under the supervision of a licensed nurse.

(B) In accordance with principles of good body alignment and with concern for circulation and allowance for change of position.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code.

Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code; and *Valdivia, et al. v. Coye*, U.S. District Court for the Eastern District of California, Case No. CIV S-90-1226.

## **HISTORY**

1. Amendment of subsection (b) and Note filed 5-25-95; operative 6-26-95 (Register 95, No. 21).

2. Amendment of subsections (b), (i)(2) and (k)(1) and Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72319, 22 CA ADC § 72319



22 CCR § 72321

**§ 72321. Nursing Service -Patients with Infectious Diseases.**

(a) Patients with infectious diseases shall not be admitted to or cared for in the facility unless the following requirements are met:

(1) A patient suspected of or diagnosed as having an infectious or reportable communicable disease or being in a carrier state who the attending officer determines is a potential danger, shall be accommodated in a room, vented to the outside, and provided with a separate toilet, hand-washing facility, soap dispenser and individual towels.

(2) There shall be:

(A) Separate provisions for handling contaminated linens.

(B) Separate provisions for handling contaminated dishes.

(b) The facility shall adopt, observe and implement written infection control policies and procedures. These policies and procedures shall be reviewed at least annually and revised as necessary.

(c) The following shall be available in each nurse's station:

(1) The facility's infection control policies and procedures.

(2) Name, address and telephone numbers of local health officers.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72321, 22 CA ADC § 72321

22 CCR § 72323

**§ 72323. Nursing Service -Cleaning, Disinfecting and Sterilizing.**

- (a) Each facility shall adopt a written manual on cleaning, disinfecting and sterilizing procedures. The manual shall include procedures to be used in the care of utensils, instruments, solutions, dressings, articles and surfaces and shall be available for use by facility personnel. All procedures shall be carried out in accordance with the manual.
- (b) Each facility shall make provisions for the cleaning and disinfecting of contaminated articles and surfaces which cannot be sterilized.
- (c) Bedside equipment including but not limited to washbasins, emesis basins, bedpans and urinals shall be sanitized only by one of the following methods:
  - (1) Submersion in boiling water for a minimum of 30 minutes.
  - (2) Autoclaving at 15 pounds pressure and 121 degrees C (250) for 20 minutes.
  - (3) Gas sterilization.
- (d) Chemicals shall not be used as a substitute for the methods specified in (c) above.
- (e) Electronic thermometers shall be cleaned and disinfected according to the manufacturer's instructions. Glass thermometers shall be cleaned and disinfected for at least 10 minutes with 70 percent ethyl alcohol or 90 percent isopropyl alcohol with 0.2 percent iodine. Oral and rectal thermometers shall be stored separately in clean, labeled containers with fitted lids.
- (f) Individual patient care supply items designed and identified by the manufacturer to be disposable shall not be reused.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72323, 22 CA ADC § 72323

22 CCR § 72325

**§ 72325. Nursing Service -Space.**

- (a) An office or other suitable space shall be provided for the director of nursing service.
- (b) A nursing station shall be maintained in each nursing unit or building.
- (c) Each nursing station shall have a cabinet, a desk, space for records, a bulletin board, a telephone and a specifically designated and well illuminated medication storage compartment with a lockable door. If a separate medication room is maintained, it shall have a lockable door and a sink with water connections for care of equipment and for handwashing.
- (d) If a refrigerator is provided in a nursing station, the refrigerator shall meet the following standards:
  - (1) Be located in a clean area not subject to contamination by human waste.
  - (2) Maintain temperatures at or below 7 degrees C (45 degrees F) for chilling.
  - (3) Maintain the freezer at minus 18 degrees C (0 degrees F).
  - (4) Contain an accurate thermometer at all times.
  - (5) If foods are retained in the refrigerator, they shall be covered and clearly identified as to contents and date initially covered.

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72325, 22 CA ADC § 72325



22 CCR § 72327

**§ 72327. Nursing Service -Director of Nursing Service.**

(a) The director of nursing service shall be a registered nurse and shall be employed eight hours a day, on the day shift five days a week.

(b) The director of nursing service shall have at least one year of experience in nursing supervision within the last five years.

(c) The director of nursing service shall have, in writing, administrative authority, responsibility and accountability for the nursing services within the facility and serve only one facility in this capacity at any one time.

Note: Authority cite: Sections 208(a) and 1275, Health and Safety Code. Reference: Section 1276, Health and Safety Code.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72327, 22 CA ADC § 72327

22 CCR § 72329

§ 72329. Nursing Service - Staff.

(a) Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. The Department may require a facility to provide additional staff as set forth in Section 72501(g).

(b) Facilities licensed for 59 or fewer beds shall have at least one registered nurse or a licensed vocational nurse, awake and on duty, in the facility at all times, day and night.

(c) Facilities licensed for 60 to 99 beds shall have at least one registered nurse or licensed vocational nurse, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The director of nursing service shall not have charge nurse responsibilities.

(d) Facilities licensed for 100 or more beds shall have at least one registered nurse, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing service. The director of nursing service shall not have charge nurse responsibilities.

(e) Nursing stations shall be staffed with nursing personnel when patients are housed in the nursing unit.

(f) Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.0 nursing hours per patient day.

(1) Facilities which provide care for mentally disordered patients and in which psychiatric technicians provide patient care shall meet the following standards:

(A) If patients are not certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum daily average of 3.0 nursing hours per patient day.

(B) For patients certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum daily average of 2.3 nursing hours per patient day for each patient certified to the special treatment program, exclusive of additional staff required to meet the staffing standards of the special treatment program.

(g) Staffing for a distinct part intermediate care unit in a skilled nursing facility:

(1) Units of less than 50 intermediate care beds shall not be required to provide licensed personnel in addition to those provided in the skilled nursing facility unless the Department determines through a written evaluation that additional licensed personnel are necessary to protect the health and safety of patients.

(2) Units of 50 or more intermediate care beds shall provide a registered nurse or licensed vocational nurse employed 8 hours on the day shift, 7 days per week in the unit.

(3) For purposes of this section intermediate care beds that are licensed as such by the Department shall not be included for establishing licensed nurse staffing as required in Section 72329(f)(1) if the unit is used exclusively for intermediate care patients.

(h) This section shall become inoperative upon the operative date of Section 72329.1.

Note: Authority cited: Sections 1275, 1276.5, 1276.65 and 131200, Health and Safety Code. Reference: Sections 1276, 1276.5, 1276.65, 131050, 131051 and 131052, Health and Safety Code; and Section 14110.7(c), Welfare and Institutions Code.

**HISTORY**

1. Amendment of subsection (f) filed 9-23-85 as an emergency; effective upon filing (Register 85, No. 39). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1-21-86.
2. Certificate of Compliance transmitted to OAL 1-17-86 and filed 2-10-86 (Register 86, No. 7).
3. New subsection (h) and amendment of Note filed 11-8-2007 as an emergency; operative 11-8-2007 (Register 2007, No. 45). This regulatory action is deemed an emergency exempt from OAL review and was filed with the Secretary of State pursuant to Chapter 684, Statutes of 2001 (AB 1075). A Certificate of Compliance must be transmitted to OAL by 5-6-2008 or emergency language will be repealed by operation of law on the following day.
4. New subsection (h) and amendment of Note refiled 5-6-2008 as an emergency; operative 5-6-2008 (Register 2008, No. 19). This regulatory action is deemed an emergency exempt from OAL review and was filed with the Secretary of State pursuant to Chapter 684, Statutes of 2001 (AB 1075). A Certificate of Compliance must be transmitted to OAL by 11-3-2008 or emergency language will be repealed by operation of law on the following day.
5. Reinstatement of section as it existed prior to 11-8-2007 emergency amendment by operation of Government Code section 11346.1(f) (Register 2008, No. 47).
6. New subsection (h) and amendment of Note filed 1-22-2009; operative 1-22-2009 (Register 2009, No. 4).
7. Change without regulatory effect amending section heading and subsection (f)(1) and amending Note filed 3-12-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 11).

This database is current through 10/2/15 Register 2015, No. 40  
22 CCR § 72329, 22 CA ADC § 72329



22 CCR § 72329.1

**§ 72329.1. Nursing Service - Staff.**

(a) Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. The staffing requirements required by this section are minimum standards only. Skilled nursing facilities shall employ and schedule additional staff as needed to ensure quality resident care based on the needs of individual residents and to ensure compliance with all relevant state and federal staffing requirements. The Department may require a facility to provide additional staff as set forth in Section 72501(g).

(b) Facilities licensed for 59 or fewer beds shall have at least one registered nurse or a licensed vocational nurse, awake and on duty, in the facility at all times, day and night.

(c) Facilities licensed for 60 to 99 beds shall have at least one registered nurse or licensed vocational nurse, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The director of nursing services shall not have charge nurse responsibilities.

(d) Facilities licensed for 100 or more beds shall have at least one registered nurse, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing services. The director of nursing services shall not have charge nurse responsibilities.

(e) Nursing stations shall be staffed with nursing personnel when patients are housed in the nursing unit.

(f) Each facility shall employ sufficient nursing staff to provide a minimum of 3.2 nursing hours per patient day.

(1) Facilities which provide care for mentally disordered patients and in which psychiatric technicians provide patient care shall meet the following standards:

(A) If patients are not certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum of 3.2 nursing hours per patient day.

(B) For patients certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum of 2.3 nursing hours per patient day for each patient certified to the special treatment program, exclusive of additional staff required to meet the staffing standards of the special treatment program.

(g) Only direct caregivers as defined in Section 72038 shall be included in the staff-to-patient ratios. The ratios shall be based on the anticipated individual patient needs for the activities of each shift and shall be distributed throughout the day to achieve a minimum of 3.2 nursing hours per patient day.

(1) Skilled nursing facilities shall employ and schedule additional staff to ensure patients receive nursing care based on their needs.

(2) The calculation of the staff-to-patient ratio shall be based on the daily census of patients in the skilled nursing facility and not the total number of beds. Bedholds shall not be included in the calculations of the staff-to-patient ratio. If the census changes during a 24 hour period, the calculation shall be based upon the highest number of patients in the facility during the period.

(3) Unless granted a waiver pursuant to subsection (j), facilities shall use the following ratios:

(A) On the day shift, the ratio shall be at least one direct caregiver for every 5 patients or fraction thereof;

(B) On the evening shift, the ratio shall be at least one direct caregiver for every 8 patients or fraction thereof; and,

(C) On the night shift, the ratio shall be at least one direct caregiver for every 13 patients or fraction thereof.

(D) There shall be one licensed nurse for every 8 or fewer patients, based on the facility census for the 24 hour period. These are not in addition to the requirements in subparagraphs (A) through (C) above, and may be assigned to shifts as required by the facility, subject to other statutory and regulatory requirements.

(4) "Day shift" refers to the 8-hour period during which a facility's patients require the greatest amount of care. "Evening shift" refers to the 8-hour period when the facility's patients require more than minimal care. "Night shift" refers to the 8-hour period during which a facility's patients require the least amount of care. A facility that uses other than 8-hour shifts for its direct caregivers shall seek a waiver under subsection (j) to continue that practice.

(5) A "shift" is defined as the working period of one direct caregiver, or the full time equivalent of one direct caregiver, who performs eight hours of nursing services, as defined in section 72038. Other than time spent on normal rest periods required by section 11020 of Title 8 of the California Code of Regulations, or in the in-service training at the facility required by section 71847, time not spent providing nursing services, such as that spent at meal periods, may not be included in calculating a shift. A facility that uses fractions of a shift to meet the ratios must ensure that the posting required by subsection (i) contains this information in a form that will enable all interested persons to verify that the required staffing is provided and the ratios are met.

(6) A citation for a class "AA", class "A" or class "B" violation may be issued for a violation of this section that meets the requirements specified in Section 1424 of the Health and Safety Code.

(h) The facility shall retain the staff assignment record that it employs to comply with subsection (i) for each shift, the licensing and/or certification status of the staff, and the patient census for each shift. Records documenting staffing, including staff assignment records and payroll records, shall be retained for a minimum of three years. Unless the request is made by Department staff who are present at the facility, in which case it must be provided immediately, documentation of staffing shall be provided to the Department within ten days of the Department's request for the documentation. If the facility is unable to provide the documentation requested by the Department, it shall cease admitting new patients until it demonstrates to the Department that it has the staff necessary to provide the care needed by the patients by submitting the requested documentation. The facility shall also comply with the provisions of Section 1429.1 of the Health and Safety Code.

(i) The facility shall post the patient census and staffing information daily. The posting shall include the actual number of licensed and certified nursing staff directly responsible for the care of patients for that particular day on each shift. The facility may

use the form it currently uses to comply with the requirements of section 483.30 of title 42 of the Code of Federal Regulations, but, in addition to the information the federal regulation requires it to contain, it shall also designate the patient assignment by specifying each room and each bed to which each certified nurse assistant is assigned during his or her shift, and shall additionally specify the assignment of each licensed nurse and any other direct caregiver not assigned to a specific room or beds. This posting shall be publicly displayed in a clearly visible place.

(j) The facility may request a waiver for the staff-to-patient ratio in accordance with Section 1276.65 of the Health and Safety Code as long as the facility continues to meet the 3.2 nursing hours per patient day requirement.

(1) The facility shall submit a written request for a waiver with substantiating information to the Department. The facility shall request the waiver by using the program flexibility procedures specified in Section 72213, and the Department shall process the request as required by Section 1276 of the Health and Safety Code.

(2) The facility shall notify the Department if there has been a change in the substantiating information. A request for a waiver with substantiating information included shall be updated and resubmitted annually.

(k) Staffing for a distinct part intermediate care unit in a skilled nursing facility:

(1) Units of less than 50 intermediate care beds shall not be required to provide licensed personnel in addition to those provided in the skilled nursing facility unless the Department determines through a written evaluation that additional licensed personnel are necessary to protect the health and safety of patients.

(2) Units of 50 or more intermediate care beds shall provide a registered nurse or licensed vocational nurse employed 8 hours on the day shift, 7 days per week in the unit.

(3) For purposes of this section intermediate care beds that are licensed as such by the Department shall not be included for establishing licensed nurse staffing as required in subsection (f)(1) if the unit is used exclusively for intermediate care patients.

(l) Initial implementation of this section shall be contingent on an appropriation in the annual Budget Act or another statute, in accordance with Health and Safety Code Section 1276.65(i).

Note: Authority cited: Sections 1275, 1276.5, 1276.65 and 131200, Health and Safety Code. Reference: Sections 1276, 1276.5, 1276.65, 131050, 131051 and 131052, Health and Safety Code; and Section 14110.7(c), Welfare and Institutions Code.

### **HISTORY**

1. New section filed 1-22-2009; operative pursuant to Health and Safety Code section 1276.65(i) (Register 2009, No. 4).

2. Change without regulatory effect amending section heading and subsection (f)(1) and amending Note filed 3-12-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 11).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 72329.1, 22 CA ADC § 72329.1



22 CCR § 73050

**§ 73050. Intermediate Care Bed Classification.**

“Intermediate care bed classification” means beds designated for patients requiring skilled nursing and supportive care on less than a continuous basis.

Note: Authority cited: Sections 208 and 1250.1, Health and Safety Code. Reference: Chapter 854, Statutes of 1976.

**HISTORY**

1. New section filed 10-5-76 as an emergency; effective upon filing (Register 76, No. 41).

2. Certificate of Compliance filed 1-31-77 (Register 77, No. 6).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73050, 22 CA ADC § 73050

22 CCR § 73051

**§ 73051. Intermediate Care Facility.**

“Intermediate Care Facility” means a health facility, or a distinct part of a hospital or skilled nursing facility, which provides the following basic services: Inpatient care to patients who have need for skilled nursing supervision and need supportive care, but who do not require continuous nursing care.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73051, 22 CA ADC § 73051

22 CCR § 73309

**§ 73309. Nursing Service -Defined.**

“Nursing service” means a service organized, staffed and equipped to provide nursing care to patients.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73309, 22 CA ADC § 73309



22 CCR § 73311

**§ 73311. Nursing Service - General.**

Nursing service shall include, but not be limited to, the following:

- (a) Identification of problems and development of an individual plan of care for each patient based upon initial and continuing assessment of the patient's needs by the nursing staff and other health care professionals. The plan shall be reviewed and revised as needed but not less often than quarterly.
- (b) Notification of the attending licensed healthcare practitioner acting within the scope of his or her professional licensure immediately of any patient exhibiting unusual signs or behavior.
- (c) Ensuring that patients are served the diets as ordered by the attending licensed healthcare practitioner acting within the scope of his or her professional licensure, and that patients are provided with the necessary and acceptable equipment for eating and that prompt assistance in eating is given when needed.
- (d) Any marked or sudden change in weight shall be reported promptly to the attending licensed healthcare practitioner acting within the scope of his or her professional licensure.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code.

Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**HISTORY**

1. Amendment of subsections (b)-(d) and new Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73311, 22 CA ADC § 73311

22 CCR § 73313

**§ 73313. Nursing Service - Drug Administration.**

Nursing service shall include but not be limited to the following, with respect to the administration of drugs:

- (a) Medications and treatments shall be administered as prescribed and shall be recorded in patient's health records.
- (b) Preparation of doses for more than one scheduled administration time shall not be permitted.
- (c) Medications shall only be administered by personnel who have completed a state-approved training program in medication administration.
- (d) Medications shall be administered as soon as possible after doses are prepared and shall be administered by the same person who prepared the doses for administration. Doses shall be administered within one hour of the prescribed time unless otherwise indicated by the prescriber.
- (e) Patients shall be identified prior to administration of a drug.
- (f) The time and dose of drug administered to the patient shall be properly recorded in each patient's medication record by the person who administered the drug.
- (g) No medication or treatment shall be given except on the order of a person lawfully authorized to give such order.
- (h) Telephone orders shall be received only by a licensed nurse or pharmacist and shall be recorded immediately in the patient's health record and shall be signed by the prescriber within 48 hours.
- (i) Medications brought by or with the patient to the facility shall not be used unless all of the conditions specified in Section 73363 are met.
- (j) A registered nurse or a pharmacist shall review each patient's medications monthly and if appropriate, request a review from the patient's attending licensed healthcare practitioner acting within the scope of his or her professional licensure.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code.  
Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**HISTORY**

1. Amendment of subsection (j) and new Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73313, 22 CA ADC § 73313

22 CCR § 73315

**§ 73315. Nursing Service - Patient Care.**

- (a) No patient shall be admitted or accepted for care by an intermediate care facility except upon the order of a licensed healthcare practitioner acting within the scope of his or her professional licensure.
- (b) Each patient shall be treated as an individual with dignity and respect and shall not be subjected to verbal or physical abuse of any kind.
- (c) Each patient, upon admission, shall be given proper orientation to the intermediate care facility and the facility's services and staff.
- (d) Each patient shall show evidence of good personal hygiene, including care of the skin, shampooing and grooming of hair, oral hygiene, shaving or beard trimming, cleaning and cutting of fingernails and toenails and shall be free of offensive odors.
- (e) Each patient shall be encouraged and/or assisted to achieve and maintain his highest level of self-care and independence. Every effort shall be made to keep patients active except when contraindicated by orders provided by a licensed health care practitioner acting within the scope of his or her professional licensure.
- (f) Such supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided.
- (g) Treatment for minor illness or routine treatments for minor disorders when ordered by the licensed health care practitioner acting within the scope of his or her professional licensure shall be administered by nursing personnel.
- (h) Bedside nursing care may be provided on a temporary basis when the attending licensed health care practitioner acting within the scope of his or her professional licensure determines the illness to be temporary and minor.
- (i) When a patient requires services which are not considered to be intermediate care services, the licensed health care practitioner acting within the scope of his or her professional licensure shall be notified and arrangements made to transfer the patient from the intermediate care facility.

Note: Authority cited: Sections 1275, 100275 and 131200, Health and Safety Code.

Reference: Sections 1276, 1316.5, 131050, 131051 and 131052, Health and Safety Code.

**HISTORY**

1. Amendment of subsections (a), (e) and (g)-(i) and new Note filed 3-3-2010; operative 4-2-2010 (Register 2010, No. 10).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73315, 22 CA ADC § 73315



22 CCR § 73317

**§ 73317. Nursing Service -Policies and Procedures.**

(a) Written policies and procedures developed by the supervisor of health services and approved by the Patient Care Policy Committee shall be available to all nursing personnel. Such policies and procedures shall include:

(1) An organization chart of the nursing service showing staff positions, lines of authority and communication.

(2) Specific instruction on the preparation, review and updating of individual patient care plans.

(3) Orientation procedures and programs for new employees.

(4) An ongoing education program planned and conducted for the development and improvement of skills of all facility's personnel including training related to problems and needs of the aged, ill and disabled.

(5) A current nursing procedure manual.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73317, 22 CA ADC § 73317

22 CCR § 73318

**§ 73318. Nursing Service - Nurse Assistant Training and Certification.  
[Repealed]**

Note: Authority cited: Section 1137.7, Health and Safety Code. Reference: Chapter 351/1978 (AB 2567).

**HISTORY**

1. Repealer and new section filed 1-12-79 as an emergency; effective upon filing (Register 79, No. 2). For prior history, see Register 77, No. 52.
2. Certificate of Compliance filed 4-16-79 (Register 79, No. 15).
3. Repealer filed 7-16-91 as an emergency; operative 7-16-91 (Register 91, No. 46). A Certificate of Compliance must be transmitted to OAL by 11-13-91 or emergency repeal will be reinstated by operation of law on the following day.
4. Repealer refiled 11-14-91 as an emergency; operative 11-14-91 (Register 92, No. 8). A Certificate of Compliance must be transmitted to OAL 3-13-92 or emergency language will be repealed by operation of law on the following day.
5. Editorial correction of History 4. and repealer refiled 5-6-92 as an emergency; operative 5-6-92 (Register 92, No. 20). A Certificate of Compliance must be transmitted to OAL 9-3-92 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 5-6-92 order transmitted to OAL 8-27-92 and filed 10-9-92 (Register 92, No. 41).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73318, 22 CA ADC § 73318

22 CCR § 73319

**§ 73319. Nursing Service - Staff.**

(a) Nursing service personnel shall be employed in the number and with the qualifications determined by the Department to provide the necessary services for those patients admitted for care. The Department may require a facility to provide additional staff whenever the Department determines through a written evaluation of patients and patient care in the facility that such additional staff are needed to provide adequate nursing care and treatment or to provide for the safety of the patients.

(b) Facilities shall employ a registered nurse or licensed vocational nurse eight hours per day on the day shift, seven days per week. In case of facilities where a licensed vocational nurse serves as supervisor of health services, consultation shall be provided by a registered nurse, through formal contract, at regular intervals, but not less than four hours weekly.

(c) Facilities with 100 or more beds shall employ a registered nurse eight hours per day, on the day shift, seven days per week. In addition, a registered nurse or licensed vocational nurse shall be employed four hours per day, seven days per week, during the day for each 50 beds or portion thereof in excess of 100.

(d) Nursing stations shall be staffed by nursing personnel day and night when patients are housed in the nursing unit.

(e) Each facility shall employ sufficient staff to provide a minimum average of 1.1 nursing hour per patient day.

(1) Facilities which provide care for mentally disordered or developmentally disabled patients and in which psychiatric technicians provide patient care shall meet the following standards:

(A) If patients are not certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum average of 1.1 nursing hour per patient day.

(B) For patients certified for special treatment programs, facilities shall employ sufficient staff to provide a minimum average of 0.7 nursing hour per patient day for each patient certified to the special treatment program, exclusive of additional staff required to meet the staffing standards of the special treatment program.

Note: Authority cited: Sections 1275, 1276.5 and 131200, Health and Safety Code.

Reference: Sections 1276, 1276.5, 131050, 131051 and 131052, Health and Safety Code; and Section 14110.7(c), Welfare and Institutions Code.

**HISTORY**

1. New subsection (e) filed 7-1-77 as an emergency; effective upon filing (Register 77, No. 27).
2. Certificate of Compliance filed 10-27-77 (Register 77, No. 44).
3. Amendment of subsection (e) filed 9-23-85 as an emergency; effective upon filing (Register 85, No. 39). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1-21-86.
4. Certificate of Compliance transmitted to OAL 1-17-86 and filed 2-10-86 (Register 86, No. 7).



5. Change without regulatory effect amending section heading and subsections (c), (e)(1) and (e)(1)(B) and amending Note filed 3-12-2013 pursuant to section 100, title 1, California Code of Regulations (Register 2013, No. 11).

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73319, 22 CA ADC § 73319

22 CCR § 73321

**§ 73321. Nursing Service -Equipment and Supplies.**

(a) Equipment and supplies of the quality and in the quantity necessary for care to patients, as ordered or indicated, shall be provided and shall include but not be limited to:

- (1) Water pitchers, emesis basins, denture cups, ice caps, urinals, bedpans, thermometers, stethoscope, sphygmomanometer, ear syringe, hypodermic syringes and needles and scales for weighing patients.
- (2) A sufficient supply of wheelchairs and walkers to meet the intermittent needs of patients and maintained in clean and operable condition.
- (3) Supplies necessary to perform urine sugar and acetone testing.
- (4) Current and authoritative nursing reference material.
- (5) First aid equipment and supplies, as determined by the patient care policy committee, readily available at all times.

This database is current through 10/2/15 Register 2015, No. 40

22 CCR § 73321, 22 CA ADC § 73321

## Appendix D

### Department of State Hospitals 24-Hour Care Nursing Services Staffing Study

#### UC Davis Research Data Actual Staffing - Hospital Nurse Staffing and Quality of Care/Hospital Nurse Staffing Survey Analysis Psychiatric Units (Acute Care Hospitals)

**\*\*Patients per Licensed Nurse\*\***

<u>All Hospitals Surveyed</u>	<u>Shift Type</u>	<u>Number of Hospitals</u>	<u>Number of Shifts</u>	<u>5%ile</u>	<u>10%ile</u>	<u>25%ile</u>	<u>Median</u>	<u>75%ile</u>	<u>90%ile</u>	<u>95%ile</u>
(excludes state hospitals)	All Shifts	20	979	2	2.5	3.5	4.5	6	11	15
	Day	20	355		2.5	3.25	4	5.33	6	
	Eve		287		2.5	3.33	4	5.67	6	
	Night		337		3.33	4	6	12	16	
	Day 8 hr	17	301		2.5	3.25	4.14	5.33	6	
	Day 12 hr	3	54		3	3.33	4	4.75	6	
	Eve 8 hr	17	287		2.5	3.33	4	5.67	6	
	Night 8 hr	17	286		3	4	6	14	17	
	Night 12 hr	3	50		3.4	4	5	5.67	7	
<u>By Hospital Type</u>		<u>Number of Hospitals</u>	<u>Number of Shifts</u>			<u>25%ile</u>	<u>Median</u>	<u>75%ile</u>		
Academic Medical Center		5	239			3.33	4	5		
Kaiser Hospitals <sup>1</sup>										
Rural (OSHPD 1982) <sup>1</sup>										
Other Public		7	345			2.5	3.33	5.67		
Other Private		8	395			3.67	4.67	6		
<u>By Hospital Type</u>		<u>Number of Hospitals</u>	<u>Number of Shifts</u>			<u>Min</u>	<u>Median</u>	<u>Max</u>		
California State Hospitals <sup>2</sup>		3	135			2.2	6.5	15		
<u>AB 394 Stakeholder Recommended Staffing Ratios</u>							<u>Proposed</u>			
California Nurses Association (CNA)							4			
Service Employees International Union (SEIU)							3			
United Nurses Associations of California (UNAC)							5			
California Hospital Association (CHA)							12			

<sup>1</sup> No percentiles were calculated where there were fewer than 8 shifts

<sup>2</sup> State facilities were surveyed separately and include facilities from: CDCR, DDS, DMH(DSH), & VA. Specifically they surveyed: Agnew Hospital, CA Institute For Men, CA Medical Facility, CA Men's Colony, CA State Hospital, Fairview Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Sonoma Developmental Center, Veteran's Home of CA-Yountville.

## FINAL STATEMENT OF REASONS

In October, 1999 the California State Legislature passed AB394 (Kuehl, Chapter 945, Statutes of 1999) adding section 1276.4 to the Health and Safety Code (HSC). This section was later amended by AB 1760 (Kuehl, Chapter 148, Statutes of 2000). The section requires the California Department of Health Services (Department/CDHS) to develop minimum, specific, numerical licensed nurse-to-patient ratios for specified units of general acute care hospitals. CDHS determined that the requirements listed in this section are the minimum necessary to protect the public health and safety. CDHS's policy decisions remediate the hospitals with the leanest staffing, effectively raising the bar for the standard of acceptable staffing.

In its preamble to the legislation, the Legislature "finds and declares all of the following:

- a) Health care services are becoming complex and it is increasingly difficult for patients to access integrated services.
- b) Quality of patient care is jeopardized because of staffing changes implemented in response to managed care.
- c) To ensure the adequate protection of patients in acute care settings, it is essential that qualified registered nurses and other licensed nurses be accessible and available to meet the needs of patients.
- d) The basic principles of staffing in the acute care setting should be based on the patients' care needs, the severity of condition, services needed, and the complexity surrounding those services."

The Legislature clearly believed that the quality of patient care was related to the number of licensed nurses at the bedside, and wished to ensure a minimum, adequate number. When Governor Davis signed the bill on October 10, 1999, he accompanied the measure with a "sign message" which read, in part, "Registered nurses are a critical component in guaranteeing patient safety and the highest quality health care. Over the past several years many hospitals, in response to managed care reimbursement contracts, have cut costs by reducing their licensed nursing staff. In some cases, the ratio of licensed nurses to patients has resulted in an erosion in the quality of patient care." (Exhibit A)

The CDHS considered proposing regulations requiring staffing ratios for registered nurses in acute care hospitals in 1992. However, upon further consideration, the Department instead opted for regulations requiring that hospitals have a patient classification system (PCS) in place. The PCS was intended to assure that the number of nursing staff was aligned to the health care needs of the patients, while allowing the provider maximum flexibility for the efficient use of staff. The Department spent more than four years working with key statewide nursing and hospital organizations, including the California Nurses Association and the California Healthcare Association, to develop the final regulations which became effective on January 1, 1997.



California's hospitals are currently required (22 CCR, 70053.2 and 70217) to use a PCS for determining the staffing needs of individual units. PCS are defined as systems that include:

- (1) A method to predict nursing care requirements of individual patients.
- (2) An established method by which the amount of nursing care needed for each category of patient is validated for each unit and for each shift.
- (3) An established method to discern trends and patterns of nursing care delivery by each unit, each shift, and each level of licensed and unlicensed staff.
- (4) A mechanism by which the accuracy of the nursing care validation method described in (2) above can be tested. This method will address the amount of nursing care needed by patient category and pattern of care delivery on an annual basis, or more frequently, if warranted by the changes in patient populations, skill mix of the staff, or patient care delivery model.
- (5) A method to determine staff resource allocations based on nursing care requirements for each shift and each unit.
- (6) A method by which the hospital validates the reliability of the patient classification system for each unit and for each shift.
- (7) A written staffing plan must be developed by the administrator of nursing service or a designee, based on patient care needs determined by the patient classification system. The staffing plan must be developed and implemented for each patient care unit and must specify patient care requirements and the staffing levels for registered nurses and other licensed and unlicensed personnel.
- (8) The plan must include the following:
  - (a) Staffing requirements as determined by the patient classification system described above for each unit, documented on a day-to-day, shift-by-shift basis.
  - (b) The actual staff and staff mix provided, documented on a day-to-day, shift-by-shift basis.
  - (c) The variance between required and actual staffing patterns, documented on a day-to-day, shift-by-shift basis.
  - (d) The staffing plan must be retained for the time period between licensing surveys, which includes the Consolidated Accreditation and Licensing Survey (CALs) Process.
- (8) The reliability of the patient classification system for validating staffing requirements must be reviewed at least annually by a committee appointed by the nursing administrator to determine whether or not the system accurately measures patient care needs.
- (9) At least half of the members of the review committee must be registered nurses who provide direct patient care.
- (10) If the review reveals that adjustments are necessary in the patient classification system in order to assure accuracy in measuring patient care needs, such adjustments must be implemented within thirty (30) days of that determination.
- (11) Hospitals must develop and document a process by which all interested staff may provide input about the patient classification system, the system's required revisions, and the overall staffing plan.

These PCS requirements will not change with the addition of the minimum nurse-to-patient ratios required by HSC 1276.4.

There have been no studies to date to determine the effectiveness of the PCS. However, it was the perception of some working nurses, and the labor organizations that represent them, that the PCS does not always accurately reflect the patients' needs for increased staffing. Consequently, the Legislature passed, and the Governor signed, AB 394 (Kuehl, Chapter 945, Statutes of 1999) requiring the establishment of minimum numerical licensed nurse-to-patient ratios.

Acute care hospitals in California are surveyed routinely using the Consolidated Accreditation and Licensing Survey (CALs) process once every three years. In addition, surveyors make unannounced visits to hospitals to conduct investigations into complaints that are received at the Licensing and Certification Program's District Offices. HSC 1276.4 does not change the number nor frequency of surveys, and neither do these proposed regulations. The survey process will be changed only in that surveyors may add the additional step of verifying compliance with the ratios. Currently, acute care hospital CALs surveys include an evaluation of the hospital's compliance with all staffing requirements imposed under 22 CCR 70053.2 and 70217 for the PCS whenever survey findings suggest that such an evaluation is appropriate.

It is the Department's intent that the minimum staffing ratios set at 22 CCR 70217(a) will co-exist with the existing PCS regulations at 70053.2 and the current 70217(a), proposed to be 70217(b). HSC 1276.4 adds a needed refinement to the existing PCS requirements. The establishment of minimum nurse-to-patient ratios will set the baseline licensed staffing requirement for every unit type. The proposed minimum ratios will increase the number of licensed nurses on the 5-25% of hospital shifts with the leanest staffing statewide as soon as the regulations go into effect. In 2005 and 2008, the ratios for medical/surgical, step-down, specialty, and telemetry units will change to further enrich staffing in those units. The PCS will remain in place to indicate the needed increases beyond minimum licensed staffing as patient acuity increases.

#### **Subacute Units and Transitional Inpatient Care Units:**

HSC 1276.4(a) lists those units that are intended to be included in the definition of "hospital unit". Included in that listing are "subacute care units and transitional inpatient care units". CDHS proposes not to address those units in these regulations. Subacute and Transitional Inpatient Care are not supplemental services nor licensed bed categories under general acute care hospital licensing regulations. They exist at 22 CCR sections 51215.4(e), 51215.5(e), and 51215.8(t) as Medi-Cal contracted reimbursement categories. Some general acute care hospitals and skilled nursing facilities contract with

Medi-Cal to provide these services, and are consequently reimbursed at rates which are lower than the acute care rate but higher than a general skilled nursing service rate. These services are provided in certified skilled nursing beds and reimbursed as skilled nursing facility level of care. Along with the set rates, required staffing for this skilled nursing facility level of care is expressed in regulation as "nursing hours per patient day" (NHPPD). The NHPPD are not readily convertible to "whole person" ratios, and so CDHS did not attempt to make a numerical conversion. These regulations do not propose to replace current staffing requirements, which are in place in regulation and in contracts and are well understood by the Medi-Cal Program as well as the contracted provider community. The reimbursement category of "Transitional Inpatient Care Unit" was eliminated by statute (AB 2877, Ch. 93, Statutes of 2000), with a sunset date of January 1, 2002. Staffing regulations governing Subacute Units will be included in a subsequent CDHS regulation package.

### **The Workforce Debate:**

The ongoing public health debate, and the resultant tension between labor organizations representing nurses and provider organizations representing hospitals, centers on the numbers, cost, and availability of nurses to provide safe and professional care for patients. Many nurses now believe that staffing levels in acute care hospitals are unsafe for patients, and continuing to decline. In a recently published study, two-thirds of nurses in the United States reported that they believe that staffing in their hospitals is inadequate to provide high-quality care, and 45% stated that the quality of care in their hospitals had deteriorated in the last year (Exhibit B). Physicians agree, with 64% rating nurse staffing levels at their hospitals as "fair" or "poor" (Exhibit C). Patients and their families are also concerned with the paucity of nursing staff at hospitals as evidenced by the growing trend of hiring private duty nurses when a loved one needs hospitalization (Exhibit D).

From December 7, 2000 through January 19, 2001, a national nursing survey was posted at [www.nursingworld.org](http://www.nursingworld.org), the website for the American Nurses' Association (ANA). The survey was promoted in the ANA's media outlets, including *The American Nurse* and *The American Journal of Nursing*. Nearly 7300 nurses took part in the study, which found the following: 75% reported that the quality of nursing care had declined in their work setting, a decline which 69% blamed on inadequate staffing. 56% noted a reduction of the time available for registered nurses to provide direct care. One of the most telling statistics was that 41% of RNs polled would not recommend that a family member receive care in the hospitals in which they work. 55% of nurses surveyed also reported that they would not recommend the nursing profession as a career for their friends or children. (Exhibit E and Exhibit F).

These results continued the trend found in a previous study conducted for the American Journal of Nursing by Boston College School of Nursing's Assistant

Professor Judith Shindul-Rothschild, RN, PhD. That study, based on a survey of 7500 RNs found that 60% noted a reduction in the number of registered nurses providing direct care, with 40% reporting substitution of unlicensed personnel for registered nurses. The study also found disturbing increases in unexpected patient readmissions, complications, medication errors, wound infections, patient injuries and patient deaths. 36% of RNs in this study would not recommend that a family member receive care in the hospitals in which they work (Exhibits G and H).

The findings of a recent 20-hospital study (Exhibit I) found substantial variation in nurse-to-patient ratios for inpatient AIDS care. The study concluded that higher nurse-to-patient ratios are strongly associated with lower mortality. The researchers estimated that, holding all other factors constant, an additional nurse per patient day cut the likelihood of dying within 30 days of admission by more than half. Another recent study found that hospitals that had the richest nurse-to-patient ratios had significantly shorter overall lengths of stay, as well as fewer ICU days (Exhibits V and V-1).

In October of 2002 Linda Aiken, PhD, RN et. al. published a study in the Journal of the American Medical Association entitled "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction". The study was designed to determine the association, if any, between nurse-to-patient ratios and risk-adjusted patient mortality and failure-to-rescue within 30 days of admission, as well as nurse-reported job dissatisfaction and job-related burnout (Exhibit V-2). ("Failure-to-rescue" refers to the licensed nurse's failure to respond quickly and intervene effectively when patients (in this study, post-surgical patients) begin to develop signs and symptoms of serious complications. Failure to rescue, then, results in increased patient mortality.) The likelihood of failure-to-rescue was expressed as odds ratios (ORs), after patient and hospital characteristics were controlled for. The study concluded that the OR of failure-to-rescue was sizeable and significant, indicating that the odds of patient mortality increased by 7% for every additional patient in an average nurse's workload and that the difference from 4 to 6 and from 4 to 8 patients per nurse would be accompanied by 14% and 31% increases in patient mortality, respectively. The study concluded, "If the staffing ratio in all hospitals was 8 patients per nurse rather than 6 patients per nurse, we would expect 2.6 additional deaths per 1000 patients and 9.5 additional deaths per 1000 patients with complications....Our results do not directly indicate how many nurses are needed to care for patients or whether there is some maximum ratio of patients per nurse above which hospitals should not venture. Our major point is that there are detectable differences in risk-adjusted mortality and failure-to-rescue rates across hospitals with different registered nurse staffing ratios." The study also showed that nurses who worked in hospitals with the highest nurse-to-patient ratios were more than twice as likely as nurses who worked at lower ratios to report burnout and job dissatisfaction, and four times as likely to report that they intended to leave their current jobs within one year. If that increase in stated intentions truly



resulted in resignations, given the high (and steadily increasing) cost of replacing nursing staff, then improving staffing may not only prevent patient deaths but may also improve staff retention and decrease hospital costs.

The positive impact of changes in workload on the nursing workforce was recently demonstrated in the state of Victoria, Australia. After intense lobbying and political pressure from the Australian Nurses Association, the Victorian Ministry for Health, which is responsible for the operation of acute care hospitals there, adopted the union-backed nurse-to-patient ratios effective December 1, 2000. For medical/surgical units, those ratios varied from 1:4 to 1:6, with more patients permitted on the night shift; for emergency departments the ratio was 1:3 at all times, and the triage and charge nurses were not counted in the ratios. The Victorian government also committed to--and funded--re-entry and refresher programs for nurses who wished to return to the workforce, as well as a vigorous advertising recruitment campaign. In addition, Victoria mandated a 12.5% pay increase over three years, paid study leave, and financial rewards based on education. The results were impressive. In 1999, Victoria's hospitals had approximately 20,000 full-time equivalent nursing positions, with 1300 of those positions vacant. By October, 2001, there were an additional 2650 full-time equivalent nurses employed in Victoria's hospitals--half filling the vacancies and the other half to staff up to meet the ratios (Exhibits J, K, and L).

#### **Public Input:**

There is intense interest in these new regulations among nurses in California. Between the time that the enabling law was passed and the initial draft regulations were made public, the Department received over 3800 postcards, telephone calls, and e-mails from individual working nurses expressing their thoughts on the ratios. There have been organized town hall meetings and rallies around the State, attended by nurses as well as hospital administrative staff, which CDHS staff also attended in order to hear firsthand the personal testimony of working nurses. CDHS also established a dedicated e-mail address to facilitate public input on the ratios before the public comment period began.

The Department received four formal proposals for setting the ratios in each unit. They came from three labor organizations: the California Nurses' Association (CNA), Service Employees International Union (SEIU) Nurse Alliance, and United Nurses' Associations of California (UNAC) of the American Federation of State, County, and Municipal Employees (AFSCME). CDHS also received a formal staffing ratio proposal from the California Healthcare Association (CHA), which is the provider organization representing more than 400, or greater than 85%, of acute care hospitals statewide.

**Proposals: L&C Summaries and Assessments:**

**CNA Proposal:**

The CNA proposed the adoption of the following ratios:

Critical Care Unit/ICU	1:2
Burn Unit	1:2
Neonatal ICU	1:2
Labor and Delivery	1:1
Postpartum	1:5
Well Baby Nursery	1:5
Postanesthesia Service	1:2
Emergency Department	1:3
Operating Room	1:1
Pediatric Unit	1:3
Stepdown Care Unit	1:3
Specialty Care Unit	1:3
Telemetry Unit	1:3
General Medical/Surgical Unit	1:3
Subacute/Transitional Care	1:4
Behavioral/Psychiatric Unit	1:4

The CNA process used a panel of 25 of their nurse-members to assign patients to one of seven "virtual units" based on about 500 All Patient Refined – Diagnostic Related Groups (APRDRG) scales. Within each APR-DRG, they calculated the Severity of Illness class using OSHPD hospital discharge data from 1993-1998. Once APRDRGs were assigned to "presumptive (or virtual) units", average acuity was calculated within that unit. The average acuity of the ICU was used as a common numerator, with the other units' calculated acuity indicator taken in turn as the denominator, and the quotient multiplied by two (because 1:2 is the mandated minimum staffing ratio in ICUs). The product was then designated as the "middle range staffing ratio" for that unit.

The conceptual framework of the CNA proposal rests on a series of assumptions, among them that appropriate staffing requirements increase linearly with severity of illness, that patients can reliably be assigned to one of seven presumptive units, that "severity subclass assignments" can be used as a metric for acuity across APRDRGs as well as within them, etc. There is also the problem of the "floor effect". That is, the APRDRG scale (severity of illness score) is a range from 1-4. Given the mean ICU severity of 2.21, no unit could have a mean acuity ratio less than 0.55 ( $2.21/4=0.55$ ) or greater than 2.21 ( $2.21/1=2.21$ ). The 0.55 is not a problem, because rounded up it will give a ratio of 1:1 ( $0.55 \times 2=1.1$ ). However,  $2.21/1 \times 2=4.42$ ; that is, a ratio of 1:4.42. Therefore, the finding that all acute care units require a ratio of at least 1:4 was predetermined by the 1-4 range that was used. (See Exhibit M for complete proposal).

In summary, the CNA took a very innovative approach to ascertaining what the ratios should be. They studied a massive amount of information and made an attempt to generate scientifically sound ratios. However, a number of concerns about the way that the study was conducted and the appropriateness of the data relied upon, as well as CDHS's determination to conduct its own study, precluded the use of the CNA proposal as submitted.

A University of California (UC) research team was contracted by CDHS to assist in the development of the on-site hospital survey (described on page 15) study tool and the analysis of the data it produced. That research team also reviewed the CNA study. Their review concluded that flaws in the assumptions driving the [CNA] analysis limited the extent to which the results can be applied to policy-making. The UC review can be found in Exhibit N.

SEIU Proposal:

The SEIU proposed the adoption of the following ratios:

Critical care Unit/ICU	1:2 (+1RT^:4 Vents#)
Burn Unit	1:2 (+1RT^:4 Vents#)
Neonatal ICU	1:2 (+1RT^:2 Vents#)
Labor and Delivery	1:2
Antepartum	1:3
Postpartum	1:3 couplets
Well Baby Nursery	1:6
Postanesthesia Service	1:2 Adults; 1:1 Peds
Emergency Department (ED)	1:3
ED-Critical Care	1:2
ED-Trauma	1:1
Operating Room	1:1RN+1LVN/1Tech
Pediatric Unit	1:3
Stepdown Care Unit	1:3
Telemetry Unit	1:3
General Medical/Surgical Unit	1:4
Subacute/Transitional Care	1:5
Behavioral/Psychiatric Unit	1:2/1:3/1:5 (by acuity)
^RT= Respiratory Therapist	
#Vents= Ventilator-Dependent Patients	

SEIU represents over 100,000 health care workers employed in many different classifications within acute care hospitals throughout California. Their process was to organize their member nurses into committees, one committee for each hospital unit. Each committee was comprised of 6-10 RNs and LVNs who were convened by conference call three to five times to deliberate on and

draft the proposed ratios. The final proposal was based on a consensus of committee members, and was ratified by assemblies of SEIU's membership around the State, at which a large number of workers from many hospitals and many classifications voted. SEIU also conducted a limited search of academic literature, and provided CDHS with the results of that search in the form of an annotated bibliography. (For SEIU's complete proposal, please see Exhibit O, dated 01/13/00, with follow-up letter dated 07/13/01).

SEIU's fundamental premise is that staffing a hospital is a team effort. SEIU encouraged CDHS to look at all categories of hospital workers, because they stated that focusing on the single profession of nursing undermines the quality of care and distorts the nature of the work that must be done. Also, they were concerned that focusing only on nursing would be inimical to the interests of the members they represent.

The SEIU proposal is very task based, i.e., it is based upon "those things which every nurse on every shift must do, what every nurse will always do for at least some patients, and what every nurse will often do for some patients". The length of time the listed tasks should take, in the opinion of the nurse-members on the Committee, dictates the number of nurses needed for each patient.

SEIU also proposed a number of improvements to the PCS, as well as unannounced inspections and re-inspections of hospitals by CDHS enforcement staff.

In summary, SEIU's proposal represents a tremendous mobilization of their membership and an effort to make their proposal truly representative of the wishes of their membership. Their approach is democratic, creative, and instructive. Since their membership is very large and divergent in the health care services they provide, their proposal has merit and has received careful consideration by the Department.

It is important to note, however, that they make no claim that their method is based on objective data. The proposals are not supported by a claim that they are representative of current practice, nor are they based on any claim of "best practice". For these reasons, and because the Department desired to conduct its own study, we did not adopt the proposal as submitted.

UNAC Proposal:

The UNAC proposed the adoption of the following ratios:

Critical Care Unit/ICU	1:2
Burn Unit	1:2
Neonatal ICU	1:2
Labor and Delivery	1:2
Postpartum	1:3 couplets
Well Baby Nursery	1:6



Postanesthesia Service	1:2
Emergency Department (ED)	1:3
ED-Critical Care	1:2
Operating Room	1:1
Pediatric Unit	1:3
Stepdown Care Unit	1:3
Specialty Care Unit	1:3
Telemetry Unit	1:3
Oncology Unit	1:4
General Medical/Surgical Unit	1:4
Subacute/Transitional Care	1:5
Behavioral/Psychiatric Unit	1:5

UNAC represents over 10,000 health care workers throughout Southern California, including several bargaining units comprised entirely of RNs. UNAC's recommendation to CDHS originated from a meeting of union's leadership, who are themselves working nurses and other types of health care professionals elected by their peers. UNAC also did a study of the California Code of Regulations, Title 22, and compared their proposals to those requirements already in regulations. (For the entire UNAC proposal, please see Exhibit P).

A fundamental premise of the UNAC proposal is that safe and adequate staffing can be based on a reasonable assessment of the anecdotal reports of the day-to-day experiences of its members. It is also important to note that all of UNAC's proposed ratios address RN-to-patient ratios only. In units where LVNs may, in the judgment of CDHS, be utilized, they request that CDHS establish a precise, closely-defined skill mix.

UNAC's leadership has provided CDHS with their perspective as leaders of a labor organization. As they represent a large and diverse corps of health care workers in non-profit, for-profit, district, and Federal hospitals, their proposals merited and received careful attention and regard.

However, because UNAC's proposal represents the judgment of its elected leadership with no direct input from its membership, and because no justification is provided for the proposals (other than the best professional judgment of that leadership), combined with CDHS's desire to conduct a study of its own, the proposal was not adopted as submitted.

CHA Proposal:

The CHA proposed the adoption of the following ratios:

Critical Care Unit/ICU	1:2
Burn Unit	1:2
Neonatal ICU	1:2
Labor and Delivery	1:3

Postpartum	1:4 couplets
Well Baby Nursery	1:8
Postanesthesia Service	1:3
Emergency Department	1:6
Operating Room	1:1
Pediatric Unit	1:6
Stepdown Care Unit	1:6
Telemetry Unit	1:10
Oncology Unit	1:10
General Medical/Surgical Unit	1:10
Subacute/Transitional Care	1:12
Behavioral/Psychiatric Unit	1:12

CHA, together with the Association of California Nurse Leaders, convened a statewide taskforce to identify what they believed were clinically appropriate staffing ratios for all major patient care units. (Please see letter from CHA dated 08/17/00, Exhibit Q). They did that by evaluating their own and other hospital's units functioning with various ratios. They consulted with designers of patient acuity systems, and developed standardized definitions to bring enhanced clarity to communications. They sent the taskforce's proposal to all California hospital chief executive officers and chief nursing officers for input and approval. The CHA's final proposal represented the majority's view. (For the complete proposal, please see Exhibit R).

CHA's essential premises include the observation that there are currently no academic or empirical studies that define nurse-to-patient ratios that are appropriate for improving the quality of patient care in the various hospital units. CHA suggested, therefore, that CDHS delay implementation of AB 394 until there are credible, evidence-based studies upon which to base the regulations. CHA also suggested in other communications with CHDS that nurse-to-patient ratios may negatively impact the quality of care if they cause the utilization of higher percentages of nurses at the expense of a "milieu rich in clinical diversity". They argued, on behalf of their membership, that hospitals cannot afford to hire more nurses because of the extreme fiscal constraints caused by seismic retrofitting, Health Insurance Portability and Accountability Act (HIPPA) implementation, etc., in concert with the fiscal pressure of managed care. They further posited that, even if hospitals somehow were able to afford to hire more nurses, there aren't enough nurses available due to the nursing shortage. They stated that, if hospitals cannot comply with the mandated ratios, hospitals will be forced to close units and suspend services, thus limiting, and possibly denying, access to care for many Californians. Closures and suspensions in services could, in turn, cause lengthy patient transports, delays in start of care, and, potentially, increased morbidity and mortality.

CHA's proposal represents the considered judgment of the leadership of the State's largest provider group. Their concerns about limiting access to care

are especially relevant, and CDHS has carefully evaluated the possibility that care and services could be diminished or denied if the proposed ratios were unreasonable. CHA's caution about imposing ratios that will place heavy and unnecessary burdens on the fiscal reserves of providers deserved and received thoughtful and deliberate consideration.

However, given the statutory mandate, CDHS did not have the option of declining to implement the ratios, notwithstanding the nursing shortage and the hospitals' financial concerns. However, the Department did evaluate the multitude of factors effecting acute care, and is working toward facilitating compliance with the staffing ratios while easing any undue fiscal burdens by providing maximum flexibility for hospitals within the bounds of patient health and safety. CDHS also chose to phase-in the richer ratios for Medical/Surgical units for one year, and for Step-down, Telemetry, and Specialty Care units for four years in order to allow providers time to develop a strategy for compliance, for the recruitment of additional nurses, and for the education and training of additional classes of nursing students.

In response to the concern raised by many providers that meeting the mandated ratios would not be possible in light of California's nursing shortage, on January 23, 2002 Governor Davis announced his Nurse Workforce Initiative (See Press Release 02:033, Exhibit S), a \$60 million effort to address the nursing shortage in California. The Initiative includes funding for expanded training and preceptorship positions in hospitals, community colleges, and the California State University (CSU) system; five regional workforce collaboratives to train 2,400 new licensed nurses; a plan for upgraded training opportunities for health care workers' career ladders; and a statewide media recruitment campaign, among other provisions. In addition, the 2001-2002 and 2002-2003 budgets include \$4 million for 1,000 additional student nurse training program seats at community colleges across the State. The Governor and his Administration are committed to increasing the number of licensed nurses available to provide patient care in California.

In summary, the four proposals outlined above reflect the interests of the submitting organizations and their best recommendations, but do not present an adequately supported, documented basis for their specific proposed ratios. CDHS chose to take into consideration all of these perspectives in reaching a broader, more objective consensus of workable, reasonable standards that would improve nurse staffing levels and quality of care to patients.

#### **Current Status of Ratios in Regulation:**

In California, the nurse-to-patient ratio of 1:2 was set for intensive care units in 1975 at 22 CCR 70495 (e). An Institute of Medicine study in 1996 (Exhibit T) concluded that there was insufficient evidence that mandating a specific ratio in hospital nursing units resulted in quality improvements for

patients, nursing staff, or institutions. More recent studies, however, are providing a link between the staffing level in ICUs and improved outcomes. In Maryland, where there is no specific minimum nurse-to-patient staffing ratio in ICUs, a study was conducted in 1997 to test if different staffing practices had an impact on the recovery of patients who were critically ill after abdominal aortic surgery. That study determined that in hospitals where the ratio of ICU nurses to patients was 1:3 or greater, the patients had a significantly higher rate of medical complications compared with patients in ICUs where nurses cared for 2 or fewer patients (Exhibit U). In addition, a previous study by the same principal investigator demonstrated that when ICU nurses cared for more than 2 patients, the mean number of days those patients remained in the ICU increased by 49% (Exhibit V). These new studies now provide some evidence-based validation for the California standard.

The public health depends on the availability of adequately staffed acute care hospitals. CDHS L&C has experienced a steadily increasing volume of complaints about patient care in acute care hospitals. L&C received 3348 such complaints in 2000, which represents a 30% increase in volume over the 1995 level. This may reflect that the quality of care is declining; it certainly suggests increasing consumer dissatisfaction with the care received.

A search of health-related literature, conducted by a team of researchers from the UC system under contract with CDHS, identified 2870 articles of potential interest for developing appropriate ratios. Of these, 456 were selected for retrieval based on established inclusion criteria. (For a detailed description of the criteria and methodology, please refer to Exhibit W). 419 of the 456 articles were subsequently rejected for not reporting key information, leaving 37 articles for analysis. The results of the analysis are detailed in the evidence tables in Section I of the "Hospital Nursing Staff Ratios and Quality of Care" study (Exhibit W). Essentially, there was no hard, scientific evidence in the literature indicating the number of patients nurses can safely and effectively handle while providing quality patient care.

Additionally, standardized nurse-to-patient ratios have not been mandated or required in any other state. Therefore, there is no experience with specific nurse-to-patient ratios from which to determine with certainty the exact number of nurses needed based strictly upon the number of patients to be provided care. The mandate in California is to set a minimum level, allowing hospitals to more specifically identify the nursing care needed based upon the hospitals' patient classification system. Faced with the lack of research and the lack of any other State's experience in setting ratios, CDHS decided to conduct a study to determine how acute care hospitals were currently staffing their units with licensed nurses.

#### **Description of the Process:**



The first step was to collect data concerning the current level of staffing in California hospitals. The Department began by utilizing the data collected by the Office of Statewide Health Planning and Development (OSHPD).

OSHPD collects data annually from all acute care hospitals in the State. They collect a number of items, including an inventory of provided services, number of beds, expenses by classification and cost center, productive hours per patient day by employee classification and cost center, and numbers of patient admissions and discharges. California's OSHPD collects, by far, more comprehensive data about hospital usage and staffing than any other state in the nation.

For purposes of developing staffing minimums, however, there are some serious limitations to the OSHPD data. The most important limitations are:

- 1) "Productive Hours per Patient Day" (PHPD) for nurses includes many hours not spent at the bedside. In fact, "productive nursing hours" includes all hours worked by the nurse (i. e., all hours not spent as vacation or sick leave). During those hours, nurses may be engaged in other activities, including continuing professional education, quality assurance, management, etc. Thus, PHPD are likely to overestimate the actual amount of bedside care, and the magnitude of the discrepancy may vary from hospital to hospital.
- 2) The "patient day" that the hospitals report is the sum of the patients in the hospital at a specified time each day. In other words, the average "patient day" is assumed to be 24 hours. For any given hospital, this may or may not be true. Assuming a standard census time of midnight, hospitals that tend to admit patients very soon after midnight (e. g. through the Emergency Department) and discharge them the next day before midnight will appear to have a lower daily census overall (and thus have fewer patient days) than hospitals that admit patients late in the afternoon or evening (just before the census is taken). All else being equal, the hospitals that admit a number of patients after midnight and discharge patients before midnight the next day would appear to have richer nurse-to-patient ratios than is actually the case.
- 3) The additional work required to admit and discharge patients is not captured by PHPD. Previous studies have shown that medical resource use is greatest during the first few days of hospitalization (Exhibit X). Therefore, two hospitals with the same daily census—one with high patient turnover and one with low patient turnover—could experience very different staffing demands.
- 4) Not all patient days are alike. Patients differ in terms of severity of illness, acuity, and care requirements. The PHPD metric does not

adjust for patient severity. Therefore, two hospitals with the same census but different overall acuity in their patient populations could require very different staffing patterns.

- 5) Not all nurses are alike. When nurses are "floated" out of their specialty area, they may not perform with the same level of competence, and may not have the same work output, as nurses trained for that area. For example, an RN assigned to the labor and delivery unit who is floated to a medical/surgical unit may not be as productive as the regular medical/surgical unit staff. Similarly, hospitals that have a high use of registry nurses may not attain a high level of work output, because those nurses are constantly learning to work in new environments. Therefore, hospitals that regularly float their own staff to different units and/or have a high use of registry staff may have higher staffing needs than hospitals with more stable staffing patterns.
- 6) PHPD reflects average staffing across a 24 hour period, and does not portray fluctuations due to day/night scheduling patterns, absenteeism, and other circumstances, both foreseen and unforeseen.

Even with these limitations, however, PHPD is the best available metric for estimating current nurse staffing levels in California using administrative data.

In order to get a clearer picture of nurse staffing in California's acute care hospitals, the administrative data needed to be supplemented by clinical data. Toward that end, the Department again partnered with the UC research team to gather empirical, real-world data about our health care workforce.

#### **Design of the On-Site Study:**

CDHS worked with the UC research team to develop a stratified sample of California's 495 hospitals. The hospitals were sorted into six categories: academic medical centers, Kaiser, small and rural, other public, other private, and state facilities. (Kaiser hospitals were given a separate category because OSHPD does not collect hospital-specific data on the Kaiser organization as it does on other hospitals. Instead, the Kaiser hospital system is permitted to report in the aggregate, in conformance with HSC 128760(f).)

Within each of the six categories, the number of hospitals that would yield a statistically valid and representative sample was determined by the contracted statistician and epidemiologist. Ultimately, the number of hospitals to be visited for each category was: Ten (10) academic medical centers (all), ten (10) Kaiser hospitals, twenty (20) small and rural hospitals, ten (10) other public, thirty (30) other private, and ten (10) state facilities (all), for a total of 90 hospitals statewide. CDHS chose seventeen (17) experienced facility surveyor registered nurses to

administer the study. All were from Licensing and Certification's headquarters staff, so that staff performing the study would not be the same surveyors who were in an enforcement role in the field. This also minimized impact on the field staff and allowed easier logistics for travel planning, etc.

CDHS utilized its registered nursing staff to work with the research team to develop a study tool to capture the way that hospitals are actually staffing their units. The tool, after numerous reiterations and refinements, consisted of three segments: the Cover Sheet, the Unit Inventory and the Unit List and Selection Form, and the Nurse Staffing Study Form. (Exhibit Y).

The Cover Sheet was designed to gather basic information about the hospital, the date and time the study began and ended, the name and contact information about the hospital administrator, the name of the PCS in use at that hospital, etc.

The Unit Inventory and the Unit List and Selection Form were designed to sort the hospital's units into categories of unit types. So that the study would maintain internal consistency, a script was developed that was read to the hospital's administrative staff, which included definitions of each unit type. Hospital administration then determined whether or not their facility had a unit (or units) meeting the stated description. The name(s) and location(s) of the units, as well as contact information for the unit, was recorded on the form.

The Nurse Staffing Study Form was used on the individual units. Information related to the shift that was currently in progress was gathered, as well as information on the previous 24 hours, including patient census, numbers of discharges and admissions, the number of licensed and unlicensed staff on duty, and the nursing care model in use. Questions were included that gathered demographic information about nurses in order to get a snapshot of their education, employment status, and years of practice. That information would serve to confirm or refute earlier studies of nursing and provide CDHS with a picture of the current nursing workforce.

On every unit, the form called for shift-specific data for the seven days preceding the date of the study visit (a maximum of twenty-one shifts in all). For each shift, the numbers of RNs, LVNs, Unlicensed Assistive Personnel, and patients were documented. Because the date of the study varied over the course of the three weeks it was being conducted around the State, the "previous seven day" shift information reflected a variety of dates. In addition, the same information was requested for ten (10) specific dates during the first three (3) months of 2001. The dates were chosen in advance by the research team to include all days of the week, including weekends and holidays. That first-quarter data produced information about the same shift on the same date at all of the hospitals in the study.

Before the tool was finalized, CDHS used the draft tool to conduct a field pre-test at four (4) hospitals representing four different strata. The results of the pre-test led to further refinements to the tool.

After the tool was finalized, CDHS developed a lesson plan to teach the nurse surveyors about the new law, the purpose of the study, and the design and use of the tool. The nurse surveyors were brought together for an intensive, one-day training session, given by CDHS. A representative of the UC research team was also on hand during the training to answer technical questions about the selection of the sample and the design of the tool. The nurse surveyors were also given instructions and contact information so that appropriate CDHS staff could be reached as needed for consultation while the studies were progressing in the field.

The one-day training was conducted, and the field studies commenced the following day.

#### **The Study Process:**

Prior to implementation, the University of California Davis Medical Center's Committee for the Protection of Human Participants approved this study. All visits were conducted between April 30, and May 18, 2001. All of the visits were unannounced. The surveyors introduced themselves to Administration as soon as they arrived, and then explained the purpose of the visit. They began the unit inventory and proceeded through the study protocol, first with hospital administration and then with the nurse managers and staff nurses on each of the selected units.

All of the information collected was reviewed by CDHS to ensure that it was correct and complete. Subsequently, all data was entered and electronically submitted to the UC researchers for analysis.

The study provided the Department with a portrait of nurse staffing as it is currently occurring in general acute care hospital units. It included shift by shift retrospective data for the week preceding the study, as well as staffing information for the ten randomly selected 24-hour periods over the first three months of 2001. Table 3a on the next page gives a broad look at the number of patients per licensed nurse in each unit type over the standard percentile rankings for all hospitals visited.



**Table 3a. Patients per licensed nurse by survey nursing unit type, weighted estimates<sup>1</sup> for all hospitals and shifts.**

Survey Unit Type	Number of Hospitals	Number of Shifts	Patients per Licensed Nurse						
			5%ile	10%ile	25%ile	Median	75%ile	90%ile	95%ile
Labor and Delivery Only	39	39	0.55	0.56	0.86	1	1.33	1.8	2
Postpartum Only	37	1650	2	2.67	4	5.07	6.38	7.67	8.67
Combined									
Post-partum/ Labor and Delivery	13	499	0.67	1	1.5	2.25	3.17	4	4.5
Stepdown Only	20	780	1.6	2	2.33	2.83	3.4	4	4
Telemetry Only	21	956	2.56	2.83	3.71	4.5	5.6	6.8	8.25
Combined									
Stepdown/Telemetry	18	793	2	2.5	2.67	3.36	4	4.62	5
Medical Only	14	726	3.17	3.71	4.4	5	5.8	7	8
Surgical Only	21	920	2.44	2.89	3.6	4.57	5.67	7.33	8.5
Combined									
Medical/Surgical	40	1781	3	3.5	4.3	5.14	6	7.5	8
Emergency	71	71	0	0.33	0.5	1	1.6	2	2.86
Pediatric	31	1320	1	1.5	2.5	3.4	4.5	5.5	6
Oncology	13	550	2.5	2.91	3.75	4.5	5.33	6.2	7.5
Psychiatric (Acute Care Hospitals)	20	979	2	2.5	3.5	4.5	6	11	15
Sub-Acute/Transitional	8	343	3.67	4.4	5.5	7.25	10.75	13.33	15
Postanesthesia	68	68	0	0	0	0.8	1.82	2.5	3.43
Mixed	47	2040	1	1.67	3.67	5	6	7.5	8

<sup>1</sup> These estimates are based on the actual number of licensed nurses, and the actual number of beds or gurneys occupied by patients, at the beginning of the sampled shift.

For an in-depth discussion of the study process, forms, and procedures, please see Exhibit Z, included as a document relied upon for the development of the regulations.

In summary, CDHS responded to the mandate to establish these nurse-to-patient ratio regulations by performing an extensive literature search, soliciting the recommendations of professional organizations representing physicians and nurses, having discussions with other states and countries about their experiences with acute care staffing, and extracting the information that could be obtained about nurse staffing from the OSHPD data. CDHS also solicited input from professional nurses on its own staff, as well as the perspectives of the major stakeholders before the proposed ratio regulations were drafted. Because none of the sources of information provided CDHS with hard scientific evidence of the optimal nurse staffing ratio for each individual unit, and in order to supplement the other sources of information empirically, CDHS conducted an on-site hospital study. The purpose of the study was to discover the level of nurse staffing practiced in hospitals in the absence of these proposed ratio regulations. It also gave CDHS the opportunity to estimate the FTE and fiscal deficits that may occur with various ratio proposals, and provided a foundation for the required study evaluating the effect of these regulations five years after adoption. The Aiken study (Exhibit V-2) has recently provided validation that increasing the amount of nurse staffing in acute care hospitals has the effect of decreasing patient mortality and improving both patient and workforce outcomes.

#### **Section 70217(a). Nursing Service Staff.**

The Department proposes to adopt this section to define the nurse-to-patient ratios mandated by AB 394 (Kuehl, Chapter 945, Statutes of 1999). Proposed regulations require that hospitals provide staffing by licensed nurses, which includes registered nurses and licensed vocational nurses within the scope of their licensure, in accordance with specific nurse-to-patient ratios. Under California law, the term "licensed nurses" includes both registered nurses and licensed vocational nurses. This is specified in the regulations so that the general public will clearly understand the term as used in this regulation.

The Department clarified that the phrase "licensed nurse" includes "licensed psychiatric technicians in psychiatric units only." This change means that the general provisions of this section that apply to licensed nurses, would also apply to licensed psychiatric technicians assigned to provide care within their scope of practice in psychiatric units for the purposes of the licensed nurse to patient ratios.

The Department added the descriptors "licensed," "registered," "licensed vocational" or "licensed psychiatric technician" throughout this section to more clearly specify which licensing category is required in the regulation.

In order to clarify that a hospital cannot reduce overall staffing by assigning licensed nurses to duties customarily and appropriately performed by unlicensed staff, it is stated that staffing for care not requiring a licensed nurse is not included within these ratios and shall be determined pursuant to the patient classification system. At 22 CCR 70053.2 and 70217(b), the PCS is defined as a system that is established to determine the amount of nursing care needed by each unit, on each shift, and for each level of licensed and unlicensed staff. Setting a minimum level of staffing for licensed nurses is not intended to alter the current requirement of the PCS to determine needed staffing levels for licensed and unlicensed staff.

HSC 1276.4 (e) requires that a nurse must be oriented to a specific clinical area "sufficient to provide competent care to patients in that area, and has demonstrated current competence in providing care in that area." The statutory requirement is repeated in regulation in response to requests made in many public comments. It is necessary to include all licensed nurses in the requirement for current competency in order to ensure patient safety in licensed hospitals. It is also necessary to include licensed psychiatric technicians in psychiatric units only as licensed nurses to ensure that the general requirements for current competency to licensed nurses are applied to licensed psychiatric technicians as well. Pursuant to HSC 1276.4 (d) and (f), hospitals are already required by regulation to establish and implement policies and procedures which set competency standards for nursing staff performance in the delivery of patient care. See 22 CCR 70016, 70016.1, 70213(c), and 70719.

"During one shift" is being changed to "at any one time" for clarity in all the subsections of 70217(a) dealing with individual hospital unit types. This was done in response to many public comments. "Assigned" is being defined in regulation in response to the requests of many public comments. The prohibition of averaging, which was contained in the statement of reasons for the original proposed regulations, is being explicitly stated in regulation in response to the requests of many public comments.

Only licensed nurses providing direct patient care are included in the ratios because the intent of the statute is to ensure that nurses are "accessible and available to meet the needs of the patient". While nurse administrators, nurse managers, and nurse supervisors have vital supportive, supervisory, and oversight responsibilities, it is not their role to be readily accessible and available to directly meet the needs of the patients when they are functioning in their administrative or supervisory positions. However, as those nurses do not have their own patient assignment, they may relieve staff nurses during the staff nurses' breaks, meals, and other routine, expected absences from the unit as long as they have demonstrated to the hospital in which they are currently working their current competency for the unit on which they will be present to provide direct patient care.

The ratios are the same minimum standard for every shift. They represent the leanest staffing the Department believes is compatible with safe and quality patient care in the acute care setting. Because of the pressures of managed care and the increasing complexity of acute care services, people who are hospitalized now tend to require more intense and sophisticated care for fewer days. When combined with the flexible shift scheduling in hospitals (i.e. eight, ten and twelve hour shifts may be available on the same unit), it is no longer feasible to reduce nursing staff during evening, night, or weekend hours. Therefore, these ratios represent the leanest staffing permitted on any shift.

The ratios represent the maximum number of patients assigned to any one nurse at any one time. It is CDHS' intent not to permit averaging the numbers of patients and nurses during a single shift, nor averaging over time. This prohibition of averaging is consistent with the way existing ICU and NICU nurse-to-patient ratios have been interpreted and enforced since they were put in place over 26 years ago. The 1:2 ratio in those units has historically been interpreted to mean that an individual nurse in an ICU may not have a patient assignment that exceeds two patients at any time. To deviate from that interpretation of the ratios in the new regulations would cause enormous confusion for both providers and working nurses.

Additionally, if CDHS were to permit averaging (as an alternative approach), there would effectively be no limit on the number of patients who could be assigned to one nurse at any given time. For example, a medical/surgical unit with four bedside nurses and 24 patients would be in compliance with an *average* ratio of 1:6 during that shift. However, if acuity dictated that three of those patients receive 1:1 care, then one nurse could theoretically become responsible for the care of the remaining twenty-one patients.

As an example of averaging over time, the same 24 bed unit could be staffed with 6 nurses on day shift, 4 nurses on evening shift, and 2 nurses on the night shift. In that scenario, the unit would be in compliance with an *average* ratio of 1:6 over the 24 hour period. The actual care provided, however, would be 1:4 on day shift, 1:6 on evening shift, and 1:12 on night shift. While facilities always have the option of increasing staffing above the minimum required levels as in the day shift example above (and indeed the obligation to increase staffing in response to patient acuity according to the PCS) the regulations are written to prevent, at any time, the assignment of fewer nurses to care for patients than the minimum level specified in these regulations.

The Department believes that such situations would not conform to the Legislature's intent, nor the Governor's message when he signed the bill into law. Most importantly, it would not provide the needed safeguard for patients in



California's acute care hospitals to be cared for by adequate numbers of nursing staff.

Existing regulations at 22 CCR 70465(e) and 70495(e) permit licensed vocational nurses (LVNs) to constitute up to 50 percent of licensed nurses. CDHS has no evidence that the quality of care has been negatively impacted by allowing the 50/50 percent skill mix of RNs and LVNs. This provision clarifies that, unless RNs are required (as in intensive care newborn nursery service in existing section 22 CCR 70485 in current regulations, in the roles of triage or trauma nurse, or if the PCS indicates a need for that level of skill) the nurse staffing on a unit may include up to 50% LVNs.

The standard at 22 CCR 70485 for RNs will remain in effect because subdivision (i) of HSC 1276.4 mandates that existing ratios may be augmented but not replaced. The 50% limitation has been a long-standing requirement necessary to ensure that RNs make up at least half of the nurses available to patients in the acute respiratory care, intensive care, and coronary care settings. The roles and function of the RN and the LVN are clearly described in their respective scopes of practice (as set forth in the Business and Professions Code sections 2725 and 2859 et. seq.) The OSHPD data reports of California hospitals demonstrate that in critical care units LVNs make up only 3% of nursing staff, and LVNs constitute only 17% of acute care staffing overall. Therefore, the 50% limit provides basic assurance that sufficient RNs will be available, but leaves room for needed flexibility for hospitals to determine how to best meet patients' nursing care needs based on fluctuating patient acuity and on skill mix. This change clarifies that licensed vocational nurses shall not care for patients when the hospital's patient classification system requires registered nurses, nor may they function in the roles of triage and trauma nurse. Triage nurses assess, screen, and sort patients so that the patients with the most emergent needs are handled in order of priority. Because triage by definition includes obtaining a brief history and performing a rapid physical assessment, and because patient assessment is reserved to the registered nurse scope of practice (Business and Professions Code (B&PC) 2725(b)(4), only registered nurses may function in the role of triage nurse. Likewise, because trauma nurses require advanced skills and abilities in addition to the ability to provide the patient with swift and ongoing assessment, only registered nurses may function in the role of trauma nurse.

Nothing in these regulations prohibits a licensed nurse from providing care within his or her scope of practice to a patient assigned to another nurse. The Department recognizes the existence of some overlapping functions between registered nurses and licensed vocational nurses, and intends to permit the sharing of those functions for the most efficient, effective delivery of patient care.

CDHS believes it is sound health policy to permit LVNs to provide nursing care within their scope of practice where RNs are not required. Permitting LVNs to constitute up to 50% of licensed nurses on units also makes the nursing

workforce more closely resemble California's diverse population, ethnically and racially. The RN workforce in California remains overwhelmingly female and white: in 1996, fully 84% of RNs were white, with only 3% African American, 8% Asian/Pacific Islander, 4% of Hispanic origin, and less than 1% Native American. That same year, the LVN workforce was 73% white, 18% African American, 3% Asian, 5% of Hispanic origin, and 1% Native American (Exhibit Z-1). According to the report prepared by the National Advisory Council on Nurse Education and Practice published in April, 2000 entitled "A National Agenda for Nursing Workforce: Racial/Ethnic Diversity", a culturally, ethnically, and racially diverse nursing workforce is essential to meet the health care needs of patients. Minority nurses are significant for their contribution to the provision of healthcare services and models of care that are more congruent with the unique needs of minority populations. They "raise the bar" of cultural competence for the entire workforce (Exhibit Z-2).

"Assist" is being defined in the proposed regulation in response to the requests of many public comments. This clarifies that it is not CDHS' intent to prohibit nurses from providing care to patients who are not assigned to that nurse, nor is it a violation of these proposed regulations when nurses provide such care so long as the tasks performed are specific and time-limited. Such tasks might include administering medications, performing assessments, assisting with personal care, providing discharge instructions, and other nursing tasks.

When LVNs are assigned to patients, it will be necessary for an RN to perform duties for those patients that are outside the scope of practice of the LVN. Likewise, although the LVN may have a patient assignment, he or she may be required to perform duties for patients that are assigned to an RN. These proposed regulations are intended to allow hospitals flexibility with regard to assignments as they utilize the PCS to determine the care needed, to be provided by RNs, LVNs, and unlicensed staff. This clarification is necessary to ensure that hospitals retain reasonable flexibility in choosing staffing models as directed by Governor Davis in his sign message (Exhibit A), to accommodate scope of practice issues, and to clarify that team nursing is not prohibited by these regulations.

70217(a)(1)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments.

"Critical care unit" is defined in the new law at HSC 1276.4(c). The decision was made to specify the critical care units by name to add clarity to the regulation. Those units which are currently defined in regulations as intensive care units may also properly be referred to as critical care units. It is CDHS'

intent that the phrases "intensive care units" and "critical care units" may be used interchangeably.

"Intensive care newborn nursery service" was added to the list of critical care units to clarify that it is included as a critical care unit. Intensive care units are mandated at 22 CCR 70495 to have a minimum nurse-to-patient ratio of 1:2 or fewer at all times. Similarly, acute respiratory units (section 70405), coronary care service units (section 70465), and intensive care newborn nursery units (section 70485) all require a minimum ratio of 1:2. These provisions are long-standing requirements that have not been, and are not now, disputed. Neither providers nor their representative organizations have suggested that the 1:2 ratio is too rich for those unit types. In fact, with the increasing sophistication and complexity of medical technology allowing patients' lives to be saved and maintained which previously would have been lost, the 1:2 ratio standard has become the minimum ratio for critical care units, with many patients in those units requiring staffing at 1:1 and even 2:1. Additionally, HSC 1276.4 (i) prohibits replacing existing ratios for the intensive care units, neonatal intensive care units, or the operating room. Burn centers are currently staffed at 1:2 as the standard of practice in California. This regulation clarifies that the Department considers burn units to be critical care units, and sets the nurse staffing ratio in conformance with other intensive care units for the health and safety of patients admitted to the burn unit setting. Including all nurse staffing ratios in this section, as well as existing ratios that are now designated as "critical care", is necessary for clarity, convenience, and organizational purposes.

70217(a)(2)

This provision makes explicit the requirement for a registered nurse (RNs) to function as the circulating assistant in the surgical service operating room (For the meaning of "surgical service operating room", please see 22 CCR, section 70223, Surgical Service General Requirements). Current regulations at 22 CCR section 70225(d) require, "There shall be registered nurses, licensed vocational nurses, and operating room technicians in the appropriate ratio to ensure that at all times a registered nurse is available to serve as the circulating assistant whenever a licensed vocational nurse or operating room technician is serving as scrub assistant." Current regulation, therefore, leaves open the possibility of a licensed vocational nurse or other personnel serving as circulating assistant if a registered nurse were serving as scrub assistant. That situation is not sensible, not safe, and not congruent with current practice as evidenced by both the analysis of the OSHPD data and the CDHS on-site study. DHS proposes to repeal section 70225(d) in this regulation package to eliminate conflicting language.

The circulating assistant is responsible for managing the nursing care within the operating room, observing the surgical team from a broad perspective, assisting the team to create and maintain a safe, comfortable environment for the

patient, and coordinating the activities of each member of the surgical team (Exhibit AA). The function of the registered nurse in that role is the accepted community standard of practice. The use of RNs as circulating assistants was specifically approved by the National Association of Perioperative Registered Nurses, as ratified at their Congress in March, 2001 (Exhibit BB). The most critical period of care for surgical patients occurs in the operating room. The instability inherent in the patients' condition while undergoing surgery necessitates the registered nurse level of skill for ongoing assessment and evaluation, while assisting the surgical team. The ongoing assessment includes minute-by-minute vigilance and availability for immediate response to emergent patient changes on the part of the circulating registered nurse. Because of the close scrutiny each patient requires, there must be one circulating registered nurse assigned to each patient-occupied operating room. For these reasons, the term "circulating assistant" was changed to "circulating nurse". This change was requested by many public comments.

The role of the scrub assistant is to assist the surgeon by handing on instruments, sponges, and other items needed during the surgical procedure, while maintaining the sterile field (Exhibit AA). This duty can be safely performed by registered nurses, licensed vocational nurses, or specially trained surgical assistants. The role of the perioperative circulating registered nurse, on the other hand, is to oversee the surgical patient's care and to be immediately available to respond to emergencies as the circulating nurse. Because each role is distinct and both are crucial to the care the patient receives while undergoing surgery, one circulating registered nurse and one scrub assistant are needed for every patient-occupied operating room. The requirement was further clarified to reflect this, and to clarify that the roles may not be combined with the other licensed professionals such as physicians who are assisting in the performance of the surgery.

70217(a)(3)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The nurse-to-patient ratio for labor and delivery units is proposed to be 1:2 or fewer at all times. This is based on the patients' need for critical care during the end of labor and through the delivery process. The 1:2 ratio conforms to the ratios for the other critical care units in the hospital. Both the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, representing the specialty's physicians (Exhibit CC), as well as the Association of Women's Health, Obstetric, and Neonatal Nurses representing the specialty's nurses, (Exhibit DD) recommend a minimum nurse-to-patient ratio of 1:2 for patients in labor. The Department relied upon both of these documents in



developing the proposed regulations. Staffing of labor and delivery suites at 1:2 is already the standard of practice in California's hospitals, as evidenced by both the analysis of the OSHPD data and the CDHS on-site study. Analysis of the CDHS' on-site study data revealed that, for 95% of hospital shifts statewide, labor and delivery units are currently staffed at 1:2 or richer.

For the purpose of caring for antepartum patients who are not in active labor in these units, CDHS has determined that the ratio shall be 1:4 or fewer at all times. This would maintain the 1:8 maximum total patient ratio in perinatal units and be congruent with the postpartum requirement for 1:4 mother/baby couplet care. This is appropriate because each mother and fetus requires assessment, care, evaluation, possibly intervention, and documentation. An antepartum ratio of 1:4 would allow for the detection of and intervention for unexpected maternal-fetal problems that may become apparent.

70217(a)(4)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The nurse-to-patient ratios in the postpartum unit of the perinatal area is proposed to be 1:4 mother/baby couplets (1:8 total patients), and, in the event of multiple births, would never exceed a total of eight (mothers plus infants) per nurse. In those units where care of recovering mothers is staffed separately from the newborn nursery areas, the nurse-to-patient ratio is proposed to be 1:6. According to the analysis of CDHS' on-site study, between 90-95% of hospital shifts statewide have perinatal units staffed at 1:8 total patients, while 75% are staffed at approximately 1:6 total patients.

In *Guidelines for Perinatal Care* (Exhibit CC), both the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, representing the specialty's physicians, recommend a nurse-to-patient ratio of 1:6 for postpartum patients without complications and 1:4 for normal mother-newborn couplet care. That publication states, "The most current scientific information, professional opinions, and clinical practices have been assembled and received in the formulation of the information in this manual..." The Association of Women's Health, Obstetric, and Neonatal Nurses, representing the specialty's nurses, agrees that those are the appropriate ratios (Exhibit DD). The Department relied upon these documents in developing the proposed regulations.

There was also a non-substantive grammatical correction from "nurses' "to "nurse's".

70217(a)(5)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

In a combined Labor/Delivery/Postpartum area of the perinatal service, the minimum nurse-to-patient ratio is proposed to be 1:2 or fewer at all times when a nurse is caring exclusively for women in active labor. When a nurse is caring exclusively for antepartum women who are not in active labor, the proposed ratio shall be 1:4 or fewer at all times. When a nurse is caring exclusively for postpartum women, the minimum nurse-to-patient ratio is proposed to be 1:6 total patients. When a nurse is caring exclusively for mother/infant couplets, the minimum nurse-to-patient ratio is proposed to be 1:4 couplets (1:8 total patients). In those facilities that combine perinatal services into one single unit for staffing purposes, a minimum nurse-to-patient ratio of 1:3 allows a nurse to care for two women in active labor, and to continue to care for both patients in the event that one of the laboring women delivered her infant while the other patient remained in labor. According to the analysis of CDHS' on-site study data, approximately 75% of hospital shifts statewide currently meet or exceed the 1:3 minimum ratio for combined Labor/Delivery/Postpartum units.

The ratios in 70217(a)(3) and (4) apply equally when the labor and delivery suites and the postpartum areas are combined into Labor/Delivery/Postpartum areas. The only unique circumstance addressed for these units is the possibility, because of the nature of the unit, that a nurse might temporarily care for one woman in active labor and also a newly delivered mother and infant.

Also, the sentence structure was changed to enhance clarity and at the request of many public comments.

70217(a)(6)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations. The word "unit" was added because current regulations at 22 CCR 70537(c) and 70543(a) differentiate between the pediatric service and the pediatric unit. These proposed pediatric ratios would only apply to those hospitals that have a pediatric unit. Other hospitals which admit pediatric patients but do not have pediatric units would admit the pediatric patients to a mixed unit, and that ratio in concert with the PCS would dictate the appropriate staffing level.

The nurse-to-patient ratio in pediatric service units is proposed to be 1:4 or fewer at any time. According to the CDHS on-site study, at the 75<sup>th</sup> percentile, where 25% of hospital shifts have leaner staffing, the ratio is 1:4.5. When compared with the OSHPD data, however, at the 75<sup>th</sup> percentile, the ratio is 1:3.8. Because of the margin for error in both approaches, staffing in the pediatric service of hospitals is probably very close to 1:4 at the 75<sup>th</sup> percentile. This regulation will enrich staffing for the leanest one-quarter of pediatric hospital shifts in California.

Because of their immaturity and their dependency, hospitalized children and youth require significantly more nursing attention than adult patients. The need is greatest where dependency is greatest: for infants and pre-school children. The American Academy of Pediatrics supports a minimum nurse-to-patient ratio of 1:4 in pediatric units (Exhibit EE). The Department relied upon this document in developing the proposed regulations.

70217(a)(7)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The nurse-to-patient ratio in a postanesthesia recovery unit (PACUs) of the anesthesia service is proposed to be 1:2 or fewer at all times. Compared with the CDHS on-site study, 25% of hospital shifts in California staff PACUs at 1:1.8; the leanest 10% staff PACUs at 1:2.5, so the ratio of 1:2 would increase staffing at the leanest 10-25% of hospitals statewide. This 1:2 ratio is consistent with the staffing requirements for critical care units in the hospital. Multiple physiological systems, notably the neurological and pulmonary systems, are compromised with the administration of anesthesia and remain unstable until the patient is recovered successfully. CDHS concurs with the California Society of Anesthesiologists which wrote as Commenter #1633, "The CSA supports the proposed DHS nurse-to-patient ratio of 1:2 or fewer for patients in the postanesthesia recovery unit. The most critical phase for a patient recovering from anesthesia whether it is general, regional, or intravenous, is the immediate period following surgery and anesthesia, before they are transitioned to an inpatient setting or discharged to a lower level of care." The American Society of PeriAnesthesia Nurses, representing the nurses in that specialty, has set standards of practice which require a minimum of one nurse for every two patients during the immediate postanesthesia period, defined as the time from the patient's admission to the PACU until they are transitioned to an inpatient setting or discharged to a lower level of care (Exhibit FF). In addition, the PeriAnesthesia Nurses Association of California concurs that 1:2 is the appropriate ratio (Exhibit GG), as does the California Society of Anesthesiologists, representing the specialty's physicians (Exhibit HH). The

Department relied upon these documents in developing the proposed regulations. The phrase "regardless of the type of anesthesia the patient received" was added to the proposed regulations for clarity and in response to the requests of many public comments.

70217(a)(8)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations for the nurse staffing requirement for basic and comprehensive emergency medical services. The word "registered" was added to "nurse assigned to triage" for clarity.

The methodology for determining appropriate nurse-to-patient ratios in Emergency Departments (EDs) is problematic for several reasons, including the great variation in patient acuity and visit frequency that an individual ED can experience over a 24 hour period. In addition, different EDs can vary greatly from one to the next in the acuity and intensity of care required for the different patient populations they serve. EDs can also be severely impacted by trauma and critical care admissions, both medical and psychiatric. In order to make the most efficient use of its resources, staffing formulae for EDs are typically calculated on an hour-to-hour basis, with the beginning and end of staff shifts staggered so that there is peak staff availability when patient volume is highest. These idiosyncratic staffing patterns necessitated creating a multifaceted regulation for nurse-to-patient ratios in EDs.

In a hospital providing basic emergency medical services or comprehensive emergency medical services, the nurse-to-patient ratio is proposed to be 1:4 or fewer at all times. This represents the median ratio between critical care units (1:2) and medical/surgical units (1:6), and is the same ratio as that applied to step-down units. This is appropriate because, while not all ED patients are critical, they all arrive in a potentially unstable condition. Most patients do not arrive with a clear diagnosis of condition, and ED evaluation and treatment usually demands multiple tasks to be done quickly, and often simultaneously.

Critical care patients in the ED deserve the same standard of care they would receive in a critical care unit, and therefore the same minimum 1:2 nurse-to-patient ratio. For trauma patients, the most critical cohort of the critical care patients, the maximum number of patients one nurse shall care for is proposed to be one. That will provide those patients a greater intensity of care than patients requiring regular critical or intensive care. In the ED, as in all other units, these are minimum standards only, with the number of licensed nurses increasing as patient acuity increases based on the PCS.



CDHS has added definitions for "critical care patient" and "critical trauma patient" as requested by many public comments. "Critical care patient" is defined as a patient who meets the criteria the hospital is currently using for admission to its own critical care units, and states that a patient who meets that criteria should logically receive a consistent level of nurse staffing, regardless of the patient's temporary placement in an area outside of a critical care unit. The definition of "critical trauma patient" is provided for clarity because it more precisely defines the CDHS intent than the previous reference to HSC 1798.160, and a clearer definition was requested by many public comments. Providing the definition of "critical trauma patient" was necessary so that a distinction could be made between those trauma patients who would not require enriched ED staffing above 1:4 and those trauma patients whose injuries are so severe that the enriched staffing to 1:2 is necessary for the provision of critical trauma care. HSC 1798.160 did not actually define "critical trauma patient"; rather, it defined "trauma case" as "any injured person...who has been found to require transportation to a trauma facility." CDHS intended to include all critical trauma patients at general acute care hospitals in the enriched staffing ratios, not just those patients who were transported to a trauma facility. Therefore, the definition was changed.

The word "Local" was added to the "Emergency Medical Services Agency" to be consistent with the way those agencies are referred to in HSC 1797.58. The word "Local" was mistakenly omitted in the initial proposed regulations.

The positions of triage nurse and base radio nurse in the ED require an immediate, focused, and often continuous response, and, therefore, must be staffed by registered nurses assigned to those roles and not otherwise counted in the minimum ratios. However, nothing in these regulations should be construed to prohibit the triage and base radio nurse from assisting by performing nursing tasks when there are no patients awaiting triage and no calls on the base radio. This is permitted as long as the registered nurses remain immediately available to resume their roles as triage nurse and base radio responder. The nursing tasks that they may assume, therefore, must be ones that can be readily put aside when they need to resume their primary assignment, without endangering a patient. The proposed regulations further clarify that either a licensed physician or a registered nurse may respond to calls on the base radio, and that these proposed regulations apply only when the base radio responder is a registered nurse.

For hospitals which do not function as a "base hospital" as defined in section 1797.58 of the Health and Safety Code, but offer basic or comprehensive emergency medical services, then, a minimum of two nurses (one triage nurse plus one treatment nurse) would be needed in the emergency room whenever a patient is present.

The above ratios, including the exception of triage and radio nurses from a patient assignment, are the minimum nurse-to-patient ratios acceptable to the California Chapter of the American College of Emergency Physicians (CAL/ACEP), which represents over 2000 medical practitioners in that specialty (Exhibit II). The California Medical Association has also endorsed these ratios (Exhibit JJ). In addition, this is the intensity of care standard acceptable to the Emergency Nurses' Association California State Council, representing the specialty's nurses (Exhibit KK). The Department relied upon these documents in developing the proposed regulations.

70217(a)(9)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The nurse-to-patient ratio in a step-down unit is proposed to be 1:4 or fewer at all times. A step-down unit is defined as a unit for the monitoring and care of patients with moderate or potentially severe physiologic instability, requiring technical support but not necessarily life support; a unit reserved for those patients requiring less care than standard intensive care, but more than that which is available from standard medical/surgical care. This definition was added to clarify the confusion expressed by some commenters that step-down care was equivalent to sub-acute care.

This is the way the unit is defined by the American College of Critical Care Medicine, which refers to these units as "Intermediate Care Units" (Exhibit LL). These same units are also sometimes called "Progressive Care Units". The regulations refer to these units as "Step-down Units" for the sake of clarity, because the term "Intermediate Care" is defined at 22 CCR 70038 as beds "designated for patients requiring skilled nursing and supportive care on a less than continuous basis." Intermediate Care Service requirements reflecting that level of care, which is a lower level of care than the skilled nursing level of care, are further explicated at 22 CCR 70501 and 70503. The units, then, are referred to as "step-down units" so that the public will be able to clearly understand which type of unit is governed by this regulation.

The 1:4 ratio represents the median ratio between the ratio required in intensive or critical care units (1:2) and the ratio required in medical/surgical units (1:6), which is appropriate for the median level of care between the two units. The ratio required for medical/surgical units is proposed to change from 1:6 to 1:5 in the year 2005. CDHS now proposes to phase-in a change to require a ratio of 1:3 in step-down units in the year 2008. This is clinically appropriate because of increased patient acuity and the required level of care in stepdown units. Enriched staffing is needed to address this increased patient fragility and

complexity of care and treatment. In addition to needing many of the extra nursing interventions that are required in Telemetry and other specialty units, patients in step-down units are much more medically fragile. This requires ongoing assessment to detect any change in condition. A change of condition in such a medically fragile patient can be the cause of more immediate and serious consequences than such a change has for patients in other unit types. These patients are literally just a step away from needing intensive care. CDHS proposes to delay the phase-in until 2008 because both critical care and stepdown-qualified nurses are the rarest in the nursing workforce and require advanced education, training, and certification. The additional time will allow for increasing the numbers of these specialized nurses. The analysis of CDHS's on-site staffing study showed that 95% of shifts in step-down units statewide are currently staffing at 1:4, with 50-75% already staffing at 1:3.

"Technical support" was defined in the original proposed regulations as "...specialized equipment and/or personnel providing for invasive monitoring, telemetry, and mechanical ventilation, for the immediate amelioration or remediation of severe pathology..." That sentence has been changed in this version to read, "...specialized equipment and/or personnel providing for the invasive monitoring, telemetry, or mechanical ventilation, for the immediate amelioration or remediation of severe pathology..." to clarify CDHS' intent that any one of those treatments for the severe pathology would be defined as technical support. All three treatment types do not need to be in use in order for the term "technical support" to apply.

"Artificial life support" is defined as a system that uses medical technology to aid, support, or replace a vital function of the body that has been seriously damaged. Patients requiring artificial life support could, depending on their acuity, be found in critical care units or on these step-down units. Patients who are stable and are on artificial life support long term may also be appropriately located on subacute units. "Artificial life support" and "technical support" are defined in the regulation in order to differentiate the types of equipment and nursing care that would commonly be required by patients in stepdown units, and, by extension, the degree of illness or impairment experienced by patients in this unit type. The term "technical support" is used in Exhibit LL in describing equipment found in a step-down unit. "Artificial life support" is defined in Exhibit MM.

70217(a)(10)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The nurse-to-patient ratio in telemetry units is proposed to be 1:5 or fewer at all times. The ratio required for medical/surgical units is proposed to change from 1:6 to 1:5 in the year 2005. CDHS now proposes to phase-in a change to require a ratio of 1:4 in telemetry units in the year 2008. This is clinically appropriate because of increased patient acuity and the required level of care. This care requires more nursing hours at the bedside to perform all the tasks required on medical/surgical units plus additional nursing tasks, including the reading and interpreting of the electronic monitor output. Phasing in the ratio in the year 2008 is also appropriate because most nursing programs can be completed in approximately three years. This phase-in in 2008 allows for another class of nursing students to graduate and become licensed before the phase-in to the richer ratios occurs.

"Telemetry unit" was defined in the original proposed regulations as a unit designated for the electronic monitoring, recording, retrieval, and display of cardiac electrical signals (Position statement of the American College of Cardiology, Exhibit NN). The final proposed definition was expanded in response to the requests of many public comments to improve clarity. The new proposed definition was supplied by commenter number 1826. The definition was expanded because the original language was so broad as to be confusing operationally. Many patients require monitoring of cardiac signals, including women in active labor, babies in utero, intensive care patients, surgical patients, and others. The added language will minimize confusion. It limits telemetry patients to those who are in stable condition, thus distinguishing them from step-down and ICU patients. It further defines a telemetry unit as dedicated to patients having or suspected of having a cardiac condition or disease requiring specific monitoring and care. This definition is consistent with existing practice, is more precise, and will minimize confusion.

Cardiac monitoring, which in the past was reserved to critical care units, is now used routinely in non-critical care settings to improve patient care and provide a more accurate and continuous assessment of cardiac function for those patients whose underlying disease state, e.g. conduction disturbances or arrhythmias, makes monitoring appropriate. This ratio is necessary because patients on telemetry require licensed nurses to be readily available to expeditiously detect and treat the irregularities that the monitor identifies. The CDHS' on-site study data showed that 50% of hospital shifts in telemetry units are currently staffed at 1:4.5, and 75% at 1:5.6. This proposed ratio would, therefore, increase staffing for telemetry unit shifts in the more than 25% of shifts with the leanest staffing. When the ratio shifts to 1:4, it will enrich staffing for more than 50% of shifts on telemetry units statewide. This is necessary because the expanded use of telemetry reflects the prevalence of heart disease in the United States. Even with the use of telemetry and other technological assessment advances, heart disease remains the leading cause of death in America in the year 2000 (Exhibit OO). Concern for the care provided in these units was heightened by a survey of telemetry care conducted by the American



Association of Critical Care Nurses in May, 1998. In response to the survey question, "Which of the following describes your usual way of handling increased acuity and/or inadequate staffing?", fully 64% responded that they simply "work with less staff" (Exhibit PP). The Department relied upon these documents in developing the proposed regulations.

The original proposed regulations required, for every ten or fewer telemetry patients, a minimum of one additional person to monitor the telemetry screens. This requirement has been removed from these proposed regulations because the equipment used by telemetry units to monitor patients is very variable. Some hospitals use telemetry equipment for which the requirement would have been appropriate, but many do not, because of newer technology. Some newer systems show twenty or more cardiac monitor tracings on the same monitor screen. Some facilities are using telemetry equipment that communicates with a paging device worn by the nurse to alert her to the patient whose cardiac rhythm and/or rate has changed; some even display the identified problematic tracing. For this reason, and because CDHS is sure that technology will continue to change and further improve clinicians' ability to monitor cardiac activity, a uniform requirement for monitoring the tracings that would be suitable for all hospitals regardless of the equipment in use was not appropriate. Instead, the above enrichment of the staffing requirements for nursing staff on these units is proposed.

The definition of "telemetry unit" was re-worded for clarity and in response to the requests of many public comments. The statement that the "telemetry unit monitoring" shall not include fetal monitoring nor fetal surveillance was made in response to the requests of many public comments, and for clarification.

70217(a)(11)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The nurse-to-patient ratio in medical, surgical, and combined medical/surgical units is proposed to be 1:6 or fewer at all times. This ratio is also proposed to apply to those medical/surgical units that serve diverse patient populations and age groups. These units, which for purposes of the CDHS on-site study were identified as "mixed units", were found to contain patients with diseases, injuries, acuity levels, and care needs that closely approximated patients in more traditional medical/surgical units. The PCS will continue to coexist with the minimum ratio in these mixed units to require an increase in nurse staffing in response to increased patient acuity and/or the needs of the specific patient population, e.g. pediatric patients. The words "who require care appropriate to a medical/surgical unit" were added to clarify that mixed and

medical/surgical units provide the same level of care and that the care level is necessitated by the patients' needs.

"Specialty care units" was added as a non-substantive change to the unit types which would contain patients who required more care and observation and a more specialized type of care than is appropriate in a medical/surgical unit. This is a non-substantive change because the words, "Services provided in these units are more specialized to meet the needs of patients with the specific condition or disease process than that which is required on medical/surgical units, and is not otherwise covered by subdivision (a)" already exists at 70217(a)(12). This addition was necessary to clarify that CDHS' intent in setting the minimum staffing ratio richer in specialty care units was to accommodate the additional care needs, specialized monitoring, use of specialized equipment and medications, etc., for those patients requiring specialty care. Those units containing patients who need the same amount and type of nursing care as patients in medical/surgical units should be deemed by facilities to be medical/surgical units regardless of their name (see discussion about proposed 70217(a)(14).

The words "who require care appropriate to a medical/surgical unit" were added to the last sentence in this regulation to emphasize that, whether the diagnoses and ages of the patients in these units were diverse or similar, it is the level and type of nursing care provided on the unit that determines the staffing level that is needed on that unit.

According to OSHPD's data, 75% of California's hospital shifts are already staffed at a level of 1:5.6 or richer for medical/surgical units. The CDHS's on-site study of hospitals statewide confirmed staffing in those unit types at 1:6 for 75% of all medical/surgical and mixed unit shifts. CDHS decided to set the starting point for the minimum ratios at this level, to improve staffing on those shifts in the leanest 25<sup>TH</sup> percentile. This is necessary because, due to the need for cost containment and the pressures of managed care, patients admitted to acute inpatient beds are sicker, and have a shorter length of stay, than ever before (Exhibits QQ and RR). Also, medical/surgical units are the inpatient setting where, by far, the largest majority of patients receive care. Setting this minimum standard for care in these units should significantly improve health care delivery statewide.

Commencing January 1, 2005, the nurse-to-patient ratio in medical, surgical, and combined medical/surgical units is proposed to change to 1:5 or fewer at all times. CDHS has decided to increase staffing on these unit shifts incrementally, by a later phase-in of this lower ratio. This is being done for both practical and clinical reasons.

In a practical sense, because these are the most common and largest unit types in acute care hospitals and in light of the current nursing shortage, this will

allow providers additional time to build up their pool of nurse staffing resources. It will give the provider community adequate lead time to develop a strategy for complying with the minimum standards before they are mandated. It allows time for providers to look ahead and plan their budgets accordingly. It also puts providers, along with the Medi-Cal program, on notice so that they can make any needed adjustments.

Clinically, CDHS believes it is important to enrich staffing in medical, surgical, and combined medical/surgical units because those are the settings where the majority of acute care patients receive care. Thus, increasing staffing in this unit type will increase the nursing care received by the greatest number of patients. Any improved outcomes that result from the increase in staffing (patient, workforce, or institutional) would, therefore, benefit the greatest number of patients, nurses, and hospitals.

There is no independent, empirical information about appropriate staffing levels in medical, surgical, and combined medical/surgical units. We will, therefore, in compliance with the new law, review the patient, workforce, and institutional effects of these regulations, and report to the Legislature in five years regarding any proposed changes.

70217(a)(12)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

Specialty care units, those units which are organized, operated, and maintained to provide care for a specific medical condition or a specific patient population, are very varied, depending on the hospital, its location, its size, and the patient population it serves.

Specialty care units are often found in large, urban hospitals and academic medical centers serving unique patient cohorts. While "specialty care unit" is not currently a supplemental service nor a licensing term, this is the generally understood meaning of the term. The specific specialties served by these units run the gamut from orthopedics to HIV/AIDS to metabolic transplants, and require more specialized skills and comprehensive care than is normally available in medical/surgical units. Minimum staffing, of course, will vary according to the needs of the patients, and will increase in response to the PCS. The most commonly found specialty care unit in California's hospitals is the oncology unit, and, therefore, that is the unit type that was included in the DHS on-site study.

The minimum safe nurse-to-patient ratio in specialty care units is proposed to be 1:5 or fewer at all times. The ratio required for medical/surgical units is proposed to change from 1:6 to 1:5 in the year 2005. CDHS now proposes to phase-in a change to require a ratio of 1:4 in specialty care units in the year 2008. This is clinically appropriate because of patient acuity and the required level of care. This care results in more nursing hours at the bedside to perform all the tasks accomplished on medical/surgical units plus additional nursing tasks, including the administration, continual monitoring, and patient assessment of response to medications which can cause life-threatening adverse reactions and must be precisely administered to avoid toxicity. Phasing in the ratio in the year 2008 is also appropriate because most nursing programs can be completed in approximately three years. This phase-in in 2008 allows for another class of nursing students to graduate and become licensed before the phase-in to the richer ratios occurs.

These ratios provide sufficient staffing in recognition of the greater specialization and intensity of care provided. According to the CDHS on-site study results for shifts on oncology units statewide, 75% currently staff at a ratio of 1:5 or richer. When the ratio shifts to 1:4, it will enrich staffing for more than 50% of shifts on specialty care units statewide. (There is no data available from OSHPD for this unit type.) In a recent study of oncology nurses working in the inpatient setting (Exhibit SS), the oncology nurses reported that five was the maximum number of patients for whom they could provide safe, appropriate care.

The words "defined as" were added to the definition of specialty care units to conform this subsection with the definitions of the other subsections. The word "available" was deleted and the word "required" was added to clarify and emphasize that the care that is provided is necessitated by the needs of the patients and is not merely an option.

#### 70217(a)(13)

"At any time" is being changed to "at all times" for consistency with the provisions in current regulations and in response to the request of many public comments. The word "licensed" was added to "nurse" for clarity and consistency with other proposed regulations.

The severity of psychiatric disorders, like the severity of physiologic disorders, varies in acuity. Therefore, the same minimum ratio as is used for general medical, surgical, and medical/surgical units, which serves the widest variety of patient diagnoses, should apply to psychiatric units. The nurse-to-patient ratio for psychiatric units in general acute care hospitals, then, is proposed to be 1:6 or fewer at all times.

According to the data that OSHPD collects, 75% of the psychiatric units in California currently staff at 1:6.2 or richer. This was confirmed by the CDHS on-

site study, which also found that shifts in those units were staffed at 1:6 or richer. The 1:6 ratio is also supported by the California Chapter of the American Psychiatric Nurses Association (Exhibit TT), representing over 310 professional psychiatric nurses in California. The Department relied upon this information in developing the proposed regulations.

Currently, in Acute Psychiatric Hospitals, Psychiatric Technicians (PTs) are equivalent to Licensed Vocational Nurses (LVNs) for the purpose of provision of patient care. For psychiatric units in general acute care hospitals, PTs are counted in the ratios in the same manner as LVNs. This is appropriate because PTs and LVNs receive the same number of hours of training as preparation for licensure, with PTs spending a greater proportion of their time in the psychiatric specialty than the more generalist LVNs. Both PTs and LVNs also share the same governing Board, the Board of Vocational Nurses and Psychiatric Technicians, within the Department of Consumer Affairs.

PTs, like LVNs, practice under the direction of a physician, psychologist, registered nurse, or other professional personnel, and are not independent practitioners. Of the 1530 required curricular hours for PT licensure, fully 756 are dedicated to the study of mental disorders and developmental disabilities. PTs are the primary direct care providers for patients in the acute psychiatric setting, and therefore should logically be counted in the ratios as licensed staff for acute psychiatric units.

The Department clarified that hospitals may use licensed psychiatric technicians as a licensed nurse category, only in the psychiatric units of the hospital.

#### 70217(a)(14)

This provision was added to allow providers maximum flexibility in the naming of their units. Some hospitals give units names that are perceived to be less troubling for patients and their families than the regulated unit names. For example, Intensive Care Newborn Nurseries may be named the "Special Care Nursery", and an Oncology Unit may be called the "Camellia Care Unit", etc. This provision ensures that, while providers may use unit names that they believe will be best received by the population they serve, the use of those names does not affect nor avoid the requirement to comply with the staffing regulations that are based on the type of care provided, and not merely the name of the unit.

#### 70217(b)

The phrase, "In addition to the requirements of subdivision (a)" was added here to make clear the Department's intent that the ratios are minimums only, and will co-exist with PCS, which will dictate increased staffing when patients' needs warrant it, based on assessments on each shift. A non-substantive



capitalization change was made to the filing order to correct a typographical error in the post-hearing change availability.

The language added repeats the statutory language defining the elements of basic principles of staffing in general acute care hospitals. It is being repeated in response to the requests of many public comments, including the Board of Registered Nursing (commenter #1754) which believed it was needed for clarity. It also clearly describes the legislative intent for the nexus between the proposed ratio regulations and the patient classification systems. It is necessary to emphasize that the proposed licensed nurse-to-patient ratios are a required minimum staffing standard, and additional nursing staff above this minimum is required when such additional nursing staff is dictated by the hospital's patient classification system.

70217(c)

The statement, "In no case shall the staffing level for licensed nurses fall below the requirements of subsection (a)" was added to require that the staffing plan that is developed and implemented for each unit be based first on the PCS, using the ratios only to designate the minimum safe staffing level.

Subsection (c)(4) was redesignated to (d)(1) and modified slightly for correct grammar in a modified regulation structure. Additional language was added to propose an additional requirement for recordkeeping for all shifts and for all units. Hospitals are already required to retain a record of the staffing requirements determined by the patient classification system, the actual staff and staff mix provided, and the variance between the two, documented on a day-to-day, shift-by-shift basis. Each licensed nurse's assignment and licensed psychiatric technician's assignment is also documented every shift. This proposed regulation will require the hospitals to retain the documented licensed nurses' and licensed psychiatric technicians' actual assignments, ensuring that the specific nursing personnel will be linked to the specific patients. These records shall be retained by the hospital for a minimum of one year.

This is necessary because, without this new provision, it would be impossible for CDHS or the public to know retrospectively whether the facility complied with these proposed regulations and would therefore make enforcement of these proposed regulations virtually impossible. Therefore, this recordkeeping requirement is necessary for the health and safety of California's citizens. HSC 1278 states that, "Any officer, employee, or agent of the state department may, upon presentation of proper identification, enter and inspect any building or premises at any reasonable time **to secure compliance with, or to prevent a violation of, any provision of this chapter.**" (Emphasis added.) Without this requirement, agents of the state department would only know in the aggregate the numbers of patients and nurses on each shift, and could calculate the average staffing, but would be unable to assess whether a violation occurred,

or prevent a violation of these proposed regulations which implement and make specific HSC 1276.4. For example, if CHDS received a complaint about inadequate staffing on a shift of a psychiatric unit, an investigation for compliance would be necessary. Without this requirement the only information that would be available would be that which is already required by the PCS at subsections 1-3: the numbers of staff required, the number of staff provided, etc., and the nurse-to-patient staffing could appear to be adequate on average. However, if one or more of the patients had required 1:1 staffing, then the staffing ratio would be non-compliant, but would have appeared appropriate under current recordkeeping requirements. This requirement will enable CDHS to secure compliance with provisions of this chapter, in accord with statute. Although this recordkeeping is an expansion of existing record keeping requirements, it will not add any significant cost to providers, including State-run facilities. It will not significantly add costs to Medi-Cal, nor will it have a significant, statewide adverse economic impact directly effecting businesses in the State of California.

Subsections (d) through (q) were redesignated to maintain alphabetical order.

70217(i)

The phrase "except as described in subsection (a) above" was added to clarify that the nurse administrator may have a patient care assignment if that nurse administrator has demonstrated current competence to the hospital in providing care on a particular unit. This may be for the duration of a shift, or for the purpose of relieving staff nurses during breaks, meals, and other routine, expected absences from the unit as described in subsection (a).

70217(q)

This provision was added to clarify that the Department expects hospitals to plan for routine fluctuations in patient census. This planning should include, but not be limited to, an evaluation of the number of patients in other areas of the hospital waiting for an inpatient bed, consideration of how many patients are customarily admitted to individual units on a day-to-day, shift-by-shift basis based on historical information for that type of unit, the season of the year, day of the week, and time of day, etc. The PCS projects needed staff for the upcoming shift and hospitals have systems in place that indicate how additional staff will be obtained when needed. Hospitals commonly use such systems as the maintenance of a pool of on-call employees, providing part-time employees with additional work hours, and the use of nurse registries to augment staffing above scheduled staff. 22 CCR currently requires that each patient's nursing care needs must be determined by the PCS, and documented on a day-to-day, shift-by-shift basis.

In the event of a change in patient census that could not reasonably have been foreseen by the hospital, this states the Department's intent to give the

hospital needed flexibility while the hospital makes prompt, diligent efforts to return each unit to the minimum required staffing ratios. The requirement cannot be more specific because the broad range of circumstances that could befall a hospital are beyond the Department's ability to anticipate. The timing and the appropriateness of the response may vary according to the circumstances and the nature of the unanticipated changes. These changes could include such diverse events as earthquakes and other natural disasters, instances of bioterrorism, and other healthcare emergencies. CDHS' meaning of "healthcare emergencies" is defined for the sake of clarity and in response to the requests of many public comments. The use of this definition was suggested by commenter number 1826. Also, this is the definition used by the Industrial Welfare Commission in a recent overtime wage order effecting acute care facilities.

70225(d)

This regulation is being repealed, and staffing in the surgical service operating room will be addressed at section 70217(a)(2). Please see that section for a discussion of the reasons for the repeal.

70455(a)

The Department made a change without regulatory effect to Section 70455(a).

70455 (e)

This proposed requirement is added to cause the minimum requirements for comprehensive emergency medical service staff to conform to the current minimum requirements for basic emergency medical service staff. Current regulations at 22 CCR 70415(d) require that there shall be a minimum of one registered nurse on duty in basic emergency departments at all times, but there is no such requirement for comprehensive emergency departments. Basic emergency departments provide more limited services than those provided in comprehensive emergency departments. This proposed regulation will conform the minimum standard for nurse staffing at the more comprehensive level of care to the minimum standard in current regulation at the more limited level of care. Nurse staffing requirements for the comprehensive level of care will then be consistent with the requirements for the basic level of care. While this language is being added for consistency, it does not create a new requirement for nurse staffing in these units, because these units are already required to have a registered nurse on duty assigned to triage patients at all times.

## Appendix F.1

### Department of State Hospitals: Legal Commitment Categories

Legal Category	Legal Class Text	Code Section	Description
NGI	NGI PC1026	PC 1026	Not Guilty by Reason of Insanity
Other NGI	RONGI RO1026	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1026 (NGI)
Other NGI	MNGI	WIC 702.3	Minor Not Guilty by Reason of Insanity
IST	IST PC1370	PC 1370 or TITLE 18 USC 4244	Incompetent to Stand Trial
Other IST	MIST	PC 1370.01	Misdemeanant Incompetent to Stand Trial
Other IST	EIST	PC 1372(e)	Restored (IST) on Court Hold
Other IST	ROIST RO1370	PC 1610	Temporary Admission while waiting for Court Revocation of a PC 1370 (IST)
Other IST	DDIST	PC 1370.1	Commitment as Incompetent to Stand Trial because of Developmental Disability (up to 6 months) and Mental Disorder
MDO	MDSO	WIC 6316	Mentally Disordered Sex Offender--Observation
MDO	MDO PC2962	PC 2962	Parolee Referred from the Department of Corrections
MDO	PC2964a	PC 2964(a)	Parolee Re-hospitalized from CONREP after DMH hearing
MDO	PC2972	PC 2972	Former Parolee Referred from Superior Court
MDO	RO2972	PC 1610	Temporary admission while waiting for court revocation of PC 2972
MDO	ROMDSO	PC 1610	Temporary Admission while waiting for Court Revocation of MDSO
MDSO	MDSOI	WIC 6316	1. MDSO Observation Indeterminate; 2. MDSO Return by Court
Other SVP	SVPH	WIC 6601.3	Sexually Violent Predator BPT Hold
Other SVP	SVPE	WIC 6600	Sexually Violent Predator Court Hold
SVP	SVP	WIC 6604	Sexually Violent Predator
SVP	SVPP	WIC 6602	Sexually Violent Predator Probable Cause
PC 2684	PC2684	PC 2684	Prisoner from the Department of Corrections
PC 2685	PC2684A	PC 2684A	Prisoner from the Department of Corrections
DJJ W&I 1756	YAC	WIC 1756	Youth Authority Certification/Youth Authority Referral through Regional Office
LPS	T.Cons	WIC 5353	Temporary Conservatorship
LPS	CONS	WIC 5358	Conservatorship
LPS	VOL	WIC 6000	Voluntary
LPS	DET	WIC 5150	72-Hour Detention
LPS	CERT	WIC 5250	14-Day Certification
LPS	SUIC	WIC 5260	Additional 14-Day Certification for Suicidal Persons

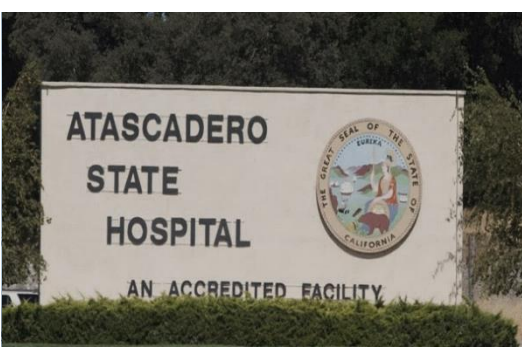
CALIFORNIA DEPARTMENT OF STATE HOSPITALS

# REPORT ON MEASURES OF PATIENT OUTCOMES



SUPPLEMENTAL REPORT TO THE LEGISLATURE

January 10, 2018



**DIRECTOR**  
Pam Ahlin



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

Pursuant to the Budget Act of 2016, item 4440-011-0001, the Department of State Hospitals submits this annual Supplemental Report to the Legislature on Measures of Patient Outcomes, “detailing outcomes to measure successful treatment and progress towards successfully treating its entire population.”

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### Table of Contents

<b>Executive Summary .....</b>	<b>5</b>
• <i>Overview.....</i>	<i>5</i>
• <i>Key Findings.....</i>	<i>5</i>
<b>The Department of State Hospitals.....</b>	<b>9</b>
• <i>Overview.....</i>	<i>9</i>
• <i>Background and Demographics.....</i>	<i>9</i>
• <i>Measures of Patient Outcomes – Report Structure .....</i>	<i>13</i>
• <i>Methodology, Data Systems and Limitations.....</i>	<i>13</i>
• <i>Clinical Perspective on Examining Psychiatric Care Outcomes Reporting .....</i>	<i>15</i>
• <i>Measures of Patient Outcomes – Report Requirements .....</i>	<i>15</i>
<b>Incompetent to Stand Trial .....</b>	<b>18</b>
• <i>Description of Legal Class .....</i>	<i>18</i>
• <i>Legal Requirements/Legal Statute for Discharge .....</i>	<i>18</i>
• <i>Discharge, Restoration and/or Release Data .....</i>	<i>18</i>
• <i>Length of Stay Data .....</i>	<i>19</i>
• <i>Decompensation Returns.....</i>	<i>19</i>
• <i>Court Case Data – Current Proceedings and Completed Court Cases .....</i>	<i>20</i>
<b>Not Guilty by Reason of Insanity .....</b>	<b>21</b>
• <i>Description of Legal Class .....</i>	<i>21</i>
• <i>Discharge, Restoration and/or Release Data .....</i>	<i>21</i>
• <i>Length of Stay Data .....</i>	<i>22</i>
<b>Mentally Disordered Offenders .....</b>	<b>23</b>
• <i>Description of Legal Class .....</i>	<i>23</i>
• <i>Legal Requirements/Legal Statute for Discharge .....</i>	<i>23</i>
• <i>Discharge, Restoration and/or Release Data .....</i>	<i>23</i>
• <i>Length of Stay Data .....</i>	<i>24</i>
<b>Sexually Violent Predators .....</b>	<b>26</b>
• <i>Description of Legal Class .....</i>	<i>26</i>
• <i>Discharge, Restoration and/or Release Data .....</i>	<i>26</i>
• <i>Length of Stay Data .....</i>	<i>27</i>
<b>Lanterman-Petris-Short Act .....</b>	<b>28</b>
• <i>Description of Legal Class .....</i>	<i>28</i>
• <i>Legal Requirements/Legal Statute for Discharge .....</i>	<i>28</i>

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

• Discharge, Restoration and/or Release Data .....	29
• Re-admission to DSH Data .....	30
<b>Coleman Class Patients .....</b>	<b>31</b>
• Description of Legal Class .....	31
• Legal Requirements/Legal Statute for Discharge .....	31
• Discharge, Restoration and/or Release Data .....	31
• Re-admission to DSH Data .....	32
<b>Conditional Release Program .....</b>	<b>33</b>
• Description of CONREP .....	33
• Legal Requirements/Legal Statute for Discharge (from Program) .....	33
• Discharge, Restoration and/or Release .....	33
• Length of Stay Data .....	34
• Re-admission to DSH Data .....	34
• Recidivism Crime Data .....	35
<b>Conditional Release Program – SVP .....</b>	<b>36</b>
• Description of CONREP – SVP .....	36
• Legal Requirements/Legal Statute for Discharge (from Program) .....	36
• Discharge, Restoration and/or Release Data .....	36
• Re-admission to DSH and Recidivism Crime Data .....	36

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### Executive Summary

#### *Overview*

Pursuant to the Budget Act of 2016, the Department of State Hospitals (DSH) submits this annual Supplemental Report to the Legislature (SRL) regarding the measures of patient outcomes. “Beginning January 10, 2017, and annually thereafter, the DSH shall submit to the Legislative Analyst’s Office and the appropriate fiscal committees of both houses of the Legislature a report detailing outcomes to measure successful treatment and progress toward successfully treating its entire patient population.”

This report addresses various data elements for the following populations and programs:

- Incompetent to Stand Trial (IST)
- Not Guilty by Reason of Insanity (NGI)
- Mentally Disordered Offenders (MDO)
- Sexually Violent Predators (SVP)
- Lanterman-Petris-Short Act (LPS)
- *Coleman* Class Patients (*Coleman*) – Mentally Ill Prisoners
- Conditional Release Program (CONREP)
- CONREP – SVP

Data elements contained in this report provide population specific analysis on the areas of patient discharges, reason for discharge and the average length of stay within a DSH facility. Descriptions of each patient population along with the legal requirements guiding discharge are presented to provide context as to when discharge is clinically or legally appropriate as specified by statute. Prior to a patient being discharged, courts must approve the recommended discharge. Recidivism data is unavailable within existing DSH data systems. Patient data is only tracked during the term of commitment. Efforts are underway with the Department of Justice (DOJ) to obtain limited access to specific data sets that would allow DSH to report on recidivism data for this annual report.

#### *Key Findings*

The key findings from this report are identified below:

- In FY 2016-17, DSH treated a total of 13,403 patients in its hospitals and psychiatric programs. DSH admitted 6,437 patients and had an average daily census of 7,087.
- In FY 2016-17, DSH discharged<sup>1</sup> a total of 6,371 patients from its hospitals, psychiatric programs and CONREP. IST and *Coleman* populations comprised the majority of the discharges, totaling almost 87 percent of the discharged state hospital population.

---

<sup>1</sup> Discharge data excludes transfers to other DSH facilities, deaths and Department of Juvenile Justice patients.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

FY 2016 17 Discharges		
Commitment Type	FY 2016 17 Count	Percent to Total
IST	3,019	48.5%
NGI	167	2.7%
MDO	447	7.2%
SVP	19	0.3%
LPS	179	2.9%
<i>Coleman</i>	2,388	38.4%
<b>Hospital Totals</b>	<b>6,219</b>	<b>100.0%</b>
CONREP	151	99.3%
CONREP – SVP	1	0.7%
<b>CONREP Totals</b>	<b>152</b>	<b>100.0%</b>
<b>Hospital and CONREP Total</b>	<b>6,371</b>	

- IST patients discharged in FY 2016-17 had a 96 percent rate of restoration, with an average length of stay of 154 days for those patients restored to competency<sup>2</sup>.

Commitment Type	FY 2016 17 Discharges	Restored to Competency	Restoration Rate (%)
IST Discharges	3,019	2,894	96%

- A total of 43 NGI patients, or approximately 25.7 percent of NGI discharges, were discharged from DSH in FY 2016-17 out to the community or community treatment facilities other than CONREP and their average length of stay was approximately 5.4 years. Additionally, approximately 64.7 percent of NGI discharges were admitted to the CONREP program following their discharge from a DSH hospital.
- A total of 447 MDO patients were discharged from DSH in FY 2016-17, 404 of whom were discharged because they no longer fit the legal definition of an MDO. For the 404 patients, their average length of stay was approximately 1.2 years. The remaining 43 MDO patients discharged were admitted into the CONREP program.
- A total of 19 SVP patients were discharged from DSH in FY 2016-17, eight of whom were discharged unconditionally because they no longer fit the legal definition of an SVP. For the eight patients that were unconditionally discharged, their average length of stay was approximately 9.7 years. The remaining 11 SVP patients discharged were either admitted to CONREP-SVP or discharged to CDCR.

<sup>2</sup> Restored to competency data excludes transfers, deaths, maximum commitments, no substantial likelihood of regaining competency in the foreseeable future and CONREP admissions.



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Re-Admissions

- IST patients restored to competency in FY 2016-17 had a very low rate of return to DSH due to decompensation. Decompensation<sup>3</sup> is defined as a temporary increase in symptoms that would require increased treatment in a more structured psychological support system, such as a hospital. Only 5.6 percent of discharges that were restored to competency returned to DSH on the same case and/or charges following their discharge in FY 2016-17. Some patients may have had multiple decompensation returns during the year. Decompensation data is based on re-admissions to DSH under the same court case during the period following the patient's discharge in FY 2016-17.

Commitment Type	FY 2016 17 Restored Discharges	Decompensation Return <sup>4</sup>	Rate of Return (%)
IST Discharges	2,894	162	5.6%

- LPS patients discharged in FY 2013-14 had a re-admission rate of 20.2 percent over the next three years, with 42 returning to DSH under an LPS commitment or under a different commitment such as an IST, NGI, MDO, or *Coleman*. Some of the patients had multiple re-admissions, with a total of 57 re-admissions over a three-year period following discharge.
- Coleman* patients that were discharged in FY 2013-14 had a re-admission rate of 71.6 percent over the following three years, with 1,243 patients returning to DSH under the *Coleman* commitment. Looking at a narrower re-admission window of 30 days following discharge, only 1.6 percent of patients discharged returned within 30 days.
- CONREP patients that were discharged in FY 2013-14 because they were no longer classified as a threat to self or others had a re-admission rate of 6.6 percent over the following three years, with four patients returning to DSH as an IST or *Coleman* patient.

Commitment Type	FY 2013 14 Discharges	Re admitted to DSH	Rate of Return (%)
LPS Discharges	208	42	20.2%
<i>Coleman</i> Discharges	1,736	1,243	71.6%
CONREP Discharges	61	4	6.6%

### Recidivism

Data on recidivism in regards to the convictions of crimes following the release from DSH for the IST, NGI, MDO, SVP, LPS or *Coleman* populations is not available within DSH data systems. DSH has been approved by DOJ's Bureau of Criminal Identification and Investigation Services to receive Criminal Offender Record Information (CORI) data for the purpose of reporting on recidivism within the annual Measures of Patient Outcomes Report. DSH is collaborating with DOJ on this research project and will provide an addendum to this report once analysis is available. Data on recidivism is available, through limited access to

<sup>3</sup> Social Security Administration definition of decompensation.

<sup>4</sup> IST re-admission data is through September 2017 therefore inclusive decompensation data for FY 2016-17 discharges would not be obtainable until the conclusion of June 2018.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

DOJ systems, for the CONREP and the CONREP – SVP populations and is presented below.

- CONREP patients that were discharged in FY 2013-14 because they were no longer classified as a threat to self or others had a recidivism rate of 23.3 percent over the following three years, with 14 patients convicted of at least one crime. Some patients had multiple offenses and convictions, with a total of 23 crimes committed<sup>5</sup> over a three-year period following discharge. The crimes varied from misdemeanors to felonies.

Commitment Type	FY 2013 14 Discharges	Re offended <sup>6</sup>	Rate of Re offense (%)
CONREP Discharges	60	14	23.3%

- SVP patients make up a very small portion of the CONREP program and only one individual was discharged unconditionally out of CONREP – SVP in FY 2013-14. The individual discharged unconditionally in FY 2013-14 did not commit another crime over the three-year period following discharge.

<sup>5</sup> The charges of an IST's original placement are excluded from the recidivism computations as the original charges do not identify a conviction.

<sup>6</sup> Re-offenses and convictions may or may not have resulted in a re-admission to DSH for treatment.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### The Department of State Hospitals

#### *Overview*

The Department of State Hospitals (DSH) manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals and employs nearly 11,000 staff. Additionally, DSH provides services in jail-based competency treatment programs and conditional release programs throughout the 58 counties. In FY 2016-17, DSH served 13,403 patients with an average daily census of 7,087; and the jail-based competency programs served a total of 729 patients with a capacity of 178. The conditional release program (CONREP) maintains an average daily census of approximately 636. DSH's five state hospitals are Atascadero, Coalinga, Metropolitan – Los Angeles, Napa and Patton. Pursuant to the Budget Act of FY 2017-18, the psychiatric programs operating at state prisons in Vacaville, Salinas Valley, and Stockton, where DSH treated mentally-ill prisoners, have been transferred to the responsibility of the California Department of Corrections & Rehabilitation (CDCR) as of July 1, 2017. DSH continues to designate 336 beds at three of its state hospitals, Atascadero, Coalinga, and Patton for the treatment of mentally-ill prisoners.

#### *Background and Demographics*

California's state psychiatric hospitals care for the most seriously mentally ill patients who, increasingly, over the last several years, have committed serious crimes and acts of violence. Patients admitted to DSH are mandated for treatment by a criminal or civil court judge. More than 91 percent of DSH patients are forensic commitments. These patients are sent to DSH through the criminal court system and have committed crimes linked to their mental illness (Not Guilty by Reason of Insanity (NGI)), or are found incompetent to understand the criminal proceedings because of their mental illness (Incompetent to Stand Trial (IST)). Forensic commitments also include patients who are current or former parolees (Mentally Disordered Offenders (MDO)) and mentally ill prisoners from CDCR (*Coleman Class Patients (Coleman)*). In addition to forensic commitments, DSH treats patients who have been classified by a judge or jury as Sexually Violent Predators (SVP), or who a judge finds there is probable cause to be classified as SVP. These patients have served prison sentences for committing crimes enumerated under the SVP Act (Welfare and Institution Code (WIC) sections 6600 et. al.). They are committed to DSH, after completing their prison term, for treatment until a judge deems they are no longer a threat to the community. The remainder of the patient population has been committed in civil court for being gravely disabled, or a danger to themselves or others. These patients are commonly referred to as Lanterman-Petris-Short (LPS) commitments. DSH also administers CONREP, which oversees patients who have been conditionally released into the community from a DSH hospital by a judge. These patients receive treatment and supervision through community-based outpatient services.

Over the last five years, the number of patients that DSH serves has steadily increased. Figure 1<sup>7</sup> displays the trends DSH has experienced in the number of patients served, average daily census, admissions and discharges over the last five years. From FY 2012-13 to FY 2016-17, the number of patients served by DSH increased by 20.9 percent. Similarly, the

---

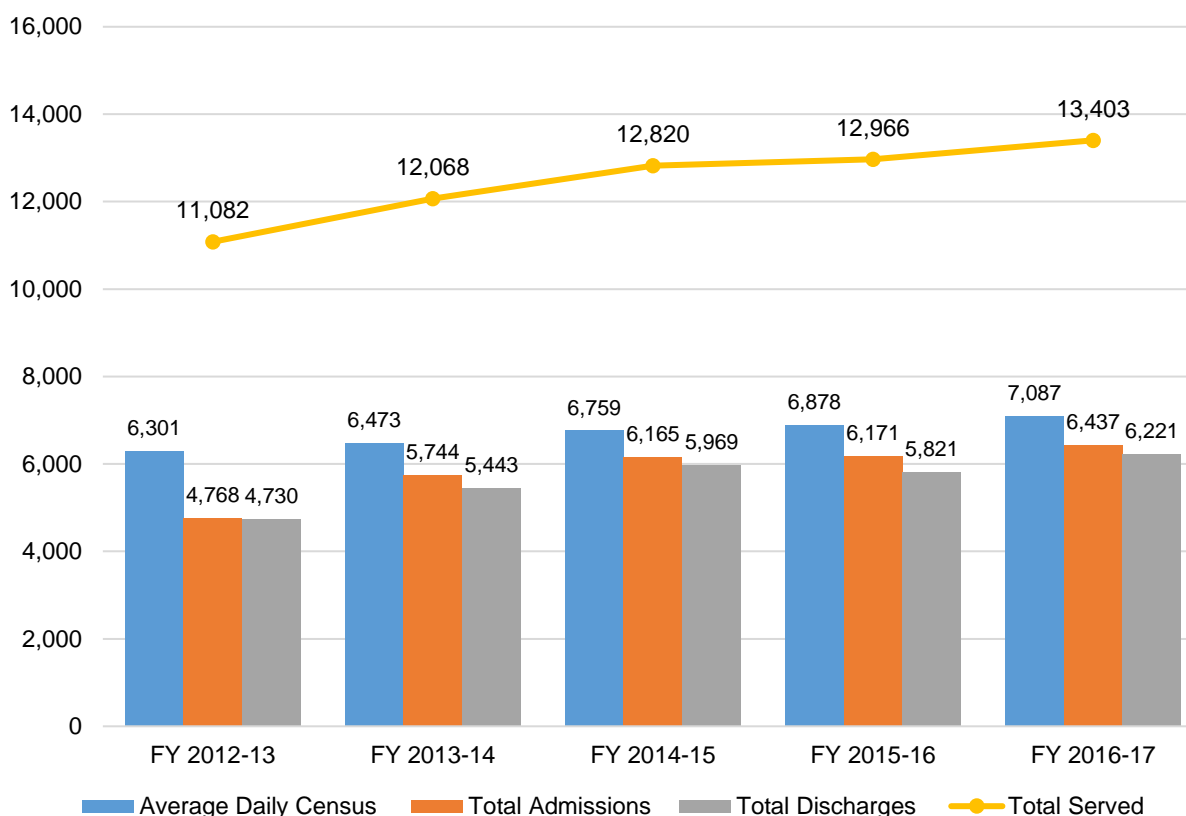
<sup>7</sup> Data excludes CONREP patients and includes Department of Juvenile Justice patients.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

average daily census at the hospitals and psychiatric programs has increased by 12.5 percent and total admissions increased by 35 percent.

**Figure 1. System-Wide Average Daily Census, Total Admissions, Total Discharges and Total Patients Served, FY 2013-14 to FY 2016-17**



DSH began tracking referral data by commitment type in FY 2013-14<sup>8</sup>. DSH migrated to the Patient Reservation Tracking System (PaRTS) in February 2015 and enhanced its referral tracking to include county of commitment and gender data. PaRTS has allowed DSH to comprehensively capture all the referrals that are coming into the hospitals. Figure 2<sup>9</sup> displays DSH referrals over the last four years, broken out by commitment type. Referrals to DSH have been on the rise since FY 2013-14 with the primary increase being in the IST population. ISTs have experienced a 22.1 percent growth since FY 2013-14<sup>10</sup>. System-wide, DSH has experienced a 37.4 percent annual rate of growth in referrals, with the IST population driving the majority of that growth, hence contributing to an increase in the number of patients DSH serves.

<sup>8</sup> Data prior to November 2013 is not available.

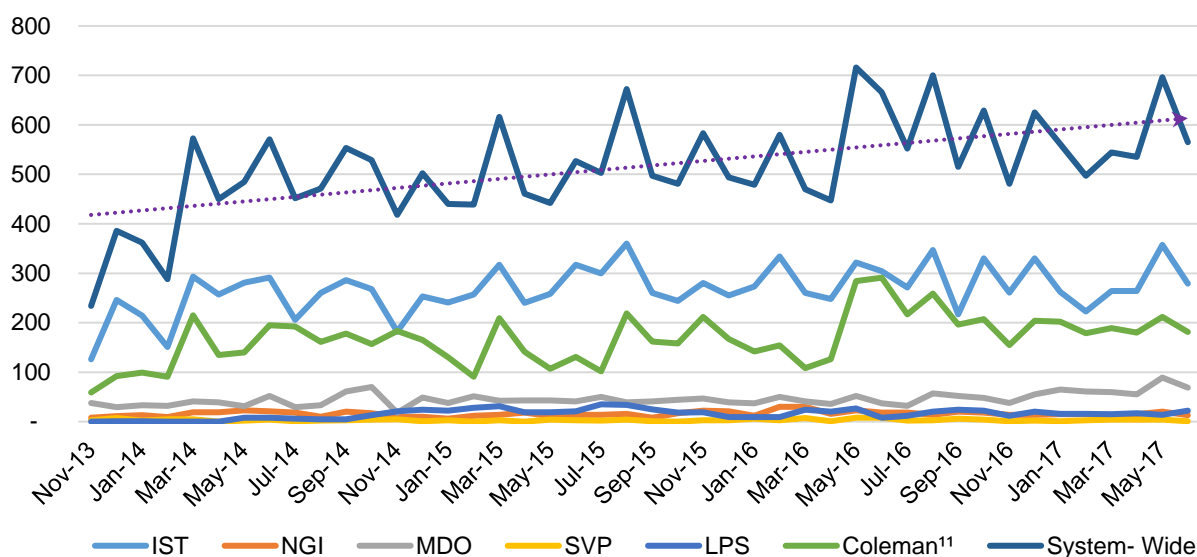
<sup>9</sup> Data excludes CONREP.

<sup>10</sup> Growth is based on the average monthly referral rate when comparing FY 2013-14 to FY 2016-17 annual monthly rate.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

**Figure 2. System-Wide Referrals, FY 2013-14 to FY 2016-17**



Across all facilities and commitment types, the DSH patient population is characterized by the prevalence of acute mental health conditions. Figure 3<sup>12</sup> displays the breakdown of major diagnoses among the DSH patient population as of the July 1, 2017 census. Schizophrenia and schizoaffective disorders account for 60 percent of the major diagnoses. Paraphilias, bipolar disorder, unspecified psychosis and major depressive disorder account for 29 percent of the major diagnoses. All other diagnoses account for 11 percent of the major diagnoses. Major diagnoses data reflects current residents on unit and is based on the patient's diagnosis upon admission.

DSH provides treatment to both forensic and civil commitment types. Major forensic commitments include IST, MDO, NGI, SVP and *Coleman*. LPS patients make up DSH's civil commitments. The majority of the DSH population are forensic patients, comprising approximately 91 percent of the population. Figure 4<sup>12</sup> displays DSH's population categorized by commitment type, based on the average daily census observed in FY 2016-17.

<sup>11</sup> Referral data specific to the *Coleman* population is not maintained in PaRTS. This data is maintained through Bed Utilization Management (BUM) Tracking.

<sup>12</sup> Data excludes CONREP patients.



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

Figure 3. Major Diagnoses<sup>13</sup> for Residents on Unit, as of July 1, 2017

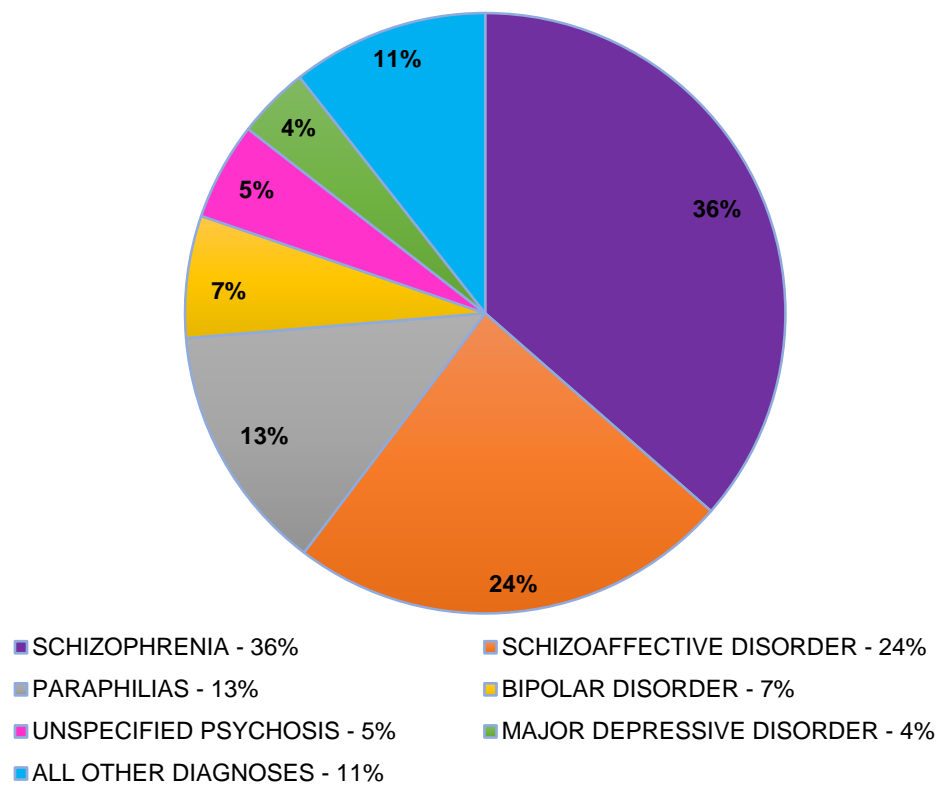
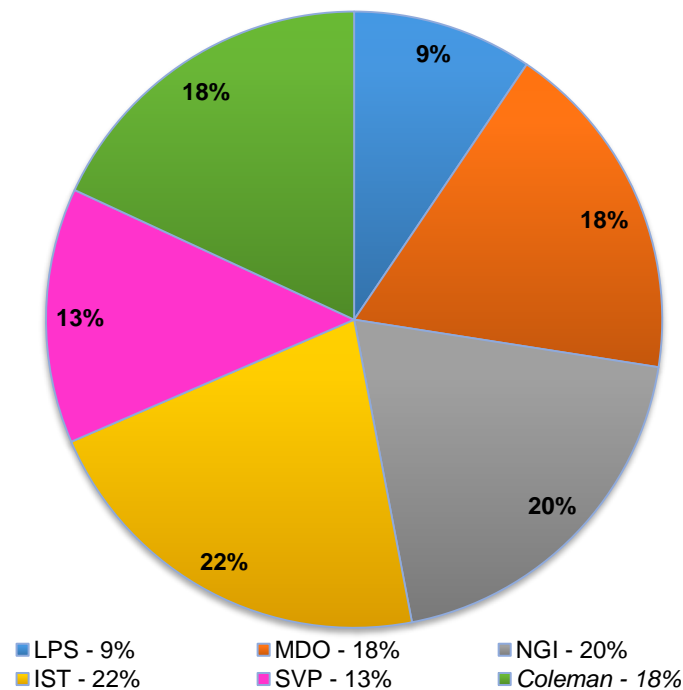


Figure 4. Population by Commitment Type, FY 2016-17



<sup>13</sup> Major diagnoses data based on patient's diagnosis upon admission.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### *Measures of Patient Outcomes – Report Structure*

This report is presented in sections that correspond with the legal class groupings outlined in the Supplemental Report to the Legislature (SRL). The following information is presented in each section:

- Description of legal class, legal class requirements and legal statutes for discharge
- Discharge data for FY 2016-17
- Restoration and/or release data for FY 2016-17 discharges
- Length of stay<sup>14</sup> data for FY 2016-17 discharges

Additional information on re-admissions was requested for the IST, LPS and *Coleman* populations. The IST section reports on re-admissions, under the same court case, due to decompensation and the LPS and *Coleman* sections report on all re-admissions to DSH.

Each legal class grouping is unique as it relates to the statutorily determined reason for admission and discharge criteria, therefore data collection, output data and data analysis varies based on the particular legal class. Additionally, the questions outlined in the SRL to which this report is responding vary by legal class groupings. Based on this the structure of each section is not uniform throughout the report and may not cover the same type of data fields.

Data on recidivism in regards to the convictions of crimes following the release from DSH for the IST, NGI, MDO, SVP, LPS or *Coleman* populations is not available within DSH data systems. DSH has been approved by Department of Justice's (DOJ) Bureau of Criminal Identification and Investigation Services to receive Criminal Offender Record Information (CORI) data for the purpose of reporting on recidivism within the annual Measures of Patient Outcomes Report. DSH is collaborating with DOJ on this research project and will provide an addendum to this report once analysis is available. Data on recidivism is available, through limited access to DOJ systems, for the CONREP and the CONREP – SVP populations and is provided later in the report. CONREP is able to provide data on recidivism with information being only accessible to specific program staff in CONREP, protective services personnel and limited clinician access for assessment purposes.

### *Methodology, Data Systems and Limitations*

This report provides discharge, restoration, release, and length of stay data at a one-year interval for patients discharged from DSH and CONREP between July 1, 2016, and June 30, 2017. The discharge cohort includes IST, NGI, MDO, SVP, LPS, *Coleman*, CONREP and CONREP – SVP patients. This report also provides discharge and re-admission data for patients discharged from DSH and CONREP between July 1, 2013, and June 30, 2014. The discharge cohort includes IST, LPS, *Coleman*, CONREP and CONREP – SVP patients. While death is not considered a discharge, it is captured in the discharge data sets and is separated out in the discharge data section for each legal class. Rates of re-admission are examined based on subsequent admissions to DSH, under the same or new case/charges, over a three-year period following discharge. Additionally, recidivism data is provided for patients released from CONREP between July 1, 2013, and June 30, 2014. The release cohort includes CONREP

---

<sup>14</sup> Length of stay data is presented in the IST, NGI, MDO, SVP, CONREP and CONREP – SVP sections. Length of stay data was not requested for LPS and *Coleman* legal classes.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

and CONREP – SVP patients. Recidivism rates are examined based on new criminal offense convictions over a three-year period following discharge.

Data for this report was extracted from the following data sources:

- Admissions, Discharges and Transfers (ADT) Database
- PaRTS Database
- Bed Utilization Management (BUM) Tracking
- Hospital patient records
- Internal, Microsoft Excel-based, tracking documents
- CONREP Data System
- California Law Enforcement Telecommunications System (CLETS) – CONREP data only

Data Source	Data Elements
ADT Database	Primary data system that houses current and historical patient information, medical records and tracks admissions, discharges and transfers.
PaRTS Database	Pre-admission tracking database used for admission packet entry, admission planning and scheduling, legal action tracking and county referral data tracking.
BUM Tracking	A tool to track <i>Coleman</i> patient referrals, census, admissions and discharge data.
Hospital Patient Records	Individual patient records, maintained by the hospitals and psychiatric programs, that contain detailed medical, admission, discharge and criminal history.
Internal Tracking Documents	Microsoft Excel-based tracking documents that record and track data not otherwise stored in a DSH data system.
CONREP Data System	Primary data system that houses current and historical CONREP patient information, services provided to patients and tracks admissions, discharges and transfers.
CLETS	A DOJ network that provides both inquiry and update access to various databases within California, other states on a national level and federal databases sponsored by the Federal Bureau of Investigation. Access is currently limited to CONREP only.

DSH has limited enterprise wide data-systems to track and record patient data. Patient data is recorded at multiple stages including prior to admission, upon admission, during the course of treatment and upon discharge. Data contained in one data system often has to be linked to records contained in another system. Data must also be assessed to ensure all relevant data elements were recorded, data definitions are consistently applied across multiple facilities, comparisons across multiple data sets produce reliable conclusions and that necessary linking of data to produce reports can be successfully completed. Another challenge is with accessing relevant information that is tied to a patient record but not available to produce a system-wide report. These described data challenges frequently require manual data look-ups at the individual patient level. Data pertaining to decompensation, re-admission, unconditional release and recidivism require extensive manual look-ups of patient records. Manual patient lookups were completed by the DSH's Data Management Office, DSH research staff and hospital admission staff for various data sets requiring additional data not otherwise stored in a DSH database.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### *Clinical Perspective on Examining Psychiatric Care Outcomes Reporting*

DSH has conducted extensive literature reviews to aid in the determination of appropriate, meaningful clinical outcomes for state hospital patients served in California. Outcomes are generally separated into two groups: process outcomes, which are dynamic factors that measure the linkage between the patient and the treatment delivery, and clinical outcomes, which are static and measure whether a patient is improved relative to the reason for admission. Because most state hospital patients in California are admitted by a court pursuant to statutorily determined criteria, establishing meaningful clinical outcomes requires consideration of clinical progress of the patient related to legal status.

### *Measures of Patient Outcomes – Report Requirements*

The table below summarizes the information requested in this report.

	IST	NGI	MDO	SVP	LPS	Coleman	CONREP	CONREP SVP
Previous FY Discharge Data	X	X	X	X	X	X	X	X
Restoration and/or Release Data	X	X	X	X	X	X	X	X
Length of Stay Data	X	X	X	X			X	X
Completed/Pending Court Case Data	X							
Decompensation/ Re-admission Data	X				X	X	X	X
Recidivism Data		X	X	X	X		X	X

Questions addressed by this publication are detailed below. DSH additions in italics are provided to further clarify how DSH defined these measures.

### Incompetent to Stand Trial

- How many patients were discharged by DSH in the previous fiscal year?
- Of patients discharged, how many were restored to competency?
- How long did it take for those patients to be restored?
- Of the patients restored, how many completed their court case?
- Of the patients restored, how many were returned to DSH because of decompensation of their mental health?
- Of the patients restored, how many have court proceedings still in progress?

### Not Guilty by Reason of Insanity

- How many patients were discharged by DSH in the previous fiscal year?

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

- Of patients discharged, how many were restored to sanity, or were discharged because they could be safely treated in the community *under CONREP supervision*?
- How long did it take those patients to be restored or released to community treatment *under CONREP supervision*?
- Of those restored *to sanity*, or released to community treatment *under CONREP supervision* three years ago, how many committed another crime?

### Mentally Disordered Offenders

- How many patients were discharged by DSH in the previous fiscal year?
- Of patients discharged, how many were discharged because they no longer fit the *legal* definition of an MDO?
- How long did it take to treat those discharged because they no longer fit the *legal* definition of an MDO?
- Of those patients released three years ago, how many committed another crime?

### Sexually Violent Predators

- How many patients were discharged by DSH in the previous fiscal year?
- Of patients discharged, how many were discharged unconditionally because they no longer fit the *legal* definition of an SVP?
- Of patients discharged, how many were discharged and sent to CONREP for SVPs?
- How long did it take to treat those discharged because they no longer fit the *legal* definition of an SVP?
- Of those patients released three years ago, how many committed another crime?

### Lanterman-Petris-Short Act

- How many patients were discharged by DSH in the previous fiscal year?
- Of patients discharged, how many were discharged because they no longer were classified as a threat to self or others *or gravely disabled*?
- Of patients discharged because they were no longer a threat to self or others *or gravely disabled* three years ago, how many were re-admitted to DSH?
- Of patients discharged because they were no longer a threat to self or others *or gravely disabled* three years ago, how many were convicted of a crime?



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### Coleman Class Patients

- How many patients were discharged by DSH from inpatient psychiatric programs in the previous fiscal year?
- Of patients discharged, how many were discharged to the CDCR?
- Of patients discharged, how many were discharged because they completed their sentences?
- Of those patients discharged to CDCR three years ago, how many returned to DSH?

### CONREP

- How many patients were discharged by DSH from CONREP in the previous fiscal year?
- For patients discharged, how long did those patients spend in CONREP?
- Of patients discharged, how many were discharged because they were no longer classified as a threat to self or others *because of his or her mental illness*?
- Of patients discharged because they were no longer classified as a threat to self or others *because of his or her mental illness* three years ago, how many were re-admitted to DSH?
- Of patients discharged because they were no longer classified as a threat to self or others *because of his or her mental illness* three years ago, how many were convicted of another crime?

### CONREP – SVP

- How many patients were discharged by DSH from CONREP – SVP in the previous fiscal year?
- For patients discharged, how long did patients spend in CONREP – SVP?
- Of patients discharged, how many were discharged because they no longer fit the definition of an SVP?
- Of patients discharged three years ago because they no longer fit the definition of an SVP, how many were re-admitted to DSH?
- Of patients discharged three years ago because they no longer fit the definition of an SVP, how many were convicted of another crime?

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Incompetent to Stand Trial

#### *Description of Legal Class*

IST patients are referred to DSH after a court has determined that they are unable to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. These defendants are then committed by the court to a DSH facility for treatment specifically designed to enable the defendant to proceed with trial. Patients receive competency-based treatment and return to court once they have regained competency and can effectively assist in their trial proceedings. IST patients committed to DSH mostly include felony criminal charges, and occasionally include misdemeanor charges.

#### *Legal Requirements/Legal Statute for Discharge*

An IST patient cannot be confined for longer than is reasonably necessary for restoration of competency or determination that competency cannot be restored. The maximum IST commitment time is three years for felony offenses, or up to the maximum term of imprisonment for the alleged crime, whichever is shorter (Penal Code (PC) section 1370, subdivision (c)(1)). An IST commitment may end when either: (1) the maximum time for confinement runs out; (2) the defendant obtains certification that he or she has regained competency pursuant to PC section 1372; or (3) DSH determines there is no substantial likelihood a patient will regain competency in the foreseeable future. If a patient/defendant has not regained competency to stand trial by the end of their IST commitment term or is determined there is no substantial likelihood he or she will regain competency in the foreseeable future, the patient/defendant must be returned to the committing county or if meets specified criteria, can be hospitalized further under a civil commitment. Misdemeanor IST commitments are only committed to DSH if there are no less restrictive placements for competency treatment and the county enters into a contract with DSH for cost of competency treatment.

#### *Discharge, Restoration and/or Release Data*

In the previous fiscal year, FY 2016-17, DSH discharged<sup>15</sup> a total of 3,041 IST patients. Of those discharged, 16 were transferred to another DSH facility, six were deaths and 3,019 were discharges out of DSH. Of the 3,019 patients discharged out of DSH in FY 2016-17, 2,894 are restored to competency, yielding a 96 percent rate of restoration to competency for FY 2016-17.

Discharge Type	FY 2016 17 Count
Total Discharges	3,041
Internal Transfers	16
Deaths	6
<b>Net Discharges</b>	<b>3,019</b>
No Substantial Likelihood to Regain Competency in Foreseeable Future	92
Maximum Commitments	31
CONREP Admissions	2
<b>Restored to Competency</b>	<b>2,894</b>

<sup>15</sup> Discharge data does not include Restoration of Competency/Jail Based Competency Treatment Programs.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### *Length of Stay Data*

Of the IST defendants that were restored to competency<sup>16</sup> in FY 2016-17, the average length of stay is 153.8 days or approximately 0.4 years. Length of stay calculation is based on the average number of days FY 2016-17 discharges spent in a DSH hospital. Length of stay is defined as a period between admission to discharge, which includes leave days and time waiting for county transfer.

### *Decompensation Returns*

Of the 2,894 patients restored to competency in FY 2016-17, 158 returned to DSH because of decompensation of their mental health. Some patients may have had multiple decompensation returns during the year, totaling to 162 decompensation returns to DSH. Decompensation data is based on re-admissions to DSH under the same court case during the period following the patient's discharge in FY 2016-17. Decompensation return data is for admissions through September 2017. The table below provides a breakdown of how long the patient was out of DSH prior to their return back into the hospital.

Decompensation Return					Number of Days Following Discharge				
0	30 days	31	60 days	61	90 days	91	120 days	121	150 days
3		10		22		28		22	
151	180 days	181	210 days	211	240 days	241	270 days	271	300 days
12		14		15		13		9	
301	330 days	331	360 days	361	390 days	391	420 days	421	450 days
8		3		0		1		2	

Note: Re-admission data is through September 2017 therefore inclusive decompensation data for FY 2016-17 discharges would not be obtainable until the conclusion of June 2018.

### Restored IST: On Court Hold

Once a patient has a certificate of restoration of competency pursuant to PC section 1372, a transfer back to the committing county to proceed with the trial will take place. If it has been established that there is a need for continued treatment in a hospital or treatment program to maintain competence to stand trial the patient may stay at, or be returned to, the treatment facility pending court appearance. If the patient has been discharged back to the committing county with a certificate of restoration of competency and it has been established that there is a need for continued treatment, the patient is returned to DSH under PC section 1372, subdivision (e) (EIST), restored IST on court hold. If the patient is a resident-on-unit under a current IST commitment and the patient received a certificate of restoration of competency, but it has been established that there is a need for continued treatment, the patient is maintained at DSH and receives a legal class change to an EIST pending court appearance. Of the 2,894 patients restored to competency in FY 2016-17, 48 patients had a legal class change to an EIST during their stay. Within those 48 patients six received a legal class change during a subsequent re-admission following their initial FY 2016-17 discharge and are counted in the decompensation return totals.

<sup>16</sup> Length of stay calculation for ISTs restored to competency excludes transfers, deaths, no substantial likelihood of regaining competency in the foreseeable future, maximum commitments and CONREP admissions.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

Decompensation Returns	EIST Class Changes*	EIST Admissions	Total
162	42	4	208

\*Note: FY 2016-17 EIST class changes total excludes those patients whose legal class change occurred during a subsequent re-admission following their initial FY 2016-17 discharge as they are counted within the decompensation returns total.

### *Court Case Data – Current Proceedings and Completed Court Cases*

DSH does not have the capability to track data on current court proceedings and completed court cases. Once an IST patient is discharged, DSH has no mechanism for receiving court case data. Additionally, DSH does not track criminal charges or court status. Due to this data limitation DSH is currently unable to determine the number of IST patients restored to competency in FY 2016-17 with completed court cases. DSH is also unable to determine how many of the IST patients restored to competency in FY 2016-17 have court proceedings still in progress.

DSH has been approved by DOJ's Bureau of Criminal Identification and Investigation Services to receive CORI data but it has not yet been determined if completed and pending court case data will be available within that dataset. DSH is collaborating with DOJ on this research project and will provide an addendum to this report once analysis is available. If it is determined that court case data, including the status of court cases for IST patients restored to competency in FY 2016-17, is available, the addendum will provide a summary analysis of that data.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Not Guilty by Reason of Insanity

#### *Description of Legal Class*

NGI patients are admitted to DSH once a court determines that the individual (defendant) is found guilty but was insane at the time the crime was committed. The court commits these defendants to DSH for a maximum term of commitment equal to the longest sentence which could have been imposed for the crime. Based on the criminal conviction, the patient is found not guilty by reason of insanity. A patient may be placed immediately in outpatient treatment in the community under supervision rather than going directly to a state hospital. The court can recommit the patient to DSH beyond the maximum term of the original commitment if the patient is found, based on his or her mental illness, to represent a substantial danger of physical harm to others. A recommitment lasts for two years from the date of the recommitment order.

#### *Legal Requirements/Legal Statute for Discharge*

Restoration of sanity is a two-step process in which evidence is presented and reviewed that would determine a patient is a danger to the health and safety of others, due to his or her mental illness, if released under supervision and treatment in the community. The two-step process requires (1) an outpatient placement hearing and (2) a restoration hearing following a year in outpatient care. During the first step of the process the court must find that the patient is no longer a danger to the health and safety of others, due to his or her illness, if released under supervision and treatment in the community. During the second step of the process, the court must determine whether the patient has been fully restored to sanity. The court's finding of restoration will result in the patient's unconditional release from supervision. A patient may bypass the mandatory one-year of outpatient commitment and have an early restoration hearing in the event the conditional release program director recommends an early release.

#### *Discharge, Restoration and/or Release Data*

In the previous fiscal year, FY 2016-17, DSH discharged a total of 201 NGI patients. Out of those discharged 23 were transferred to another DSH facility, 11 were deaths and 167 were discharges out of DSH based on court orders.

Discharge Type	FY 2016 17 Count
Total Discharges	201
Internal Transfers	23
Deaths	11
<b>Net Discharges</b>	<b>167</b>

The term "insanity" connotes a legal definition, not a clinical diagnosis, therefore this is not a measurable clinical condition. Individuals may not be deemed insane unless they meet the strict legal test for cognitive incapacity, which is set by case law and legislation. Restoration of sanity does not necessarily mean that a defendant has recovered from his or her mental disorder. The standard for release is not determined by a patient's mental status, but by whether the patient would present a danger to the community because of his or her mental condition. The table below provides a detailed breakdown for the 167 NGI patients that were discharged out of DSH by the location of where they were discharged to. Approximately 64.7 percent of NGI discharges were admitted into the CONREP program and approximately 9.6 percent were admitted into a locked facility, yielding a 25.7 percent discharge rate to the community and into community treatment facilities.



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

Discharge Location	FY 2016 17 Count	Percent to Total
Community Outpatient Treatment / CONREP	108	64.7%
Locked Facility: CDCR, Jail, Court, Other Locked Facility	16	9.6%
Home	19	11.4%
Medical Facility	0	0.0%
Non-Medical Facility: Board and Care, Group Home, Halfway House, Room and Board	22	13.2%
Other/Unknown Location <sup>17</sup>	2	1.2%
<b>Total Net Discharges</b>	<b>167</b>	<b>100.0%</b>
<b>Discharged NGI Breakdown</b>		
Less CONREP Admissions	108	64.7%
Less Locked Facility Discharges	16	9.6%
<b>NGI Discharges to Community</b>	<b>43</b>	<b>25.7%</b>

### *Length of Stay Data*

DSH discharged 167 NGI patients in FY 2016-17 with 108 patients being discharged into the CONREP program and 16 patients being discharged into a locked facility. For the remaining 43 NGI patients that have been released to the community or to community treatment facilities in FY 2016-17, the average length of stay is 1,329.7 days, or approximately 3.6 years. If discharges to the CONREP program for community outpatient treatment are included in the length of stay calculations, the average length of stay increases to 1959.1 days, or approximately 5.4 years. Length of stay calculation is based on the average number of days FY 2016-17 discharges spent in a DSH hospital. Length of stay is defined as a period between admission to discharge, which includes leave days and time waiting for county transfer.

<sup>17</sup> Discharge location is not identified in DSH data systems.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### Mentally Disordered Offenders

#### *Description of Legal Class*

MDO commitments are patients who are parolees (or former parolees) who meet the six criteria for MDO classification. The criteria include (1) the presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment for at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury and (6) the prisoner continues to be dangerous due to the severe mental disorder.

Parolees who committed one of a specified list of crimes and who were treated for a severe mental disorder connected to their original crime can be committed to a state hospital as a condition of parole for a period not to exceed the length of their parole term; these patients are committed under PC 2962. If the person still requires treatment at the end of their parole term, they can be committed under PC 2972 if it is determined that the patient has a severe mental disorder, that the patient's severe mental disorder is not in remission or cannot be kept in remission without treatment, and that by reason of his or her severe mental disorder, the patient represents a substantial danger of physical harm to others. A person committed under PC 2972 is committed for one year.

#### *Legal Requirements/Legal Statute for Discharge*

After one year, a parolee is entitled to an annual review hearing conducted by the Board of Prison Terms (BPT) to determine if (1) the parolee still meets the six criteria for MDO classification and (2) whether the parolee can be treated on an outpatient basis. The length of a parole period is determined by statute and depends on the type of sentence imposed. Parole terms can extend beyond the maximum parole period due to revocation or escape attempts. A parole period can be waived at the discretion of BPT. Most parolees have a maximum parole period of three years, with a four-year maximum if parole was suspended due to revocation. The parole period may exceed four years for more serious offenses.

An MDO patient (or parolee) may be placed into outpatient treatment in CONREP if the court believes that the MDO patient can be safely and effectively treated on an outpatient basis. Outpatient status may not exceed one year, after which time the court must either discharge the patient, order the patient confined to a facility, or renew the outpatient status.

#### *Discharge, Restoration and/or Release Data*

In the previous fiscal year, FY 2016-17, DSH discharged a total of 507 MDO patients. Of those discharged, 51 were transferred to another DSH facility, nine were deaths and 447 were discharges out of DSH based on court orders. The majority of the MDO discharges, or approximately 81 percent, were PC 2962 patients; the remaining 19 percent were PC 2972 patients.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

Discharge Type	FY 2016 17 PC 2962 Count	FY 2016 17 PC 2972 Count	FY 2016 17 Total Count
Total Discharges	367	140	<b>507</b>
Internal Transfers	5	46	<b>51</b>
Deaths	2	7	<b>9</b>
<b>Net Discharges</b>	<b>360</b>	<b>87</b>	<b>447</b>

The table below provides a detailed breakdown for the 447 MDO patients that were discharged out of DSH by the location of where they were discharged to. Of the 447 MDO discharges, 360 were PC 2962 patients and 87 were PC 2972 patients. Approximately 9.6 percent of MDO discharges (43 patients) were admitted into the CONREP program to continue treatment and are still considered an MDO. Of the 43 CONREP admissions 18 were PC 2962 patients and 25 were PC 2972 patients. The remaining 404 patients (approximately 90.4 percent) are decertified by court and no longer fit the definition of an MDO. Of those MDO patients that are decertified by court, 342 are PC 2962 patients and 62 are PC 2972 patients.

Discharge Location	FY 2016 17 PC 2962 Count	FY 2016 17 PC 2972 Count	FY 2016 17 Total Count	Percent to Total
Community Outpatient Treatment / CONREP	18	25	<b>43</b>	9.6%
Locked Facility: CDCR, Jail, Court, Other Locked Facility	27	6	<b>33</b>	7.4%
Home	313	33	<b>346</b>	77.4%
Medical Facility	0	2	<b>2</b>	0.4%
Non-Medical Facility: Board and Care, Group Home, Halfway House, Room and Board	1	11	<b>12</b>	2.7%
Other/Unknown Location <sup>18</sup>	1	10	<b>11</b>	2.5%
<b>Total Net Discharges</b>	<b>360</b>	<b>87</b>	<b>447</b>	<b>100.0%</b>
<b>Discharged MDO Breakdown</b>				
Less CONREP Admissions	18	25	<b>43</b>	9.6%
<b>Decertified MDO</b>	<b>342</b>	<b>62</b>	<b>404</b>	<b>90.4%</b>

### Length of Stay Data

Of the 342 PC 2962 MDO patients that have been discharged in FY 2016-17 because they no longer fit the definition of an MDO, the average length of stay is 293.5 days or approximately 0.8 years. Of the 62 PC 2972 MDO patients that have been discharged in FY 2016-17 because they no longer fit the definition of an MDO, the average length of stay is 1,225.5 days or approximately 3.4 years. The combined length of stay for all decertified MDO legal classes on average is 436.5 days or approximately 1.2 years. These calculations exclude the MDO patients that have been admitted into the CONREP program for further treatment. If the decertified MDO patients that have been discharged to a locked facility are excluded from the length of stay calculation, the average length of stay decreases to 429.3 days or approximately 1.2 years. Length of stay calculation is based on the average number of days FY 2016-17 discharges

<sup>18</sup> Discharge location is not identified in DSH data systems.

## Department of State Hospitals

### Supplemental Report to the Legislature – Measures of Patient Outcomes

spent in a DSH hospital. Length of stay is defined as a period between admission to discharge, which includes leave days and time waiting for county transfer.

Legal Class	Length of Stay (days)	Length of Stay (years)
PC 2962 MDO	293.5	0.8
PC 2972 MDO	1,225.5	3.4
<b>All MDO Legal Classes</b>	<b>436.5</b>	<b>1.2</b>
<b>Less Locked Facility Discharges</b>	<b>429.3</b>	<b>1.2</b>

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Sexually Violent Predators

#### *Description of Legal Class*

SVP commitments are civil commitments of prisoners released from prison who meet criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses against one or more victims and who has a diagnosed mental disorder that makes the person a danger to the health and safety of others in that it is likely that he or she will engage in sexually violent criminal behavior.

#### *Legal Requirements/Legal Statute for Discharge*

Once a court determines a patient meets the criteria for an SVP commitment, these patients undergo an annual review process where the patient's SVP status is evaluated. At that point, DSH may decide that the patient is ready to be released into the community on a conditional release basis. A patient may have a hearing to determine whether he or she should be released from the hospital under conditional release to the community or unconditional release to the community without supervision.

If the court agrees that the patient no longer meets the SVP criteria and will not pose a public safety threat if conditionally released into a supervised program, it will order the patient be conditionally released. If the patient is conditionally released, CONREP takes over the monitoring and supervision of the patient. Alternatively, the court may decide that the patient is ready for unconditional release; if a patient is placed on unconditional release a CDCR parole agent takes over the monitoring and supervision of that individual.

#### *Discharge, Restoration and/or Release Data*

In the previous fiscal year, FY 2016-17, DSH processed discharges for a total of 31 SVP patients. Of those discharges two were transferred to another DSH facility, ten were deaths and 19 were discharged out of DSH.

Discharge Type	FY 2016 17 Count
Total Discharges	31
Internal Transfers	2 <sup>19</sup>
Deaths	10
<b>Net Discharges</b>	<b>19</b>
CONREP	6
Discharged to CDCR	5
<b>Unconditional Discharge</b>	<b>8</b>

Of the 19 SVP patients that have been discharged out of DSH in FY 2016-17, six were discharged and sent to CONREP for SVPs and five were discharged to CDCR. The remaining eight patients were discharged unconditionally because they no longer fit the definition of an SVP, yielding approximately a 42 percent rate of unconditional discharge for SVPs.

<sup>19</sup> Admitted as dual commitments PC 2962/WIC 6602 to DSH – Atascadero on 12/01/16 and 01/23/17 and both transferred to DSH – Coalinga as a WIC 6602 on 05/8/17.



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### *Length of Stay Data*

For the eight patients discharged unconditionally in FY 2016-17 because they no longer fit the definition of an SVP, the average length of stay was 3,534 days or approximately 9.7 years. Length of stay calculation is based on the average number of days FY 2016-17 discharges spent in a DSH hospital. Length of stay is defined as a period between admission to discharge, which includes leave days and time waiting for county transfer.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

---

### Lanterman-Petris-Short Act

#### *Description of Legal Class*

The LPS population includes multiple civil commitment types of patients who have been admitted under the LPS Act. These patients require physically secure 24-hour care and are committed through civil court proceedings if legal criteria concerning a danger to themselves or others or grave disability are met. Certain current parolees or former parolees may also be conserved under LPS commitments. It is also possible for other forensic commitments to convert to LPS commitments, such as if an IST is found substantially unlikely to regain competence in the foreseeable future, but requires ongoing mental health inpatient treatment and the respective county pursues legal conservatorship.

#### *Legal Requirements/Legal Statute for Discharge*

LPS conservatorships have not been charged with a crime, but are instead referred by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act. Those whose psychiatric conditions require a higher level of care and cannot be treated in locked facilities or board and care homes are sent to DSH for treatment. A patient's LPS conservatorship lasts for one year and can be renewed by the court on an annual basis. A new petition for renewal is filed with the court prior to the current conservatorship's expiration. LPS patients are discharged from DSH when (1) their county of residence places them in a different facility, (2) their county of residence places them in independent living or with family, or (3) they have successfully petitioned the court to remove the conservatorship.

Murphy conservatorships (MURCON) are patients that have been previously found to be IST and at the end of the IST commitment period the patient has been retained for further treatment because (1) the patient is subject to a pending indictment or information charging him or her with a felony involving death, great bodily harm, or threat to the physical well-being of another; (2) as a result of a mental disorder, the patient continues to be unable to understand or meaningfully participate in the pending criminal proceedings; (3) the patient has been found incompetent pursuant to Penal Code section 1370; and (4) the patient is currently dangerous as the result of a mental disorder, defect or disorder. The conservatorship lasts for one year, just like any other LPS conservatorship, and can be extended indefinitely if a new conservatorship is obtained each year. MURCON patients also have the right to a yearly court review and/or jury trial to petition the court to remove the conservatorship.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Discharge, Restoration and/or Release Data

In the previous fiscal year, FY 2016-17, DSH discharged a total of 226 LPS patients. Of those discharged, 31 were transferred to another DSH facility, 16 were deaths and 179 were discharges out of DSH. Of the 179 LPS patients discharged out of DSH, six were MURCON patients.

Discharge Type	FY 2016 17 LPS <sup>20</sup> Count	FY 2016 17 MURCON <sup>21</sup> Count	FY 2016 17 Total Count
Total Discharges	210	16	226
Internal Transfers	22	9	31
Deaths	15	1	16
<b>Net Discharges</b>	<b>173</b>	<b>6</b>	<b>179</b>

LPS conservatorships are based on the patient being a danger to self, a danger to others, or having a grave disability. The conservatorship lasts for one year but can be renewed on an annual basis. The county of conservatorship determines if a renewal for LPS conservatorship is to be filed with the court or if the patient is to be discharged out of DSH. Due to this, the release of an LPS patient out of DSH is largely determined by the county of conservatorship and is based on the ability to be safely managed in the community. LPS patients are discharged when either their county places them in a different facility or they have met their discharge criteria for a lower level of care. In some cases, patients are discharged because they have successfully petitioned the court to remove the conservatorship. The table below provides a detailed breakdown for the 179 LPS patients that were discharged out of DSH by the location of where they were discharged to. Approximately 55 percent of the LPS patients discharged out of DSH were discharged into a locked facility or a medical facility such as an intermediate or a medical treatment facility, skilled nursing facility or an acute hospital. The remaining 45 percent were discharged home, to a non-medical facility that provides residential care or independent living arrangements, or other unspecified locations.

Discharge Location	FY 2016 17 LPS <sup>20</sup> Count	FY 2016 17 MURCON <sup>21</sup> Count	FY 2016 17 Total Count	Percent to Total
Community Outpatient Treatment	0	0	0	0.0%
Locked Facility: CDCR, Jail, Court, Other Locked Facility	53	2	55	30.7%
Home	15	0	15	8.4%
Medical Facility	43	0	43	24.0%
Non-Medical Facility: Board and Care, Group Home, Halfway House, Room and Board	55	4	59	33.0%
Other/Unknown Location <sup>22</sup>	7	0	7	3.9%
<b>Total Net Discharges</b>	<b>173</b>	<b>6</b>	<b>179</b>	<b>100.0%</b>

<sup>20</sup> Includes all LPS legal classes except for Murphy's Conservatorships.

<sup>21</sup> Murphy's Conservatorship WIC 5008(h)(1)(B).

<sup>22</sup> Discharge location is not identified in DSH data systems.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### *Re-admission to DSH Data*

In FY 2013-14 DSH discharged 228 LPS patients. Out of those discharged, ten were transferred to another DSH facility, ten were deaths and 208 were discharges out of DSH. Of the 208 LPS patients discharged from DSH in FY 2013-14, 42 unique patients were re-admitted to DSH over the next three fiscal years, approximately 20 percent of discharges over a three-year period. The 42 patients that were identified in this query may have had multiple re-admissions over the three-year period and each re-admission is counted in the fiscal year in which it occurred. For the LPS patients discharged in FY 2013-14, there were 19 re-admissions in FY 2014-15, 16 re-admissions in FY 2015-16 and 22 re-admissions in FY 2016-17. Re-admissions may include patients re-admitted under the same case/charges or under new case/charges.

FY 2013 14 LPS Discharges	FY 2014 15 Re admissions	FY 2015 16 Re admissions	FY 2016 17 Re admissions
<b>208</b>	19	16	22
Breakdown of LPS Re admissions			
IST Re-admission	7	7	9
NGI Re-admission	0	1	0
MDO Re-admission	0	0	1
SVP Re-admission	0	0	0
LPS Re-admission	9	7	9
<i>Coleman</i> Re-admission	3	1	3

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Coleman Class Patients

#### *Description of Legal Class*

The *Coleman* patients are California Department of Corrections and Rehabilitation (CDCR) patients, who are found to be mentally ill while in prison and are transferred from CDCR for inpatient mental health care with the expectation that they will return to CDCR when they have reached maximum benefit from treatment. If they are still mentally ill at the end of their prison term, they may receive further state hospital treatment as an MDO if they meet the criteria under PC 2962, or PC 2974 mentally disordered parolees who do not come within the provisions under PC 2962, as a LPS civil commitment.

#### *Legal Requirements/Legal Statute for Discharge*

The goal of DSH is to provide each *Coleman* patient with the appropriate treatment to gain the necessary skills to safely transition and reintegrate into the appropriate environment within CDCR. A patient may be eligible for discharge from DSH when the Interdisciplinary Treatment Team determines that the patient has met the requested treatment outcome expectations, current treatment goals and objectives and appropriate continued care can be arranged. A new policy was implemented, through Administrative Letter 2015-26, to allow DSH to discharge patients directly into the community when they are institutionally released from CDCR.

#### *Discharge, Restoration and/or Release Data*

In the previous fiscal year, FY 2016-17, DSH discharged a total of 2,596 *Coleman* patients. Out of those discharged 208 were transferred to another DSH facility and 2,388 were discharges out of DSH. Of the patients that were discharged out of DSH, 2,360 were discharged back to CDCR and 28 were discharged directly to the community. *Coleman* discharge data is inclusive of all psychiatric programs prior to their transfer under the responsibility of CDCR on July 1, 2017.

Discharge Type	FY 2016 17 Count
Total Discharges	2,596
Internal Transfers	208
Deaths	0
<b>Net Discharges</b>	<b>2,388</b>
<b>Breakdown of Discharge Location</b>	
Discharged to CDCR	2,360
Discharged Directly to Community	28



# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### *Re-admission to DSH Data*

Of the *Coleman* patients discharged out of DSH in FY 2013-14, 475 were re-admitted in FY 2014-15, 381 were re-admitted in FY 2015-16 and 387 were re-admitted in FY 2016-17. Looking at a narrower re-admission window of 30 days following FY 2013-14 discharge, only 28 patients, or 1.6 percent of discharges, returned within 30 days. All subsequent re-admissions following the patient's discharge in FY 2013-14 occurred under the *Coleman* legal class.

FY 2013 14 <i>Coleman</i> Discharges	FY 2014 15 Re admissions	FY 2015 16 Re admissions	FY 2016 17 Re admissions
1,736	475	381	387

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Conditional Release Program

#### *Description of CONREP*

CONREP operates pursuant to statutes in WIC Section 4360, subdivisions (a) and (b). The program is a statewide system of community-based services which is responsible for the community treatment and supervision of patients with IST, NGI, MDO commitments, as well as some parolees who have been released to outpatient status. These legislatively mandated services may be provided directly by DSH or by county-operated or contracted private organizations. The goal of CONREP is to provide public protection in California communities while providing an effective and standardized outpatient treatment system. Patients may be placed in CONREP when both the medical director of the treating hospital and the CONREP community program director recommends to the court that the individual can be treated safely and effectively in the community. CONREP offers individuals direct access to an array of mental health services during their period of outpatient treatment. These services are provided by specialized forensic mental health clinicians and include individual and group therapies, collateral contacts, home visits, substance abuse screening and psychological assessments. The terms and conditions of outpatient treatment is individualized to each patient based on their individualized treatment needs and incorporates court-sanctioned provisions for involuntary outpatient services and formally specifies the conditions of that treatment and supervision.

#### *Legal Requirements/Legal Statute for Discharge (from Program)*

DSH medical directors recommend patients for release from CONREP when their symptoms have been stabilized and they no longer present a danger to society, but only the courts have the authority to order a release. After a patient has been in CONREP for one year a hearing is held for the court to determine to (1) continue the patient in the CONREP program (2) have the patient sent back to a DSH facility, or (3) release the patient from CONREP.

#### *Discharge, Restoration and/or Release*

In the previous fiscal year, FY 2016-17, CONREP discharged a total of 168 patients from the program. Out of those discharged, 17 were deaths and 151 were discharges out of the CONREP program. Of the 151 CONREP discharges 39 were IST patients, 74 were NGI patients, 14 were MDO PC 2964<sup>23</sup> patients and 24 were MDO PC 2972 patients.

Discharge Type	IST	NGI	MDO PC 2964 <sup>23</sup>	MDO PC 2972	FY 2016 17 Count
Total Discharges	41	84	15	28	<b>168</b>
Deaths	2	10	1	4	<b>17</b>
<b>Net Discharges</b>	<b>39</b>	<b>74</b>	<b>14</b>	<b>24</b>	<b>151</b>

CONREP provides community treatment and supervision to patients with IST, NGI and MDO commitments, as well as some parolees who have been released to outpatient status. Since CONREP's patients are made up of different commitments, the legal requirements for discharge from the program are governed by different statutes. Of the 151 CONREP patients that have been discharged out of the program in FY 2016-17, 68 patients (approximately 45 percent) are considered successful discharges. Patients in this category are ones that were discharged because they no longer met the criteria for their legal classification, discharged due to case

<sup>23</sup> Once MDO PC 2962 patients are ordered into outpatient treatment they become MDO PC 2964 patients.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

dismissal, patients that have met their controlling discharge date, patients that were restored to competency or sanity, or other discharges that classified them as no longer being a threat to others. The remainder of the patients were discharged due to parole or CONREP revocations, re-hospitalization, transfer to a MURCON, deemed unlikely to be restored to competency or have reached their maximum term of commitment.

Discharge Location / Reason	IST	NGI	MDO PC 2964 <sup>24</sup>	MDO PC 2972	FY 2016 17 Count	Percent to Total
<b>Net Discharges</b>	<b>39</b>	<b>74</b>	<b>14</b>	<b>24</b>	<b>151</b>	
<b>Discharges May Still be a Threat to Self or Others Breakdown</b>						
Discharge due to Revocation	7	42	0	15	<b>64</b>	77.1%
Max Commitments	0	2	0	1	<b>3</b>	3.6%
Re-hospitalization, conservatorship	2	0	8	0	<b>10</b>	12.1%
No substantial likelihood of regaining competency in the foreseeable future	6	0	0	0	<b>6</b>	7.2%
<b>Total Discharges</b>	<b>15</b>	<b>44</b>	<b>8</b>	<b>16</b>	<b>83</b>	<b>100.0%</b>
<b>Discharges No Longer a Threat to Self or Others Breakdown</b>						
Case Dismissed	8	2	0	0	<b>10</b>	14.7%
Controlling Discharge Date Met	0	0	2	0	<b>2</b>	2.9%
Legal Class Criteria Not Met	0	0	3	8	<b>11</b>	16.2%
Restoration of Competency / Sanity	15	27	0	0	<b>42</b>	61.8%
Other	1	1	1	0	<b>3</b>	4.4%
<b>Total Discharges</b>	<b>24</b>	<b>30</b>	<b>6</b>	<b>8</b>	<b>68</b>	<b>100.0%</b>

### Length of Stay Data

Of the CONREP patients that have been discharged in FY 2016-17, the average length of stay is 1,414 days or approximately 3.9 years. This length of stay is a cumulative of all CONREP discharges, excluding deaths. Length of stay calculation is based on the average number of days FY 2016-17 discharges spent in a community outpatient program through CONREP. Length of stay is defined as a period between admission to discharge, which includes leave days and time waiting for county transfer.

### Re-admission to DSH Data

In FY 2013-14 CONREP discharged a total of 164 patients and 61 of those patients, or approximately 37 percent of CONREP discharges, were discharged because they were no longer classified as a threat to self or others. Of those patients discharged from CONREP three years ago because they were no longer classified as a threat to self or others, none were re-admitted in FY 2014-15, two were re-admitted in FY 2015-16 and two were re-admitted in

<sup>24</sup> Once MDO PC 2962 patients are ordered into outpatient treatment they become MDO PC 2964 patients.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

FY 2016-17, yielding a 6.6 percent re-admission rate from the CONREP program. Re-admissions include patients re-admitted under the same case/charges or under new case/charges.

Discharge Type	IST	NGI	MDO PC 2964 <sup>25</sup>	MDO PC 2972	FY 2013 14 Count
Total Discharges	29	96	9	30	<b>164</b>
Max Commitment	8	2	0	3	<b>13</b>
Re-hospitalization, conservatorship	1	0	4	0	<b>5</b>
Revocation of CONREP	5	52	0	17	<b>74</b>
Deaths	0	9	0	2	<b>11</b>
<b>Net Discharges</b>	<b>15</b>	<b>33</b>	<b>5</b>	<b>8</b>	<b>61</b>

FY 2013 14 CONREP Discharges	FY 2014 15 Re admissions	FY 2015 16 Re admissions	FY 2016 17 Re admissions
<b>60</b>	0	2	2
<b>Breakdown of CONREP Re admissions to DSH</b>			
IST Re-admission	0	2	1
NGI Re-admission	0	0	0
MDO Re-admission	0	0	0
LPS Re-admission	0	0	0
<i>Coleman</i> Re-admission	0	0	1

### Recidivism Crime Data

Data on criminal offenses committed following discharge is available for the CONREP population. The statute that governs CONREP's research, reporting and assessment of program effectiveness functions allows for access to the CLETS data-system. This provides CONREP with the ability to track recidivism data for CONREP discharges. Of the 60 patients discharged from CONREP in FY 2013-14 because they were no longer classified as a threat to self or others, 14 were convicted of at least one crime over the next three years, yielding a 23.3 percent rate of recidivism. The crimes committed<sup>26</sup> consisted of felonies, misdemeanors and unknown conviction statuses; the same individual may have committed multiple crimes over the three-year period.

FY 2013 14 CONREP Discharges	FY 2014 15 Convictions <sup>26</sup>	FY 2015 16 Convictions <sup>26</sup>	FY 2016 17 Convictions <sup>26</sup>
<b>60</b>	7	7	9
<b>Breakdown of CONREP Crime Convictions</b>			
Felony	1	0	2
Misdemeanor	4	7	6
Infraction	0	0	0
Unknown	2	0	1

<sup>25</sup> Once MDO PC 2962 patients are ordered into outpatient treatment they become MDO PC 2964 patients.

<sup>26</sup> The charges of an IST's original placement are excluded from the recidivism computations as the original charges do not identify a conviction.

# Department of State Hospitals

## Supplemental Report to the Legislature – Measures of Patient Outcomes

### Conditional Release Program – SVP

#### *Description of CONREP – SVP*

Similar to CONREP, CONREP – SVP is a statewide system of community based services which is responsible for the community treatment and supervision of SVP patients. Effective January 1, 1996, the SVP commitment was added to the CONREP population. SVPs are required to be conditionally released into their county of domicile where treatment and supervision services are provided when an SVP is court-ordered conditionally released into the community. SVPs in CONREP receive an intensive regimen of treatment and supervision that includes at least weekly individual contact by supervision staff, specialized sex offender treatment, weekly drug screening, surveillance, polygraph examinations and active Global Positioning System tracking.

#### *Legal Requirements/Legal Statute for Discharge (from Program)*

DSH medical directors recommend patients for release from CONREP when their symptoms have been stabilized and they no longer present a danger to society, but only the courts have the authority to order a release. After a patient has been in CONREP for one year a hearing is held for the court to determine to (1) continue the patient in the CONREP program (2) have the patient sent back to a DSH facility, or (3) release the patient from CONREP.

#### *Discharge, Restoration and/or Release Data*

In the previous fiscal year, FY 2016-17, CONREP – SVP discharged one patient from the program. The average length of stay for that patient was 919 days, or approximately 2.5 years. The SVP patient was discharged from CONREP – SVP due to revocation for noncompliance. In FY 2016-17 there were no discharges that were unconditionally released because they no longer met the civil commitment criteria of an SVP.

Discharge Type	FY 2016 17 Count
Total Discharges	1
Deaths	0
<b>Net Discharges</b>	<b>1</b>
Breakdown of Discharge Location / Reason	
Discharge due to Revocation	1
Unconditional Release	0

#### *Re-admission to DSH and Recidivism Crime Data*

Data on criminal offenses committed following discharge is available for the CONREP – SVP population. The statute that governs CONREP – SVP's research, reporting and assessment of program effectiveness functions allows for access to the CLETS data-system. This provides CONREP – SVP with the ability to track recidivism data for CONREP – SVP discharges. In FY 2013-14 CONREP – SVP discharged one patient from the program. Over the next three years that patient has not been re-admitted into DSH and has not committed another crime (felony, misdemeanor, or infraction).



## Appendix G

### Department of State Hospitals 24-Hour Care Nursing Services Staffing Study Current Staffing Practices

Identifying and documenting the staffing practices within all five state hospitals involved many data collection efforts. Key questions used to guide the data collections included:

- How are hospital units currently staffed?
- How are staffing needs determined?
- What regular data is collected on staff usage?
- How does delivered staffing compare among the hospitals?
- How does staffing vary among different commitment types, different treatment programs and different shifts?

#### Nursing Position Classifications and Duties

The primary nursing classifications utilized within DSH hospitals consist of registered nurses, supervising registered nurses, psychiatric technicians, senior psychiatric technicians, psychiatric technician assistants, unit supervisors and licensed vocational nurses. Information on nursing duties and distinct functions of certain posts was collected in the following ways:

- Duty statements from each hospital (over 70 collected)
- Conference calls with subject matter experts at each hospital and with DSH COAC nursing representatives
- In-person interviews with hospital nursing supervisory staff
- E-mail correspondence and written follow-up questions
- Individual hospital administrative directives and staffing documents

The primary nursing classifications used on the units are registered nurses and psychiatric technicians. Registered nurses are professional nurses licensed by the California Board of Registered Nurses and therefor possess the legal requirements to practice as a professional nurse in California within their scope of licensure and standards of practice. Psychiatric technicians are licensed by the California Board of Vocational Nurse and Psychiatric Technician Examiner to provide a basic level of general psychiatric nursing care. While there may be some overlap in daily functions between the two classifications major duties include:

#### *Registered Nurse*

- Conducts assessments including assessments required upon admission, assessments to determine each patient's patient acuity rating and other assessments—daily, weekly and/or monthly—as required by the patient's acuity, physician order, and/or treatment plan.
- Develops and writes Nursing Care Plans to address each patient's medical and psychiatric conditions.

## Appendix G

- Assists medical physicians, psychiatrists and/or nurse practitioners with patient sick-call appointments and ensures follow-up is completed including all ordered labs and x-rays.
- Reviews physician orders written by off-unit or off-grounds non-DSH medical providers upon the patient's return to the unit.
- Documents patient progress in the patient's medical record in the form of registered nurse progress notes—daily, weekly and/or monthly—as required by each patient's acuity.
- Observes and assesses patient's physical condition and behavior and reports significant changes to the shift lead or physician, and records observations in nursing notes in the patient's medical record.
- May provide initial authorization of restraint and seclusion procedures until a physician is present.
- Administers medications and treatments including oral medications and hypodermic injections.
- Maintains order and supervises the conduct of patients to ensure a stable unit milieu.
- Responds to emergencies and may provide first aid and cardiopulmonary resuscitation (CPR).
- Helps prepare patient treatment plans by assisting other interdisciplinary treatment team members in gathering information from available prior records, the patient, community agency staff, court documents and family and/or significant others.
- Attends regularly scheduled treatment team conferences and emergency mini-team conferences that are convened to address immediate and significant changes in a patient's psychiatric or behavioral status.

### *Psychiatric Technician*

- Provides a basic level of general behavioral psychiatric nursing care to patients and participates in the overall psychiatric treatment programs by developing, encouraging participation in, and supervising on-unit groups and individual program activities for patients.
- Provides enhanced patient observations in the form of Q15 minute checks or 1:1/2:1 observations for high-risk or suicidal patients.
- Administers medications and treatments including oral medications and hypodermic injections.
- Prepares and cares for patients during treatments administered by other level-of-care staff.
- Transcribes, notes and picks up medication orders.
- Takes and monitors patient vital signs.
- Documents patient progress in medical records in the form of regular psychiatric technician progress notes—daily, weekly and/or monthly—as required by each patient's acuity.
- Observes patient's physical condition and behavior and reports significant changes to the shift lead or physician and records observations in nursing notes in the patient's medical record.
- Motivates patients to develop self-reliance in daily living and assists them with activities of daily living (ADL) such as feeding, habit training and maintaining a well-groomed appearance.
- Maintains order and supervises the conduct of patients to ensure a stable unit milieu.
- Conducts and calls in patient counts to protective services staff throughout the day.
- Issues property to patients such as clothing and toiletries.
- Performs housekeeping duties such as daily laundry pickup, sort and removal of soiled laundry.

## Appendix G

- Performs medical supply and unit inventory to ensure adequate stock is available on the unit.
- Helps to create a clean, safe, and therapeutic environment for patients.
- Coordinates and schedules treatment planning conferences; provides documentation support to the treatment team and ensures the plan is finalized, signed, and placed in the patient's medical record.
- Responds to emergencies and may provide first aid and CPR.

Additionally, all nursing staff have custody responsibilities. These responsibilities include:

- Observing and intervening in patient behavior that may injure people, damage property or signal impending escape attempts.
- Responding to calls for assistance in situations where patients are in the process of injuring themselves or others.
- Protecting and maintaining the safety of persons and property.
- Providing coverage during unit activities, meals, and courtyard time.
- Conducting regular rounds of all areas within the unit including communal space and patient rooms.
- Providing on-grounds escorts to off-unit areas such as patient dining rooms, medical appointments, trust appointments, and visiting centers; and off-grounds escorts for such things as external medical appointments and community outings.
- Observing daily showers and supervising shaves to ensure patient safety.
- Conducting random checks and unit/room searches for drugs, contraband and weapons.
- Counting, distributing and accounting for eating utensils to prevent their use as weapons.
- Inspecting all incoming and outgoing patient mail and packages for contraband.
- Inspecting facilities to identify security breaches that could lead to the escape of a patient.

In addition to registered nurses and psychiatric technicians, the other common classifications considered to be part of nursing staffing include unit supervisors, supervising registered nurses and senior psychiatric technicians.

- Unit supervisors are responsible for the continuous management and supervision of a unit. Primary responsibilities include scheduling and directing the activities of nursing service personnel assigned to their unit; evaluating the performance of assigned personnel and promoting individual staff development; investigating and recommending solutions to complaints from patients, visitors, or unit staff; procuring, storing, and establishing unit inventory standards; carrying out administrative procedures required by hospital policies and practices; assisting in developing nursing services budget and personnel needs for the unit; and preparing or directing the preparation of records and reports. Unit supervisors must possess the legal requirements to practice as a professional registered nurse in California or possession of a valid license to practice as a psychiatric technician. They must also have one year of experience performing the duties of a nursing classification comparable in level of responsibility to a registered nurse, range B or senior psychiatric technician with the duty of directing the nursing services for a level-of-care unit during a shift.

## Appendix G

- Supervising registered nurses, in a unit supervisor capacity, carry the same responsibilities as a unit supervisor described in the section above but are utilized on units where medical, surgical, or neurological nursing techniques are regularly required or offered on the unit, or where there is a formal requirement for the use of a registered nurse as a unit supervisor. In addition to possession of the legal requirements to practice as a professional registered nurse in California, incumbents must have one year of experience in the California state service performing the duties of a nursing classification comparable in level of responsibility to a registered nurse, range B; or two years of professional nursing experience in a facility licensed for inpatient care.
- Senior psychiatric technicians primarily serve as shift leads on treatment units within DSH hospitals. They provide supervision of nursing staff and are responsible for directing the work of an 8-hour shift. They assign staff to specific job duties, ensure completion of duties and make sure all employees are knowledgeable about their specific job duties. They ensure all policies, procedures and regulatory agency standards are followed including all security measures for patients, visitors and staff. They ensure appropriate staffing levels are maintained on the unit at all times and oversee the provision of quality patient care during their assigned shift. Senior psychiatric technicians are required to possess a valid license to practice as a psychiatric technician issued by the California Board of Vocational Nurse and Psychiatric Technician Examiner and one year of experience performing the duties of a psychiatric technician in a California State hospital or developmental center.

### Individual Hospital Staffing Practices

Staffing practices at each hospital vary due to the population they serve, the services they offer and their unique location specific limitations. Historically, each hospital has operated independently of one another and while all maintain compliance with licensure and regulatory staffing minimums, they have each developed their own method for determining nursing staffing requirements based on patient needs.

- **Atascadero** utilizes a Patient Classification Rating System (PCRS) to determine the clinical needs of patients. The PCRS evaluates a patient's behavioral stability in eight behavioral areas: ingestive, eliminative, affiliative, dependency, sexual, aggressive/protective, achievement, and restorative. It was adopted from the Dorothy Johnson Behavioral System Model and is completed by a registered nurse each shift.
- **Coalinga** utilizes the Neuropsychiatric Individual Classification System (NPH-Patient Classification System)<sup>1</sup> for determining patient acuity levels and required staffing on acute medical units MA-1 and MA-2; and utilizes a minimum base staffing level plus enhancements as necessary for all other units, including non-acute medical specialized services units. Temporary

---

<sup>1</sup> This system was developed by Dr. Jeanne Auger and Dr. Vivien Dee utilizing the Johnson Behavioral Model, which is the same model on which Atascadero based its PCRS.

## Appendix G

enhancements must be approved by the nursing coordinator<sup>2</sup> and ongoing enhancement requests must be submitted in a formal memorandum with justification to the nurse administrator<sup>3</sup>.

- **Metropolitan** utilizes a patient classification system based on the same eight behavioral areas defined in the Dorothy Johnson Behavioral System Model as a guideline for their nurse staffing. Patients on federally regulated SNF and acute certified units<sup>4</sup> are assessed and rated by a registered nurse daily or more frequently as necessary. For patients on all other units, patient acuity is assessed and rated every Monday or more frequently as necessary. Staffing allocations are monitored and reviewed by the Nursing Executive Committee.
- **Napa** primarily utilizes fixed staffing levels for each unit that have been determined by the clinical administrator, assistant clinical administrator, nursing administrator, and other key members of management. Staffing decisions take into account fiscal limitations and are based on patient acuity, past staff delivered data, temporary enhancement needs, and ongoing enhancement needs. The clinical administrator and nurse administrator review prior staff logs and incident reports in order to justify ongoing unit enhancements. SNF and acute certified units maintain staffing levels to ensure federal Centers for Medicare and/or Medicaid Services compliance.
- **Patton** utilizes a minimum base staffing level plus enhancements. Staffing levels are determined by the nurse administrator and clinical administrator and are based on patient acuity (medical and psychiatric), patient treatment needs, and the overall function of the unit. Patton also takes into account unit milieu ratings calculated by the Psychology Department's unit milieu assessment tool. This tool generates a unit milieu rating based on aggression data, number of behavioral one-to-ones and two-to-ones, prevalence of contraband issues, frequency of restraint use, frequency of seclusion use and number of self-harm occurrences.

---

<sup>2</sup> The nursing coordinator provides nursing supervision at the program level.

<sup>3</sup> The nurse administrator is the Chief of Nursing for the hospital and operates at an executive management level.

<sup>4</sup> These are units certified and regulated by the Centers for Medicare and/or Medicaid Services.



## Appendix H

### Department of State Hospitals 24-Hour Care Nursing Services Staffing Study Categorization of Units – Methodology and Descriptions

Multiple data elements were assessed in an effort to develop a grouping system and way to categorize units. The elements considered in this assessment are listed below.

- Unit function and treatment offered: Most units can be categorized as admission units, medical treatment units, specialized services units, multi-commitment type and commitment type specific treatment units, and discharge preparation units. While hospitals vary slightly in this respect, certain commonalities can be identified to allow for a system-wide categorization to be applied. A full-listing and description of each category identified can be found below.
- Number of aggressive incidences: Aggression data was pulled from the DSH Wellness and Recovery Model Support System (WaRMSS) for all aggressive acts by unit for the same six-month period as the staffing data. Aggressive acts are ranked by severity code ranging from no treatment required (code one) to required hospitalization (code four). All severity codes were factored.
- Frequency of enhancements to unit staffing: Units receive enhanced staffing for various reasons including the need for enhanced observations, one-to-one observations, two-to-one observations and for changes to patient acuity impacting the milieu.
- Types of rooms present in the unit: Physical layout of a unit can impact the time required for nurses to complete functions such as sign-of-life checks and medication pass, along with the type of patient that can be housed in dorm or single room settings.
- Population housed: The composition of a unit's population can vary in many factors such as how long each patient has been hospitalized, patient commitment type, patient gender, patient diagnosis and presence of symptoms and specialized services and/or accommodations needed.
- Physical layout of hospital grounds: The physical location of a unit within a hospital can impact the types of patients being treated. For example, penal code (PC)/forensic patients must be housed in units located behind a secure treatment area (STA).
- Similarity of staff-to-patient ratios: Units with similar operating staff-to-patient ratios based on the actual staff delivered data were assessed for commonalities in the other unit defining variables.

Through examination of the above elements, units within each hospital were categorized into groups. These groupings were then analyzed across all five hospitals in order to compile an itemized system-wide list of units and their staff delivered data by category. Of all the elements assessed, the primary variables identified to have the most significant impact on staffing levels and considered in the system-wide unit analysis and categorization are unit function and treatment offered, population type housed

## Appendix H

on the unit, physical layout of hospital grounds and units, and similarity of staff-to-patient ratios calculated from the staff delivered data. It should be mentioned that the frequency of need to enhance a unit is indirectly reflected in the primary variables since staffing enhancements are captured in the staff delivered data. Furthermore, aggression data, while informative was not in itself enough to be a primary variable for categorizing units since aggression can be present for various reasons and would also indirectly be reflected in staff delivered if the aggression required enhanced observations or additional staff to stabilize a unit's milieu.

### Hospital Treatment and Housing Unit Groupings

The methodology developed through the staffing study proposes a system-wide classification of hospital units. This classification system groups units of similar staffing needs and similar functionalities together, ultimately calculating staffing based on the ratios within each group. Proposed unit classifications include:

- Admissions
- Medical Treatment
- Specialized Services Treatment
- Incompetent to Stand Trial Treatment
- Mentally Disordered Offender Treatment
- Multi-Commitment Treatment
- CDCR (Coleman) Treatment
- Sexually Violent Predator Treatment
- Lanterman-Petris-Short Treatment
- Discharge Preparation Treatment

Descriptions of each category and subgroups are identified below:

- **Admissions:** Patients are stabilized, acclimated to the state hospital, and undergo a range of interdisciplinary assessments and screenings including, but not limited to, medical, psychiatric, psychological, cultural, forensic (legal), nursing, emotional, behavioral, social, rehabilitation, nutritional, violence potential, psychopathy, neurological, vocational, dispositional, and security risk. The integrated assessments allow the treatment team to identify risk factors and serve as a guide to offer recommended treatment groups based on the patients' strengths, cognitive ability and barriers to discharge. Each patient is provided with a comprehensive individualized treatment plan. The average length of stay on an admissions unit is less than 90 days.

Units in this category include<sup>1</sup>:

---

<sup>1</sup> During the data collection time period (January 2015 – June 2015) DSH-Napa had an LPS Welfare and Institutions Code (WIC) section 5150 admissions unit. As of the 2018 update to unit categories, no units within DSH are classified as WIC section 5150 admissions units and therefore the category has been removed.

## Appendix H

- PC Standard Admissions
- Hybrid Admissions— Units which take a limited number of direct admissions. These units are primarily for IST patients that, on the average, have a shorter length-of-stay than other commitment types.
- **Medical Treatment:** Provides the highest level of medical care available in DSH hospitals. Patients housed on these units may be treated for acute serious medical conditions or chronic terminal medical conditions and accommodate patients in need of isolation due to infection of a contagious disease.

Units in this category include:

- Medical Units— Provides the highest level of medical care available in DSH hospitals<sup>2</sup>. Patients housed on these units may be treated for acute serious medical conditions or chronic terminal medical conditions and accommodate patients in need of isolation due to infection of a contagious disease.
- Skilled Nursing Facility (SNF)— Units specifically licensed as a SNF and serve patients who have a primary physical and/or medical need and a concomitant mental disorder which requires continuous skilled nursing intervention, and adults who are aged or infirm and require supportive nursing care. SNF residents generally require long term care. These units are also federally regulated by Centers for Medicare and Medicaid Services.
- Medically Fragile/Geropsych<sup>3</sup>— Provides treatment to patients whom are considered medically fragile with a behavior component but do not meet the criteria for a SNF and/or geriatric patients whom, in many cases, have chronic medical conditions and require some form of adaptive equipment such as wheelchairs, walkers and canes. These units provide a safe treatment environment for patients who are vulnerable to victimization due to advanced age, physical disability, and/or medical issues.
- **Specialized Services Treatment:** Provides specialized treatment and services to specific populations. Treatments provided in these specialized programs are specific to patients' medical and psychiatric treatment needs; therefore, these units are not suitable for the treatment of all DSH populations.

Units categorized as specialized services include:

---

<sup>2</sup> Atascadero and Coalinga have urgent care rooms within their medical units.

<sup>3</sup> During the initial data collections from January 2015 – June 2015, Medically Fragile and Geropsych were accounted for as two separate units. Through additional research and refinements of methodologies these categories have been combined. This is primarily due to the overlap in the medical issues present in the patients treated on these units.

## Appendix H

- High Aggression/Enhanced Treatment Unit/Enhance Treatment Program (ETP)— Provides treatment to patients who have significant acts of aggression, unsuccessful to interventions by the treatment team and behavioral issues which pose extraordinary risk of harm to others and risk to the safety and security of the hospital.
- Polydipsia— Provides highly tailored treatment to patients specific to their diagnosis including locked water-controlled wings within units housing polydipsia patients. Polydipsia is intoxication resulting from excessive consumption of fluids.
- Dialectical Behavior Therapy (DBT)— DBT is a cognitive behavioral treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder. Additional research has shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder, and eating disorders.
- Substance Abuse— Provides multi-level substance abuse treatment that includes a locked wing for patients going through substance detoxification.
- Psychologically Fragile— Provides treatment to patients who are psychologically fragile and at increased risk of victimization.
- Intermediate Care High Behavior Acuity— Provides treatment to patients with psychiatric conditions that cannot be managed on a non-specialized intermediate care facility (ICF) unit.
- Sex Offender<sup>4</sup> Treatment— Provides treatment to patients who have a history of sex offenses and who have expressed a desire to work on the causes of these offenses in treatment. The offenses need not be the committing offense, but treatment for the offenses must be criteria for the patient's discharge.
- Deaf, Hard of Hearing— Provides treatment to patients with auditory challenges.
- Monolingual— Provides treatment to patients who are exclusively or predominantly Spanish-speaking and receive treatment in their primary language.
- **Incompetent to Stand Trial Treatment:** Provides treatment for IST patients with a focus on stabilization of the patient's mental condition, identification of malingerers and restoration of trial competency so the court may adjudicate their pending charges.

Units in this category include:

- IST Permanent Housing – Single Roomed Units

---

<sup>4</sup> These are not SVP patients admitted under WIC sections 6602 and 6604.

## Appendix H

- IST Permanent Housing – Dorm and Mixed Roomed Units
- IST Admission to Discharge
- **Mentally Disordered Offender Treatment:** Provides treatment and nursing care for MDO patients referred from CDCR as a condition of their parole. These patients have severe mental disorders that may have aggravated the commission of their crime and as a result of their disorder they present a substantial danger to themselves and/or others. Treatment focuses on promoting stabilization as quickly and effectively as possible, reducing the symptoms of their mental illness and helping them understand their mental illness and associated symptoms, as well as, possible accompanying co-morbidity (i.e., substance abuse) that typically contributes to their illness.

Units in this category include:

- MDO Permanent Housing – Single and Mixed Roomed Units
- **Multi-Commitment Treatment:** Provides treatment and intermediate levels of nursing care to patients of various commitment types who are housed together on one unit. Commitment types include MDO, NGI, LPS and CDCR patients. They are housed together based on individual hospital layout, overall stabilization of unit milieu and similarities in patient length-of-stay and patient behavior. Treatment interventions vary according to each patient's identified needs and emphasize the potential for each patient to learn new skills and adaptive coping mechanisms to enhance the quality of the patient's life and to prepare for eventual transfer to outpatient treatment in the community. Other goals are to motivate patients to participate in treatment, develop greater self-autonomy and independence, and the mastery of activities of daily living skills and self-discipline. Treatment specific for NGI patients focuses on restoring sanity and treating the patient until he/she is no longer a danger to the health and safety of him/herself or others as defined in PC section 1026.

Units in this category include:

- MDO, NGI, and LPS Permanent Housing – Dorm and Mixed Roomed Units
- MDO and NGI Permanent Housing – Single Roomed Units
- CDCR and MDO Permanent Housing – Single and Dorm Roomed Units
- **CDCR (Coleman) Treatment:** Provides treatment for CDCR inmate-patients referred by CDCR under PC section 2684 within the framework of the Memorandum of Understanding (MOU) between DSH and CDCR. These patients have a major mental health disorder with active symptoms and pose a danger to self, others and/or are gravely disabled. Treatment services are tailored towards stabilization, barriers to discharge and long-term efficacy. Patients usually 1) return to CDCR under PC section 2685, 2) receive further treatment and commitment as a MDO under PC section 2962, or 3) parole to the community via CDCR.



## Appendix H

Units in this category include:

- CDCR Permanent Housing – Dorm and Mixed Roomed Units
- **Sexually Violent Predator Treatment:** Provides treatment for adult male patients committed under WIC sections 6602 and 6604. Most of these patients are diagnosed with pedophilia or paraphilia disorders.

Units in this category include:

- SVP Permanent Housing
- SVP Residential Recovery Units (RRU)<sup>5</sup>
- **Lanterman-Petris-Short Treatment:** Provides treatment for patients under LPS Conservatorship that are gravely disabled and who represent a danger to themselves or others due to mental illness, but who have not been charged with a crime in conjunction with their mental state. These persons are referred by local community mental health programs through involuntary civil commitment procedures pursuant to the LPS Act.

Units in this category include:

- LPS Permanent Housing
- **Discharge Preparation Treatment:** Provides treatment to patients who are anywhere from a few days to a few years of being discharge ready. Primary treatment goals on these units are to assist the patient in gaining self-control and to prepare them for a successful transition to community living. Discharge goals include acceptance to a Conditional Release Program (CONREP), parole, or release back to a community setting.

Units in this category include:

- Discharge Ready

---

<sup>5</sup> Coaltinga is the only hospital with RRUs; these units are not licensed by the California Department of Public Health but operate pursuant to WIC section 6606, subdivision (d). RRUs house SVP patients who can ambulate and function independently, require minimal medical and/or psychiatric treatment care, require minimal prompting for Activities of Daily Living and are compliant with their treatment plan.

## Appendix I

### Department of State Hospitals

#### 24-Hour Care Nursing Services Staffing Study

#### Methodology Test: Actual Staff Delivered vs System-Wide Grouping Ratio Staffing Levels

The nursing staff generated by these ratios include all floor nursing staff, medication pass coverage and shift leads. To test the accuracy of this methodology staff delivered data and unit groupings at the time of the study were compared against the level of staffing that would be generated based on the application of the unit grouping parameters and system-wide group ratios proposed in Figure 2.2. Appendix I.1 through I.5 is the tool developed and used for this comparison in order to test the validity of the system-wide grouping ratio methodology. Appendix I.1 – I.5 displays, for each hospital, the following detail:

- Hospital units by group and sub-group along with additional informative unit characteristics at the time of the staffing study and data collection period.
- For each shift the actual 6-month average of staff delivered to each unit and calculated operational ratios as derived from the daily staffing report analysis. Staff delivered numbers are further broken out by either an actual or projected discipline split depending on what is displayed on each hospital's daily staffing report template.
- Displayed adjacent to the actual staff delivered information and calculations for each shift are the projected staff delivered levels for each unit based on the proposed system-wide grouping ratios and a proposed standard discipline split of 30 percent registered nurses and 70 percent psychiatric technicians for all units except those categorized as medical treatment and high aggression/ETU units. These units would receive a 50 percent registered nurse and 50 percent psychiatric technician split and a 40 percent registered nurse and 60 percent psychiatric technician split respectively due to a higher operational need of registered nurses to address the higher medical acuities and number of interventions required by patients on these units.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Atascadero																							
Unit Characteristics											AM Shift												
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios						
											Ratio-Driven						Ratio-Driven						
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT <sup>2</sup> (Projected)		
Admissions	PC Standard Admissions	3	6	Acute	Admissions		MDO	M	Single	30.0	1: 5.0	6.0	1.7	28%	4.3	72%	1: 4.5	6.7	2.0	30%	4.7	70%	
Admissions	PC Standard Admissions	6	8	Acute	Admissions		MDO	M	Single	28.5	1: 4.0	7.2	1.9	26%	5.3	74%	1: 4.5	6.3	1.9	30%	4.4	70%	
Admissions	PC Standard Admissions	1	12	Acute	Admissions		IST	M	Single	27.9	1: 3.7	7.5	1.9	25%	5.6	75%	1: 4.5	6.2	1.9	30%	4.3	70%	
Admissions	PC Standard Admissions	5	13	Acute	Admissions		CDCR/MDO	M	Single	29.9	1: 4.7	6.4	1.8	28%	4.6	72%	1: 4.5	6.6	2.0	30%	4.7	70%	
Admissions	PC Standard Admissions	7	23	Acute	Admissions		MDO	M	Single	30.8	1: 4.7	6.6	1.5	23%	5.1	77%	1: 4.5	6.8	2.1	30%	4.8	70%	
										147.1		33.7	8.8		24.9			32.7	9.8		22.9		
Medical Treatment	Medical Units	6	1	Acute	Specialized Svcs	Infirmary	All	M	Single	17.7	1: 2.0	8.8	4.6	52%	4.2	48%	1: 2.0	8.9	4.4	50%	4.4	50%	
Specialized Services Treatment	High Aggression/ETU	6	4	Acute	Specialized Svcs	ETU	All	M	Single	12.0	1: 1.7	7.1	1.4	20%	5.7	80%	1: 1.5	8.0	3.2	40%	4.8	60%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	5	ICF	Permanent Housing		IST	M	Single	28.6	1: 5.5	5.2	1.1	21%	4.1	79%	1: 5.5	5.2	1.6	30%	3.6	70%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	11	ICF	Permanent Housing		IST	M	Single	29.9	1: 6.1	4.9	1.3	27%	3.6	73%	1: 5.5	5.4	1.6	30%	3.8	70%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	20	ICF	Permanent Housing		IST	M	Single	31.1	1: 5.3	5.9	1.4	24%	4.5	76%	1: 5.5	5.7	1.7	30%	4.0	70%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	21	ICF	Permanent Housing		IST	M	Single	31.3	1: 6.1	5.1	1.1	22%	4.0	78%	1: 5.5	5.7	1.7	30%	4.0	70%	
										120.9		21.1	4.9		16.2			22.0	6.6		15.4		
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	3 <sup>3</sup>	ICF	Permanent Housing		MDO	M	Mixed	14.8	1: 3.1	4.7	1.1	23%	3.6	77%	1: 5.0	3.0	0.9	30%	2.1	70%	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	9	ICF	Permanent Housing		MDO	M	Mixed	38.9	1: 6.5	6.0	1.2	20%	4.8	80%	1: 5.0	7.8	2.3	30%	5.4	70%	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	6	10	ICF	Permanent Housing		MDO	M	Single	29.0	1: 5.2	5.6	1.2	21%	4.4	79%	1: 5.0	5.8	1.7	30%	4.1	70%	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	3	14 <sup>3</sup>	ICF	Permanent Housing		MDO	M	Single	36.1	1: 7.1	5.1	1.6	31%	3.5	69%	1: 5.0	7.2	2.2	30%	5.1	70%	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	3	15	ICF	Permanent Housing		MDO	M	Single	30.8	1: 5.2	5.9	1.6	27%	4.3	73%	1: 5.0	6.2	1.8	30%	4.3	70%	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	27 <sup>4,5</sup>	ICF	Permanent Housing		MDO	M	Mixed	40	1: 6.3	6.3	2.2	35%	4.1	65%	1: 5.0	8.0	2.4	30%	5.6	70%	
										189.6		33.6	8.9		24.7			37.9	11.4		26.5		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	3	16	ICF	Permanent Housing		MDO	M	Dorm	42.6	1: 7.5	5.7	1.2	21%	4.5	79%	1: 6.5	6.6	2.0	30%	4.6	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	3	17	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 7.8	5.5	1.1	20%	4.4	80%	1: 6.5	6.6	2.0	30%	4.6	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	6	18	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 7.0	6.1	1.2	20%	4.9	80%	1: 6.5	6.6	2.0	30%	4.6	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	6	19	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 7.5	5.7	1.3	23%	4.4	77%	1: 6.5	6.6	2.0	30%	4.6	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	25	ICF	Permanent Housing		MDO, NGI	M	Dorm	41.7	1: 7.4	5.6	1.3	23%	4.3	77%	1: 6.5	6.4	1.9	30%	4.5	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	26	ICF	Permanent Housing		MDO	M	Dorm	42.5	1: 8.0	5.3	1.5	28%	3.8	72%	1: 6.5	6.5	2.0	30%	4.6	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	29	ICF	Permanent Housing		MDO, NGI	M	Dorm	44.8	1: 7.1	6.3	1.6	25%	4.7	75%	1: 6.5	6.9	2.1	30%	4.8	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	30	ICF	Permanent Housing		MDO, NGI	M	Dorm	45.2	1: 7.7	5.9	1.5	25%	4.4	75%	1: 6.5	7.0	2.1	30%	4.9	70%	
										345.2		46.1	10.7		35.4			53.1	15.9		37.2		
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	3	7	ICF	Permanent Housing		MDO, NGI	M	Single	31.9	1: 5.4	5.9	1.2	20%	4.7	80%	1: 5.5	5.8	1.7	30%	4.1	70%	
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	7	22	ICF	Permanent Housing		MDO, NGI	M	Single	33.9	1: 5.8	5.8	1.6	28%	4.2	72%	1: 5.5	6.2	1.8	30%	4.3	70%	
										65.8		11.7	2.8		8.9			12.0	3.6		8.4		
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	2	ICF	Permanent Housing		CDCR/MDO	M	Single	31.6	1: 6.7	4.7	1.0	21%	3.7	79%	1: 7.5	4.2	1.3	30%	2.9	70%	
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	31	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.0	1: 7.1	6.3	1.4	22%	4.9	78%	1: 7.5	6.0	1.8	30%	4.2	70%	
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	33	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.1	1: 7.8	5.8	1.5	26%	4.3	74%	1: 7.5	6.0	1.8	30%	4.2	70%	
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	34	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.3	1: 7.9	5.7	1.3	23%	4.4	77%	1: 7.5	6.0	1.8	30%	4.2	70%	
										167		22.5	5.2		17.3			22.3	6.7		15.6		
CDCR Treatment	CDCR Permanent Housing	5	28 <sup>5,6</sup>	ICF	Permanent Housing		CDCR	M	Mixed	40	1: 7.4	5.4	1.4	26%	4.0	74%	1: 5.5	7.3	2.2	30%	5.1	70%	
CDCR Treatment	CDCR Permanent Housing	5	32	ICF	Permanent Housing		CDCR	M	Dorm	45.0	1: 7.9	5.7	1.2	21%	4.5	79%	1: 5.5	8.2	2.5	30%	5.7	70%	
										85.0		11.1	2.6		8.5			15.5	4.6		10.8		
										1150.3		195.7	49.9		145.8			212.2	66.2		146.0		
										1369.5		243.2	62.9		180.3			261.1	83.5		177.6		

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> Unit 3 and 14 are outliers and were not included in ratio averages.

<sup>4</sup> Unit 27 - Staff delivered was derived from an average of two years (not 6 months); it was used as swing space during PDAS installation; applied system-wide grouping that is applicable as of completion of PDAS installation (was previously an acute admissions unit).

<sup>5</sup> Unit 27 and 28 are not included in ratio averages since their function changed while being used for PDAS swing space.

<sup>6</sup> Unit 28 - Staff delivered was derived from an average of two years (not 6 months); it was used as swing space during PDAS installation; applied system-wide grouping that is applicable as of completion of PDAS installation.

Data only includes units with staffing allocations during the data collection time period.

- Unit 24 - closed at time of data collection.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Atascadero																						
Unit Characteristics											PM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)	
Admissions	PC Standard Admissions	3	6	Acute	Admissions		MDO	M	Single	30.0	1: 4.9	6.1	1.4	23%	4.7	77%	1: 5.0	6.0	1.8	30%	4.2	70%
Admissions	PC Standard Admissions	6	8	Acute	Admissions		MDO	M	Single	28.5	1: 4.1	7.0	1.8	26%	5.2	74%	1: 5.0	5.7	1.7	30%	4.0	70%
Admissions	PC Standard Admissions	1	12	Acute	Admissions		IST	M	Single	27.9	1: 4.1	6.8	1.7	25%	5.1	75%	1: 5.0	5.6	1.7	30%	3.9	70%
Admissions	PC Standard Admissions	5	13	Acute	Admissions		CDCR/MDO	M	Single	29.9	1: 4.9	6.1	1.7	28%	4.4	72%	1: 5.0	6.0	1.8	30%	4.2	70%
Admissions	PC Standard Admissions	7	23	Acute	Admissions		MDO	M	Single	30.8	1: 5.3	5.8	1.2	21%	4.6	79%	1: 5.0	6.2	1.8	30%	4.3	70%
										147.1		31.8	7.8		24.0			29.4	8.8		20.6	
Medical Treatment	Medical Units	6	1	Acute	Specialized Svcs	Infirmary	All	M	Single	17.7	1: 2.2	8.1	4.4	54%	3.7	46%	1: 2.0	8.9	4.4	50%	4.4	50%
Specialized Services Treatment	High Aggression/ETU	6	4	Acute	Specialized Svcs	ETU	All	M	Single	12.0	1: 1.7	7.1	1.7	24%	5.4	76%	1: 1.5	8.0	3.2	40%	4.8	60%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	5	ICF	Permanent Housing		IST	M	Single	28.6	1: 5.8	4.9	1.1	22%	3.8	78%	1: 6.5	4.4	1.3	30%	3.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	11	ICF	Permanent Housing		IST	M	Single	29.9	1: 6.8	4.4	1.2	27%	3.2	73%	1: 6.5	4.6	1.4	30%	3.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	20	ICF	Permanent Housing		IST	M	Single	31.1	1: 5.9	5.3	1.3	25%	4.0	75%	1: 6.5	4.8	1.4	30%	3.3	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	21	ICF	Permanent Housing		IST	M	Single	31.3	1: 7.0	4.5	1.2	27%	3.3	73%	1: 6.5	4.8	1.4	30%	3.4	70%
										120.9		19.1	4.8		14.3			18.6	5.6		13.0	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	3 <sup>3</sup>	ICF	Permanent Housing		MDO	M	Mixed	14.8	1: 3.4	4.3	1.0	23%	3.3	77%	1: 5.0	3.0	0.9	30%	2.1	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	9	ICF	Permanent Housing		MDO	M	Mixed	38.9	1: 6.8	5.7	1.2	21%	4.5	79%	1: 5.0	7.8	2.3	30%	5.4	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	6	10	ICF	Permanent Housing		MDO	M	Single	29.0	1: 5.8	5.0	1.4	28%	3.6	72%	1: 5.0	5.8	1.7	30%	4.1	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	3	14 <sup>3</sup>	ICF	Permanent Housing		MDO	M	Single	36.1	1: 7.7	4.7	1.0	21%	3.7	79%	1: 5.0	7.2	2.2	30%	5.1	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	3	15	ICF	Permanent Housing		MDO	M	Single	30.8	1: 5.5	5.6	1.1	20%	4.5	80%	1: 5.0	6.2	1.8	30%	4.3	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	27 <sup>4,5</sup>	ICF	Permanent Housing		MDO	M	Mixed	40	1: 7.0	5.7	1.8	32%	3.9	68%	1: 5.0	8.0	2.4	30%	5.6	70%
										189.6		31.0	7.5		23.5			37.9	11.4		26.5	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	3	16	ICF	Permanent Housing		MDO	M	Dorm	42.6	1: 7.7	5.5	1.4	25%	4.1	75%	1: 6.5	6.6	2.0	30%	4.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	3	17	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 8.6	5.0	1.1	22%	3.9	78%	1: 6.5	6.6	2.0	30%	4.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	6	18	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 7.5	5.7	1.4	25%	4.3	75%	1: 6.5	6.6	2.0	30%	4.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	6	19	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 8.4	5.1	1.4	27%	3.7	73%	1: 6.5	6.6	2.0	30%	4.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	25	ICF	Permanent Housing		MDO, NGI	M	Dorm	41.7	1: 8.9	4.7	1.3	28%	3.4	72%	1: 6.5	6.4	1.9	30%	4.5	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	26	ICF	Permanent Housing		MDO	M	Dorm	42.5	1: 9.7	4.4	1.1	25%	3.3	75%	1: 6.5	6.5	2.0	30%	4.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	29	ICF	Permanent Housing		MDO, NGI	M	Dorm	44.8	1: 7.9	5.7	1.6	28%	4.1	72%	1: 6.5	6.9	2.1	30%	4.8	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	30	ICF	Permanent Housing		MDO, NGI	M	Dorm	45.2	1: 8.9	5.1	1.3	25%	3.8	75%	1: 6.5	7.0	2.1	30%	4.9	70%
										345.2		41.2	10.6		30.6			53.1	15.9		37.2	
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	3	7	ICF	Permanent Housing		MDO, NGI	M	Single	31.9	1: 5.8	5.5	1.3	24%	4.2	76%	1: 6.5	4.9	1.5	30%	3.4	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	7	22	ICF	Permanent Housing		MDO, NGI	M	Single	33.9	1: 6.8	5.0	1.4	28%	3.6	72%	1: 6.5	5.2	1.6	30%	3.7	70%
										65.8		10.5	2.7		7.8			10.1	3.0		7.1	
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	2	ICF	Permanent Housing		CDCR/MDO	M	Single	31.6	1: 7.2	4.4	1.3	30%	3.1	70%	1: 8.0	4.0	1.2	30%	2.8	70%
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	31	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.0	1: 7.4	6.1	1.3	21%	4.8	79%	1: 8.0	5.6	1.7	30%	3.9	70%
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	33	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.1	1: 8.5	5.3	1.2	23%	4.1	77%	1: 8.0	5.6	1.7	30%	3.9	70%
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	34	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.3	1: 8.4	5.4	1.3	24%	4.1	76%	1: 8.0	5.7	1.7	30%	4.0	70%
										167		21.2	5.1		16.1			20.9	6.3		14.6	
CDCR Treatment	CDCR Permanent Housing	5	28 <sup>5,6</sup>	ICF	Permanent Housing		CDCR	M	Mixed	40	1: 8.2	4.9	1.6	33%	3.3	67%	1: 6.0	6.7	2.0	30%	4.7	70%
CDCR Treatment	CDCR Permanent Housing	5	32	ICF	Permanent Housing		CDCR	M	Dorm	45.0	1: 8.7	5.2	1.3	25%	3.9	75%	1: 6.0	7.5	2.3	30%	5.3	70%
										85.0		10.1	2.9		7.2			14.2	4.3		9.9	
										1150.3	180.1		47.5	132.6			201.1		62.9	138.2		
										1369.5	224.8		61.3	163.5			247.4		79.3	168.0		

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> Unit 3 and 14 are outliers and were not included in ratio averages.

<sup>4</sup> Unit 27 - Staff delivered was derived from an average of two years (not 6 months); it was used as swing space during PDAS installation; applied system-wide grouping that is applicable as of completion of PDAS installation (was previously an acute ac

<sup>5</sup> Unit 27 and 28 are not included in ratio averages since their function changed while being used for PDAS swing space.

<sup>6</sup> Unit 28 - Staff delivered was derived from an average of two years (not 6 months); it was used as swing space during PDAS installation; applied system-wide grouping that is applicable as of completion of PDAS installation.

Data only includes units with staffing allocations during the data collection time period.

- Unit 24 - closed at time of data collection.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Atascadero																						
Unit Characteristics											NOC Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)	
Admissions	PC Standard Admissions	3	6	Acute	Admissions		MDO	M	Single	30.0	1: 8.6	3.5	0.9	26%	2.6	74%	1: 8.0	3.8	1.1	30%	2.6	70%
Admissions	PC Standard Admissions	6	8	Acute	Admissions		MDO	M	Single	28.5	1: 8.1	3.5	1.1	31%	2.4	69%	1: 8.0	3.6	1.1	30%	2.5	70%
Admissions	PC Standard Admissions	1	12	Acute	Admissions		IST	M	Single	27.9	1: 6.2	4.5	1.6	36%	2.9	64%	1: 8.0	3.5	1.0	30%	2.4	70%
Admissions	PC Standard Admissions	5	13	Acute	Admissions		CDCR/MDO	M	Single	29.9	1: 9.3	3.2	1.2	38%	2.0	63%	1: 8.0	3.7	1.1	30%	2.6	70%
Admissions	PC Standard Admissions	7	23	Acute	Admissions		MDO	M	Single	30.8	1: 9.3	3.3	0.9	27%	2.4	73%	1: 8.0	3.9	1.2	30%	2.7	70%
										147.1		18.0	5.7		12.3			18.4	5.5		12.9	
Medical Treatment	Medical Units	6	1	Acute	Specialized Svcs	Infirmary	All	M	Single	17.7	1: 3.4	5.2	2.1	40%	3.1	60%	1: 2.5	7.1	3.5	50%	3.5	50%
Specialized Services Treatment	High Aggression/ETU	6	4	Acute	Specialized Svcs	ETU	All	M	Single	12.0	1: 2.7	4.4	1.1	25%	3.3	75%	1: 3.0	4.0	1.6	40%	2.4	60%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	5	ICF	Permanent Housing		IST	M	Single	28.6	1: 9.2	3.1	0.8	26%	2.3	74%	1: 9.5	3.0	0.9	30%	2.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	11	ICF	Permanent Housing		IST	M	Single	29.9	1: 9.3	3.2	0.5	16%	2.7	84%	1: 9.5	3.1	0.9	30%	2.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	20	ICF	Permanent Housing		IST	M	Single	31.1	1: 9.4	3.3	0.9	27%	2.4	73%	1: 9.5	3.3	1.0	30%	2.3	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Single	1	21	ICF	Permanent Housing		IST	M	Single	31.3	1: 10.8	2.9	0.9	31%	2.0	69%	1: 9.5	3.3	1.0	30%	2.3	70%
										120.9		12.5	3.1		9.4			12.7	3.8		8.9	
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	3 <sup>3</sup>	ICF	Permanent Housing		MDO	M	Mixed	14.8	1: 5.5	2.7	0.6	22%	2.1	78%	1: 10.0	1.5	0.4	30%	1.0	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	9	ICF	Permanent Housing		MDO	M	Mixed	38.9	1: 10.5	3.7	1.0	27%	2.7	73%	1: 10.0	3.9	1.2	30%	2.7	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	6	10	ICF	Permanent Housing		MDO	M	Single	29.0	1: 9.4	3.1	1.0	32%	2.1	68%	1: 10.0	2.9	0.9	30%	2.0	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	3	14 <sup>3</sup>	ICF	Permanent Housing		MDO	M	Single	36.1	1: 11.3	3.2	0.8	25%	2.4	75%	1: 10.0	3.6	1.1	30%	2.5	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	3	15	ICF	Permanent Housing		MDO	M	Single	30.8	1: 7.2	4.3	1.1	26%	3.2	74%	1: 10.0	3.1	0.9	30%	2.2	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single & Mixed	1	27 <sup>4,5</sup>	ICF	Permanent Housing		MDO	M	Mixed	40	1: 12.5	3.2	1.4	44%	1.8	56%	1: 10.0	4.0	1.2	30%	2.8	70%
										189.6		20.2	5.9		14.3			19.0	5.7		13.3	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	3	16	ICF	Permanent Housing		MDO	M	Dorm	42.6	1: 12.9	3.3	0.7	21%	2.6	79%	1: 11.5	3.7	1.1	30%	2.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	3	17	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 14.3	3.0	0.8	27%	2.2	73%	1: 11.5	3.7	1.1	30%	2.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	6	18	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 12.6	3.4	0.6	18%	2.8	82%	1: 11.5	3.7	1.1	30%	2.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	6	19	ICF	Permanent Housing		MDO	M	Dorm	42.8	1: 13.4	3.2	0.5	16%	2.7	84%	1: 11.5	3.7	1.1	30%	2.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	25	ICF	Permanent Housing		MDO, NGI	M	Dorm	41.7	1: 11.9	3.5	1.0	29%	2.5	71%	1: 11.5	3.6	1.1	30%	2.5	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	26	ICF	Permanent Housing		MDO	M	Dorm	42.5	1: 12.9	3.3	1.0	30%	2.3	70%	1: 11.5	3.7	1.1	30%	2.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	29	ICF	Permanent Housing		MDO, NGI	M	Dorm	44.8	1: 14.9	3.0	1.0	33%	2.0	67%	1: 11.5	3.9	1.2	30%	2.7	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm & Mixed	7	30	ICF	Permanent Housing		MDO, NGI	M	Dorm	45.2	1: 16.7	2.7	0.4	15%	2.3	85%	1: 11.5	3.9	1.2	30%	2.8	70%
										345.2		25.4	6.0		19.4			30.0	9.0		21.0	
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	3	7	ICF	Permanent Housing		MDO, NGI	M	Single	31.9	1: 10.6	3.0	0.8	27%	2.2	73%	1: 10.5	3.0	0.9	30%	2.1	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	7	22	ICF	Permanent Housing		MDO, NGI	M	Single	33.9	1: 10.6	3.2	0.4	13%	2.8	88%	1: 10.5	3.2	1.0	30%	2.3	70%
										65.8		6.2	1.2		5.0			6.3	1.9		4.4	
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	2	ICF	Permanent Housing		CDCR/MDO	M	Single	31.6	1: 9.9	3.2	0.9	28%	2.3	72%	1: 12.5	2.5	0.8	30%	1.8	70%
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	31	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.0	1: 12.5	3.6	1.2	33%	2.4	67%	1: 12.5	3.6	1.1	30%	2.5	70%
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	33	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.1	1: 13.7	3.3	0.7	21%	2.6	79%	1: 12.5	3.6	1.1	30%	2.5	70%
Multi-Commitment Treatment	CDCR and MDO Permanent Housing	5	34	ICF	Permanent Housing		CDCR/MDO	M	Dorm	45.3	1: 13.7	3.3	0.9	27%	2.4	73%	1: 12.5	3.6	1.1	30%	2.5	70%
										167		13.4	3.7		9.7			13.4	4.0		9.4	
CDCR Treatment	CDCR Permanent Housing	5	28 <sup>5,6</sup>	ICF	Permanent Housing		CDCR	M	Mixed	40	1: 12.1	3.3	1.4	42%	1.9	58%	1: 11.5	3.5	1.0	30%	2.4	70%
CDCR Treatment	CDCR Permanent Housing	5	32	ICF	Permanent Housing		CDCR	M	Dorm	45.0	1: 15.5	2.9	0.8	28%	2.1	72%	1: 11.5	3.9	1.2	30%	2.7	70%
										85.0		6.2	2.2		4.0			7.4	2.2		5.2	
										1150.3		111.5	31.0		80.5			118.2	37.3		80.9	
										1369.5		139.7	39.4		100.3			146.5	47.6		98.9	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> Unit 3 and 14 are outliers and were not included in ratio averages.

<sup>4</sup> Unit 27 - Staff delivered was derived from an average of two years (not 6 months); it was used as swing space during PDAS installation; applied system-wide grouping that is applicable as of completion of PDAS installation (was previously an acute ac

<sup>5</sup> Unit 27 and 28 are not included in ratio averages since their function changed while being used for PDAS swing space.

<sup>6</sup> Unit 28 - Staff delivered was derived from an average of two years (not 6 months); it was used as swing space during PDAS installation; applied system-wide grouping that is applicable as of completion of PDAS installation.

Data only includes units with staffing allocations during the data collection time period.

- Unit 24 - closed at time of data collection.



DSH-Coalinga																						
Unit Characteristics											AM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census <sup>3</sup> (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)	
Admissions	PC Standard Admissions	3	5	ICF	Admissions	Admission to 57 days	SVP	M	Mixed	34.0	1: 4.0	8.5	1.7	20%	6.8	80%	1: 4.5	7.6	2.3	30%	5.3	70%
Medical Treatment	Medical Units	1	MA-1	Acute	Specialized Svcs	Medical Unit: Long Term	SVP/MDO	M	Single	12.0	1: 1.8	6.7	2.7	40%	4.0	60%	1: 2.0	6.0	3.0	50%	3.0	50%
Medical Treatment	Medical Units	1	MA-2	Acute	Specialized Svcs	Medical Unit: Short Term	SVP/MDO	M	Single	9.0	1: 1.6	5.7	2.6	46%	3.1	54%	1: 2.0	4.5	2.3	50%	2.3	50%
										21.0			12.4	5.3		7.1			10.5	5.3		5.3
Specialized Services Treatment	PC Geropsych	3	6	ICF	Specialized Svcs	Geropsych	SVP	M	Mixed	49.0	1: 4.5	10.8	1.7	16%	9.1	84%	1: 5.0	9.8	2.9	30%	6.9	70%
Specialized Services Treatment	High Aggression/ETU	4	9	ICF	Specialized Svcs	Aggression Unit	SVP	M	Mixed	16.0	1: 1.8	8.7	1.0	11%	7.7	89%	1: 1.5	10.7	4.3	40%	6.4	60%
Specialized Services Treatment	PC Specialized Services: High Behavior Acuity	6	17	ICF	Specialized Svcs	Psychiatric	SVP	M	Mixed	40.0	1: 3.7	10.8	1.7	16%	9.1	84%	1: 4.5	8.9	2.7	30%	6.2	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	22	ICF			MDO	M	Mixed	40.0	1: 4.4	9.0	1.7	19%	7.3	81%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	23	ICF			MDO	M	Mixed	40.0	1: 4.3	9.2	1.7	18%	7.5	82%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	25	ICF			MDO	M	Mixed	40.0	1: 4.3	9.3	1.7	18%	7.6	82%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	26	ICF			MDO	M	Mixed	40.0	1: 4.5	8.8	1.7	19%	7.1	81%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	27	ICF			MDO	M	Mixed	40.0	1: 4.8	8.3	1.7	20%	6.6	80%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	28	ICF			MDO	M	Mixed	40.0	1: 4.7	8.6	1.7	20%	6.9	80%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	24 <sup>4</sup>	ICF			MDO	M	Mixed	40.0	1: 4.8	8.3	1.5	18%	6.8	82%	1: 5.0	8.0	2.4	30%	5.6	70%
										280.0			61.5	11.7	49.8			56.0	16.8		39.2	
CDCR Treatment	CDCR Permanent Housing	7	21	ICF	Specialized Svcs	CDCR	CDCR	M	Mixed	46.0	1: 4.1	11.2	1.7	15%	9.5	85%	1: 5.5	8.4	2.5	30%	5.9	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	2	1	ICF			SVP	M	Mixed	49.0	1: 5.8	8.4	1.7	20%	6.7	80%	1: 6.0	8.2	2.5	30%	5.7	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	2	2	ICF			SVP	M	Mixed	49.0	1: 6.0	8.2	1.7	21%	6.5	79%	1: 6.0	8.2	2.5	30%	5.7	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	3	8	ICF			SVP	M	Mixed	48.0	1: 5.9	8.2	1.7	21%	6.5	79%	1: 6.0	8.0	2.4	30%	5.6	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	13	ICF			SVP	M	Mixed	49.0	1: 5.3	9.2	1.7	18%	7.5	82%	1: 6.0	8.2	2.5	30%	5.7	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	14	ICF			SVP	M	Mixed	48.0	1: 5.8	8.3	1.7	20%	6.6	80%	1: 6.0	8.0	2.4	30%	5.6	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	16	ICF			SVP	M	Mixed	48.0	1: 5.6	8.5	1.7	20%	6.8	80%	1: 6.0	8.0	2.4	30%	5.6	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	6	18	ICF			SVP	M	Mixed	49.0	1: 6.0	8.2	1.7	21%	6.5	79%	1: 6.0	8.2	2.5	30%	5.7	70%
										340.0			59.0	11.9	47.1			56.7	17.0		39.7	
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	2	3	RRU			SVP	M	Mixed	50.0	1: 12.5	4.0	1.3	33%	2.7	68%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	2	4	RRU			SVP	M	Mixed	50.0	1: 13.2	3.8	1.3	34%	2.5	66%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	3	7	RRU			SVP	M	Mixed	50.0	1: 14.3	3.5	1.0	29%	2.5	71%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	11	RRU			SVP	M	Mixed	50.0	1: 12.8	3.9	1.3	33%	2.6	67%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	12	RRU			SVP	M	Mixed	50.0	1: 12.5	4.0	1.3	33%	2.7	68%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	5	15	RRU			SVP	M	Mixed	50.0	1: 14.3	3.5	0.9	26%	2.6	74%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	6	19	RRU			SVP	M	Mixed	50.0	1: 13.2	3.8	1.0	26%	2.8	74%	1: 13.0	3.8	1.2	30%	2.7	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	10 <sup>5</sup>	RRU		ICF level of care	SVP	M	Mixed	48.0	1: 9.2	5.2	1.6	31%	3.6	69%	1: 6.0	8.0	2.4	30%	5.6	70%
										398.0			31.7	9.7	22.0			34.9	10.5		24.4	
										1224.0			214.6	46.4	168.2			203.4	64.2		139.2	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: December 2014 - May 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The census for the residential recovery and MDO units were based on full capacity and not a 6 month average.

<sup>4</sup> Unit 24 was activated in March 2015; staff delivered is an average of April & May data; only included in sum of staff delivered, not in grouping's average ratio since it is only based on two months of data.

<sup>5</sup> Unit 10 is an RRU that operates closer to an ICF level of care. It is an outlier and not included in the ratio averages.

Data only includes units with staffing allocations during the data collection time period.

- Unit 20 was not activated until June 2015; there was no staff delivered data for this unit.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Coalinga																						
Unit Characteristics											PM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census <sup>3</sup> (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)	
Admissions	PC Standard Admissions	3	5	ICF	Admissions	Admission to 57 days	SVP	M	Mixed	34.0	1: 4.4	7.7	1.4	18%	6.3	82%	1: 5.0	6.8	2.0	30%	4.8	70%
Medical Treatment	Medical Units	1	MA-1	Acute	Specialized Svcs	Medical Unit: Long Term	SVP/MDO	M	Single	12.0	1: 1.8	6.5	2.4	37%	4.1	63%	1: 2.0	6.0	3.0	50%	3.0	50%
Medical Treatment	Medical Units	1	MA-2	Acute	Specialized Svcs	Medical Unit: Short Term	SVP/MDO	M	Single	9.0	1: 1.9	4.7	2.2	47%	2.5	53%	1: 2.0	4.5	2.3	50%	2.3	50%
										21.0			11.2	4.6		6.6			10.5	5.3		5.3
Specialized Services Treatment	PC Geropsych	3	6	ICF	Specialized Svcs	Geropsych	SVP	M	Mixed	49.0	1: 5.1	9.7	1.3	13%	8.4	87%	1: 5.5	8.9	2.7	30%	6.2	70%
Specialized Services Treatment	High Aggression/ETU	4	9	ICF	Specialized Svcs	Aggression Unit	SVP	M	Mixed	16.0	1: 2.1	7.6	0.8	11%	6.8	89%	1: 1.5	10.7	4.3	40%	6.4	60%
Specialized Services Treatment	PC Specialized Services: High Behavior Acuity	6	17	ICF	Specialized Svcs	Psychiatric	SVP	M	Mixed	40.0	1: 4.0	10.0	1.4	14%	8.6	86%	1: 4.5	8.9	2.7	30%	6.2	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	22	ICF			MDO	M	Mixed	40.0	1: 4.9	8.1	1.4	17%	6.7	83%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	23	ICF			MDO	M	Mixed	40.0	1: 4.9	8.2	1.3	16%	6.9	84%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	25	ICF			MDO	M	Mixed	40.0	1: 4.5	8.8	1.4	16%	7.4	84%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	26	ICF			MDO	M	Mixed	40.0	1: 4.9	8.1	1.4	17%	6.7	83%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	27	ICF			MDO	M	Mixed	40.0	1: 5.1	7.9	1.4	18%	6.5	82%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	28	ICF			MDO	M	Mixed	40.0	1: 5.0	8.0	1.4	18%	6.6	83%	1: 5.0	8.0	2.4	30%	5.6	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	24 <sup>4</sup>	ICF			MDO	M	Mixed	40.0	1: 5.4	7.4	1.3	18%	6.1	82%	1: 5.0	8.0	2.4	30%	5.6	70%
										280.0			56.5	9.6	46.9			56.0	16.8		39.2	
CDCR Treatment	CDCR Permanent Housing	7	21	ICF	Specialized Svcs	CDCR	CDCR	M	Mixed	46.0	1: 4.6	10.1	1.4	14%	8.7	86%	1: 6.0	7.7	2.3	30%	5.4	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	2	1	ICF			SVP	M	Mixed	49.0	1: 6.4	7.6	1.2	16%	6.4	84%	1: 6.5	7.5	2.3	30%	5.3	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	2	2	ICF			SVP	M	Mixed	49.0	1: 6.7	7.3	1.2	16%	6.1	84%	1: 6.5	7.5	2.3	30%	5.3	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	3	8	ICF			SVP	M	Mixed	48.0	1: 6.4	7.5	1.3	17%	6.2	83%	1: 6.5	7.4	2.2	30%	5.2	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	13	ICF			SVP	M	Mixed	49.0	1: 5.8	8.5	1.4	16%	7.1	84%	1: 6.5	7.5	2.3	30%	5.3	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	14	ICF			SVP	M	Mixed	48.0	1: 6.3	7.6	1.3	17%	6.3	83%	1: 6.5	7.4	2.2	30%	5.2	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	16	ICF			SVP	M	Mixed	48.0	1: 6.3	7.6	1.3	17%	6.3	83%	1: 6.5	7.4	2.2	30%	5.2	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	6	18	ICF			SVP	M	Mixed	49.0	1: 6.7	7.3	1.3	18%	6.0	82%	1: 6.5	7.5	2.3	30%	5.3	70%
										340.0			53.4	9.0	44.4			52.3	15.7		36.6	
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	2	3	RRU			SVP	M	Mixed	50.0	1: 17.2	2.9	0.9	31%	2.0	69%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	2	4	RRU			SVP	M	Mixed	50.0	1: 17.2	2.9	0.9	31%	2.0	69%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	3	7	RRU			SVP	M	Mixed	50.0	1: 17.9	2.8	0.8	29%	2.0	71%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	11	RRU			SVP	M	Mixed	50.0	1: 16.1	3.1	1.0	32%	2.1	68%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	12	RRU			SVP	M	Mixed	50.0	1: 16.7	3.0	1.0	33%	2.0	67%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	5	15	RRU			SVP	M	Mixed	50.0	1: 17.2	2.9	0.8	28%	2.1	72%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	6	19	RRU			SVP	M	Mixed	50.0	1: 17.9	2.8	0.8	29%	2.0	71%	1: 17.0	2.9	0.9	30%	2.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	10 <sup>5</sup>	RRU		ICF level of care	SVP	M	Mixed	48.0	1: 11.2	4.3	1.2	28%	3.1	72%	1: 6.5	7.4	2.2	30%	5.2	70%
										398.0			24.7	7.4	17.3			28.0	8.4		19.6	
										1224.0			190.9	36.9	154.0			189.7	60.1		129.6	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: December 2014 - May 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The census for the residential recovery and MDO units were based on full capacity and not a 6 month average.

<sup>4</sup> Unit 24 was activated in March 2015; staff delivered is an average of April & May data; only included in sum of staff delivered, not in grouping's average ratio since it is only based on two months of data.

<sup>5</sup> Unit 10 is an RRU that operates closer to an ICF level of care. It is an outlier and not included in the ratio averages.

Data only includes units with staffing allocations during the data collection time period.

- Unit 20 was not activated until June 2015; there was no staff delivered data for this unit.

DSH-Coalinga																						
Unit Characteristics											NOC Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census <sup>3</sup> (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)	
Admissions	PC Standard Admissions	3	5	ICF	Admissions	Admission to 57 days	SVP	M	Mixed	34.0	1: 10.0	3.4	1.0	29%	2.4	71%	1: 8.0	4.3	1.3	30%	3.0	70%
Medical Treatment	Medical Units	1	MA-1	Acute	Specialized Svcs	Medical Unit: Long Term	SVP/MDO	M	Single	12.0	1: 2.1	5.8	2.2	38%	3.6	62%	1: 2.5	4.8	2.4	50%	2.4	50%
Medical Treatment	Medical Units	1	MA-2	Acute	Specialized Svcs	Medical Unit: Short Term	SVP/MDO	M	Single	9.0	1: 2.1	4.2	2.2	52%	2.0	48%	1: 2.5	3.6	1.8	50%	1.8	50%
										21.0			10.0	4.4		5.6			8.4	4.2		4.2
Specialized Services Treatment	PC Geropsych	3	6	ICF	Specialized Svcs	Geropsych	SVP	M	Mixed	49.0	1: 9.4	5.2	0.8	15%	4.4	85%	1: 10.0	4.9	1.5	30%	3.4	70%
Specialized Services Treatment	High Aggression/ETU	4	9	ICF	Specialized Svcs	Aggression Unit	SVP	M	Mixed	16.0	1: 3.3	4.8	0.7	15%	4.1	85%	1: 3.0	5.3	2.1	40%	3.2	60%
Specialized Services Treatment	PC Specialized Services: High Behavior Acuity	6	17	ICF	Specialized Svcs	Psychiatric	SVP	M	Mixed	40.0	1: 8.0	5.0	0.9	18%	4.1	82%	1: 7.5	5.3	1.6	30%	3.7	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	22	ICF			MDO	M	Mixed	40.0	1: 10.5	3.8	1.0	26%	2.8	74%	1: 10.0	4.0	1.2	30%	2.8	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	23	ICF			MDO	M	Mixed	40.0	1: 9.8	4.1	1.0	24%	3.1	76%	1: 10.0	4.0	1.2	30%	2.8	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	25	ICF			MDO	M	Mixed	40.0	1: 8.9	4.5	1.0	22%	3.5	78%	1: 10.0	4.0	1.2	30%	2.8	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	26	ICF			MDO	M	Mixed	40.0	1: 10.0	4.0	1.0	25%	3.0	75%	1: 10.0	4.0	1.2	30%	2.8	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	27	ICF			MDO	M	Mixed	40.0	1: 11.8	3.4	1.0	29%	2.4	71%	1: 10.0	4.0	1.2	30%	2.8	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	8	28	ICF			MDO	M	Mixed	40.0	1: 11.1	3.6	1.0	28%	2.6	72%	1: 10.0	4.0	1.2	30%	2.8	70%
Mentally Disordered Offender Treatment	MDO Permanent Housing-Single, Mixed	7	24 <sup>4</sup>	ICF			MDO	M	Mixed	40.0	1: 10.8	3.7	1.0	27%	2.7	73%	1: 10.0	4.0	1.2	30%	2.8	70%
										280.0			27.1	7.0		20.1			28.0	8.4		19.6
CDCR Treatment	CDCR Permanent Housing	7	21	ICF	Specialized Svcs	CDCR	CDCR	M	Mixed	46.0	1: 9.0	5.1	1.0	20%	4.1	80%	1: 11.5	4.0	1.2	30%	2.8	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	2	1	ICF			SVP	M	Mixed	49.0	1: 13.6	3.6	0.8	22%	2.8	78%	1: 13.5	3.6	1.1	30%	2.5	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	2	2	ICF			SVP	M	Mixed	49.0	1: 14.4	3.4	0.8	24%	2.6	76%	1: 13.5	3.6	1.1	30%	2.5	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	3	8	ICF			SVP	M	Mixed	48.0	1: 13.7	3.5	0.7	20%	2.8	80%	1: 13.5	3.6	1.1	30%	2.5	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	13	ICF			SVP	M	Mixed	49.0	1: 12.0	4.1	1.0	24%	3.1	76%	1: 13.5	3.6	1.1	30%	2.5	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	14	ICF			SVP	M	Mixed	48.0	1: 14.1	3.4	1.0	29%	2.4	71%	1: 13.5	3.6	1.1	30%	2.5	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	5	16	ICF			SVP	M	Mixed	48.0	1: 13.7	3.5	0.9	26%	2.6	74%	1: 13.5	3.6	1.1	30%	2.5	70%
Sexually Violent Predator Treatment	SVP Permanent Housing	6	18	ICF			SVP	M	Mixed	49.0	1: 14.8	3.3	0.9	27%	2.4	73%	1: 13.5	3.6	1.1	30%	2.5	70%
										340.0			24.8	6.1		18.7			25.2	7.6		17.6
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	2	3	RRU			SVP	M	Mixed	50.0	1: 33.3	1.5	0.5	33%	1.0	67%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	2	4	RRU			SVP	M	Mixed	50.0	1: 33.3	1.5	0.5	33%	1.0	67%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	3	7	RRU			SVP	M	Mixed	50.0	1: 33.3	1.5	0.5	33%	1.0	67%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	11	RRU			SVP	M	Mixed	50.0	1: 31.3	1.6	0.6	38%	1.0	63%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	12	RRU			SVP	M	Mixed	50.0	1: 29.4	1.7	0.6	35%	1.1	65%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	5	15	RRU			SVP	M	Mixed	50.0	1: 33.3	1.5	0.5	33%	1.0	67%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	6	19	RRU			SVP	M	Mixed	50.0	1: 33.3	1.5	0.5	33%	1.0	67%	1: 32.5	1.5	0.5	30%	1.1	70%
Sexually Violent Predator Treatment	SVP Residential Recovery Unit	4	10 <sup>5</sup>	RRU		ICF level of care	SVP	M	Mixed	48.0	1: 13.7	3.5	0.6	17%	2.9	83%	1: 13.5	3.6	1.1	30%	2.5	70%
										398.0			14.3	4.3		10.0			14.3	4.3		10.0
										1224.0			99.7	26.2		73.5			99.7	32.1		67.6

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: December 2014 - May 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The census for the residential recovery and MDO units were based on full capacity and not a 6 month average.

<sup>4</sup> Unit 24 was activated in March 2015; staff delivered is an average of April & May data; only included in sum of staff delivered, not in grouping's average ratio since it is only based on two months of data.

<sup>5</sup> Unit 10 is an RRU that operates closer to an ICF level of care. It is an outlier and not included in the ratio averages.

Data only includes units with staffing allocations during the data collection time period.

- Unit 20 was not activated until June 2015; there was no staff delivered data for this unit.

DSH-Metropolitan																						
Unit Characteristics											AM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)		Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>3</sup> (Projected)	
Medical Treatment	Skilled Nursing Facility	6	417	SNF	SNF Certified	CMS	Any	Co-Ed	Dorm	27.1	1: 2.5	11.0	5.5	50%	5.5	50%	1: 2.5	10.8	5.4	50%	5.4	50%
Medical Treatment	Skilled Nursing Facility	6	419	SNF	SNF Certified	CMS	Any	Co-Ed	Dorm	29.2	1: 2.7	11.0	5.5	50%	5.5	50%	1: 2.5	11.7	5.8	50%	5.8	50%
										56.3		22.0	11.0		11.0			22.5	11.3		11.3	
Specialized Services Treatment	LPS Specialized Services	2	408	Acute	Permanent Housing	Pre-DBT with some medically fragile	LPS	Co-Ed	Dorm	45.5	1: 3.8	12.0	3.6	30%	8.4	70%	1: 3.0	15.2	4.6	30%	10.6	70%
Specialized Services Treatment	LPS Specialized Services	4	410	Acute Certified	Permanent Housing	Acute Psychiatric (CMS Certified)	LPS	Co-Ed	Dorm	41.2	1: 3.4	12.0	3.6	30%	8.4	70%	1: 3.0	13.7	4.1	30%	9.6	70%
Specialized Services Treatment	LPS Specialized Services	4	416	Acute	Permanent Housing	DBT Unit	LPS	Co-Ed	Dorm	17.6	1: 2.9	6.0	1.8	30%	4.2	70%	1: 3.0	5.9	1.8	30%	4.1	70%
										104.3		30.0	9.0		21.0			34.8	10.4		24.3	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	3	401	Acute	Permanent Housing	All IST	IST	M	Dorm	52.7	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.8	2.6	30%	6.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	403	Acute	Permanent Housing	Majority IST	IST	F	Dorm	53.3	1: 5.3	10.0	3.0	30%	7.0	70%	1: 6.0	8.9	2.7	30%	6.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	405	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.8	1: 6.6	8.0	2.4	30%	5.6	70%	1: 6.0	8.8	2.6	30%	6.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	411 <sup>4</sup>	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.1	1: 6.5	8.0	2.4	30%	5.6	70%	1: 6.0	8.7	2.6	30%	6.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	413 <sup>4</sup>	Acute	Permanent Housing	Majority IST	IST	M	Dorm	51.9	1: 6.5	8.0	2.4	30%	5.6	70%	1: 6.0	8.7	2.6	30%	6.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	3	415	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.0	1: 5.8	9.0	2.7	30%	6.3	70%	1: 6.0	8.7	2.6	30%	6.1	70%
										314.8		52.0	15.6		36.4			52.5	15.7		36.7	
Multi- Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	407	Acute	Permanent Housing	Long- Term PC	NGI/MDO	M	Dorm	53.5	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.9	2.7	30%	6.2	70%
Multi- Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	409	Acute	Permanent Housing	Long- Term PC	NGI/MDO	M	Dorm	53.1	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.9	2.7	30%	6.2	70%
										106.6		18.0	5.4		12.6			17.8	5.3		12.4	
Lanterman-Petris-Short Treatment	LPS Permanent Housing	2	412	Acute	Permanent Housing		LPS	Co-Ed	Dorm	44.1	1: 4.4	10.0	3.0	30%	7.0	70%	1: 5.0	8.8	2.6	30%	6.2	70%
Lanterman-Petris-Short Treatment	LPS Permanent Housing	2	414	Acute	Permanent Housing		LPS	M	Dorm	45.6	1: 5.1	9.0	2.7	30%	6.3	70%	1: 5.0	9.1	2.7	30%	6.4	70%
										89.7		19.0	5.7		13.3			17.9	5.4		12.6	
Discharge Preparation Units	Discharge Ready	2	402	Acute	Permanent Housing	Discharge ready	LPS	Co-Ed	Dorm	33.3	1: 6.7	5.0	1.5	30%	3.5	70%	1: 6.0	5.6	1.7	30%	3.9	70%
										705.0		146.0	48.2		97.8			151.0	49.8		101.2	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The percentage split for RNs and PTs is projected and not based on actual staff delivered since Metro's Daily Staffing Sheets do not breakout staff delivered by classification.

<sup>4</sup> Unit 411 is an outlier in regards to its NOC ratio and Unit 413 is an outlier in regards to its PM ratio; units were not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period.

- Unit 406 (acute), Unit 420 (acute), and Unit 418 (SNF) - closed at time of data collection.
- Unit 404 is not accounted for in this report since it was activated in July 2015; which is not within the data collection time period.

DSH-Metropolitan																						
Unit Characteristics											PM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)		Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>3</sup> (Projected)	
Medical Treatment	Skilled Nursing Facility	6	417	SNF	SNF Certified	CMS	Any	Co-Ed	Dorm	27.1	1: 2.7	10.0	5.0	50%	5.0	50%	1: 2.5	10.8	5.4	50%	5.4	50%
Medical Treatment	Skilled Nursing Facility	6	419	SNF	SNF Certified	CMS	Any	Co-Ed	Dorm	29.2	1: 2.7	11.0	5.5	50%	5.5	50%	1: 2.5	11.7	5.8	50%	5.8	50%
										56.3		21.0	10.5		10.5			22.5	11.3		11.3	
Specialized Services Treatment	LPS Specialized Services	2	408	Acute	Permanent Housing	Pre-DBT with some medically fragile	LPS	Co-Ed	Dorm	45.5	1: 3.5	13.0	3.9	30%	9.1	70%	1: 3.0	15.2	4.6	30%	10.6	70%
Specialized Services Treatment	LPS Specialized Services	4	410	Acute Certified	Permanent Housing	Acute Psychiatric (CMS Certified)	LPS	Co-Ed	Dorm	41.2	1: 3.2	13.0	3.9	30%	9.1	70%	1: 3.0	13.7	4.1	30%	9.6	70%
Specialized Services Treatment	LPS Specialized Services	4	416	Acute	Permanent Housing	DBT Unit	LPS	Co-Ed	Dorm	17.6	1: 2.9	6.0	1.8	30%	4.2	70%	1: 3.0	5.9	1.8	30%	4.1	70%
										104.3		32.0	9.6		22.4			34.8	10.4		24.3	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	3	401	Acute	Permanent Housing	All IST	IST	M	Dorm	52.7	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.8	2.6	30%	6.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	403	Acute	Permanent Housing	Majority IST	IST	F	Dorm	53.3	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.9	2.7	30%	6.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	405	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.8	1: 6.6	8.0	2.4	30%	5.6	70%	1: 6.0	8.8	2.6	30%	6.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	411 <sup>4</sup>	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.1	1: 5.8	9.0	2.7	30%	6.3	70%	1: 6.0	8.7	2.6	30%	6.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	413 <sup>4</sup>	Acute	Permanent Housing	Majority IST	IST	M	Dorm	51.9	1: 4.3	12.0	3.6	30%	8.4	70%	1: 6.0	8.7	2.6	30%	6.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	3	415	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.0	1: 5.8	9.0	2.7	30%	6.3	70%	1: 6.0	8.7	2.6	30%	6.1	70%
										314.8		56.0	16.8		39.2			52.5	15.7		36.7	
Multi- Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	407	Acute	Permanent Housing	Long- Term PC	NGI/MDO M		Dorm	53.5	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.9	2.7	30%	6.2	70%
Multi- Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	409	Acute	Permanent Housing	Long- Term PC	NGI/MDO M		Dorm	53.1	1: 5.9	9.0	2.7	30%	6.3	70%	1: 6.0	8.9	2.7	30%	6.2	70%
										106.6		18.0	5.4		12.6			17.8	5.3		12.4	
Lanterman-Petris-Short Treatment	LPS Permanent Housing	2	412	Acute	Permanent Housing		LPS	Co-Ed	Dorm	44.1	1: 4.4	10.0	3.0	30%	7.0	70%	1: 5.0	8.8	2.6	30%	6.2	70%
Lanterman-Petris-Short Treatment	LPS Permanent Housing	2	414	Acute	Permanent Housing		LPS	M	Dorm	45.6	1: 5.1	9.0	2.7	30%	6.3	70%	1: 5.0	9.1	2.7	30%	6.4	70%
										89.7		19.0	5.7		13.3			17.9	5.4		12.6	
Discharge Preparation Units	Discharge Ready	2	402	Acute	Permanent Housing	Discharge ready	LPS	Co-Ed	Dorm	33.3	1: 6.7	5.0	1.5	30%	3.5	70%	1: 6.0	5.6	1.7	30%	3.9	70%
										705.0		151.0	49.5		101.5			151.0	49.8		101.2	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The percentage split for RNs and PTs is projected and not based on actual staff delivered since Metro's Daily Staffing Sheets do not breakout staff delivered by classification.

<sup>4</sup> Unit 411 is an outlier in regards to its NOC ratio and Unit 413 is an outlier in regards to its PM ratio; units were not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period.

- Unit 406 (acute), Unit 420 (acute), and Unit 418 (SNF) - closed at time of data collection.
- Unit 404 is not accounted for in this report since it was activated in July 2015; which is not within the data collection time period.



DSH-Metropolitan																						
Unit Characteristics											NOC Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)		Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>3</sup> (Projected)	
Medical Treatment	Skilled Nursing Facility	6	417	SNF	SNF Certified	CMS	Any	Co-Ed	Dorm	27.1	1: 4.5	6.0	3.0	50%	3.0	50%	1: 4.0	6.8	3.4	50%	3.4	50%
Medical Treatment	Skilled Nursing Facility	6	419	SNF	SNF Certified	CMS	Any	Co-Ed	Dorm	29.2	1: 4.2	7.0	3.5	50%	3.5	50%	1: 4.0	7.3	3.7	50%	3.7	50%
										56.3		13.0	6.5		6.5			14.1	7.0		7.0	
Specialized Services Treatment	LPS Specialized Services	2	408	Acute	Permanent Housing	Pre-DBT with some medically fragile	LPS	Co-Ed	Dorm	45.5	1: 5.7	8.0	2.4	30%	5.6	70%	1: 4.5	10.1	3.0	30%	7.1	70%
Specialized Services Treatment	LPS Specialized Services	4	410	Acute Certified	Permanent Housing	Acute Psychiatric (CMS Certified)	LPS	Co-Ed	Dorm	41.2	1: 6.9	6.0	1.8	30%	4.2	70%	1: 4.5	9.2	2.7	30%	6.4	70%
Specialized Services Treatment	LPS Specialized Services	4	416	Acute	Permanent Housing	DBT Unit	LPS	Co-Ed	Dorm	17.6	1: 2.9	6.0	1.8	30%	4.2	70%	1: 4.5	3.9	1.2	30%	2.7	70%
										104.3		20.0	6.0		14.0			23.2	7.0		16.2	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	3	401	Acute	Permanent Housing	All IST	IST	M	Dorm	52.7	1: 10.5	5.0	1.5	30%	3.5	70%	1: 12.0	4.4	1.3	30%	3.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	403	Acute	Permanent Housing	Majority IST	IST	F	Dorm	53.3	1: 13.3	4.0	1.2	30%	2.8	70%	1: 12.0	4.4	1.3	30%	3.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	405	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.8	1: 13.2	4.0	1.2	30%	2.8	70%	1: 12.0	4.4	1.3	30%	3.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	411 <sup>4</sup>	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.1	1: 17.4	3.0	0.9	30%	2.1	70%	1: 12.0	4.3	1.3	30%	3.0	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	5	413 <sup>4</sup>	Acute	Permanent Housing	Majority IST	IST	M	Dorm	51.9	1: 13.0	4.0	1.2	30%	2.8	70%	1: 12.0	4.3	1.3	30%	3.0	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm Mixed	3	415	Acute	Permanent Housing	Majority IST	IST	M	Dorm	52.0	1: 13.0	4.0	1.2	30%	2.8	70%	1: 12.0	4.3	1.3	30%	3.0	70%
										314.8		24.0	7.2		16.8			26.2	7.9		18.4	
Multi- Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	407	Acute	Permanent Housing	Long- Term PC	NGI/MDO M		Dorm	53.5	1: 13.4	4.0	1.2	30%	2.8	70%	1: 11.5	4.7	1.4	30%	3.3	70%
Multi- Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	409	Acute	Permanent Housing	Long- Term PC	NGI/MDO M		Dorm	53.1	1: 13.3	4.0	1.2	30%	2.8	70%	1: 11.5	4.6	1.4	30%	3.2	70%
										106.6		8.0	2.4		5.6			9.3	2.8		6.5	
Lanterman-Petris-Short Treatment	LPS Permanent Housing	2	412	Acute	Permanent Housing		LPS	Co-Ed	Dorm	44.1	1: 8.8	5.0	1.5	30%	3.5	70%	1: 9.0	4.9	1.5	30%	3.4	70%
Lanterman-Petris-Short Treatment	LPS Permanent Housing	2	414	Acute	Permanent Housing		LPS	M	Dorm	45.6	1: 9.1	5.0	1.5	30%	3.5	70%	1: 9.0	5.1	1.5	30%	3.5	70%
										89.7		10.0	3.0		7.0			10.0	3.0		7.0	
Discharge Preparation Units	Discharge Ready	2	402	Acute	Permanent Housing	Discharge ready	LPS	Co-Ed	Dorm	33.3	1: 11.1	3.0	0.9	30%	2.1	70%	1: 12.0	2.8	0.8	30%	1.9	70%
										705.0		78.0	26.0		52.0			85.5	28.5		57.0	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The percentage split for RNs and PTs is projected and not based on actual staff delivered since Metro's Daily Staffing Sheets do not breakout staff delivered by classification.

<sup>4</sup> Unit 411 is an outlier in regards to its NOC ratio and Unit 413 is an outlier in regards to its PM ratio; units were not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period.

- Unit 406 (acute), Unit 420 (acute), and Unit 418 (SNF) - closed at time of data collection.
- Unit 404 is not accounted for in this report since it was activated in July 2015; which is not within the data collection time period.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Napa																						
Unit Characteristics											AM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)		Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)	
Admissions	PC Standard Admissions	2	T1 <sup>4</sup>	ICF	Admissions	1 Admit, unlikelys	IST	M	Dorm	17.3	1: 3.3	5.2	2.1	40%	3.1	60%	1: 4.5	3.8	1.2	30%	2.7	70%
Admissions	PC Standard Admissions	2	T2	ICF	Admissions	2 Admit	MDO, NGI, IST	F	Dorm	28.5	1: 4.8	5.9	2.4	40%	3.5	60%	1: 4.5	6.3	1.9	30%	4.4	70%
Admissions	PC Standard Admissions	5	T3	ICF	Admissions	2 Admit, 1:15	IST	M	Both	28.7	1: 4.9	5.9	2.4	40%	3.5	60%	1: 4.5	6.4	1.9	30%	4.5	70%
Admissions	PC Standard Admissions	5	T4	ICF	Admissions	2 Admit, 1:15	IST	M	Dorm	28.8	1: 5	5.8	2.3	40%	3.5	60%	1: 4.5	6.4	1.9	30%	4.5	70%
										103.3		22.8	9.2		13.6			23.0	6.9		16.1	
Admissions	LPS Admissions/ 5150s	4	A9	Acute Certified	Admissions	High behave acuity with 5150s.	LPS	Coed	Both	9.8	1: 2.1	4.7	1.9	40%	2.8	60%	1: 2.0	4.9	1.5	30%	3.4	70%
Admissions	Hybrid Admissions	5	Q5	ICF	Hybrid Admission	Q5 & Q6 Double Unit. IST admit 1:15	IST	M	Both	29.2	1: 5.3	5.5	2.2	40%	3.3	60%	1: 5.5	5.3	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	5	Q6	ICF	Hybrid Admission	Q5 & Q6 Double Unit. IST admit 1:15	IST	M	Both	28.9	1: 6.3	4.6	1.8	40%	2.8	60%	1: 5.5	5.3	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	5	Q7	ICF	Hybrid Admission	Q7 & Q8 Double Unit. IST admit 1:15	IST	M	Both	29.3	1: 5.1	5.8	2.3	40%	3.5	60%	1: 5.5	5.3	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	5	Q8	ICF	Hybrid Admission	Q7 & Q8 Double Unit. IST admit 1:15	IST	M	Both	29.6	1: 7.2	4.1	1.6	40%	2.5	60%	1: 5.5	5.4	1.6	30%	3.8	70%
Admissions	Hybrid Admissions	3	T13	ICF	Hybrid Admission	1 Admit, 1:15	MDO, NGI	M	Both	41.4	1: 6.1	6.8	2.7	40%	4.1	60%	1: 5.5	7.5	2.3	30%	5.3	70%
										158.4		26.8	10.6		16.2			28.8	8.6		20.2	
Medical Treatment	Medical Unit	4	A3	Acute Certified	Specialized Svcs	Acute Medical	Any Commitments	Coed	Both	6.5	1: 1.9	3.5	1.8	50%	1.8	50%	1: 2.0	3.3	1.6	50%	1.6	50%
Medical Treatment	Skilled Nursing Facility	4	A4	SNF Certified	SNF		Any excluding CDCR	Coed	Both	27.2	1: 2.4	11.2	5.6	50%	5.6	50%	1: 2.5	10.9	5.4	50%	5.4	50%
Specialized Services Treatment	PC Geropsych	2	Q1	ICF	Specialized Svcs-Q1 & Q2 Double Unit	Geropsych	Mixed	Coed	Both	32.6	1: 6	5.4	2.2	40%	3.2	60%	1: 5.0	6.5	2.0	30%	4.6	70%
Specialized Services Treatment	PC Geropsych	2	Q11	ICF	Specialized Svcs	Geropsych	MDO, NGI	M	Both	49.5	1: 4.6	10.7	4.3	40%	6.4	60%	1: 5.0	9.9	3.0	30%	6.9	70%
Specialized Services Treatment	PC Geropsych	2	Q2	ICF	Specialized Svcs-Q1 & Q2 Double Unit	Geropsych	Mixed	Coed	Both	34.6	1: 5.8	6.0	2.4	40%	3.6	60%	1: 5.0	6.9	2.1	30%	4.8	70%
Specialized Services Treatment	PC Geropsych	5	Q9	ICF	Specialized Svcs	Geropsych	IST	M	Dorm	48.9	1: 5.4	9.1	3.6	40%	5.5	60%	1: 5.0	9.8	2.9	30%	6.8	70%
										165.6		31.2	12.5		18.7			33.1	9.9		23.2	
Specialized Services Treatment	LPS Geropsych	4	A2	ICF	Specialized Svcs	Geropsych	LPS	Coed	Both	34.4	1: 4.5	7.7	3.1	40%	4.6	60%	1: 4.5	7.6	2.3	30%	5.4	70%
Specialized Services Treatment	PC Specialized Services	3	T12	ICF	Specialized Svcs	Substance recovery	MDO, NGI	M	Both	43.7	1: 5.9	7.4	3.0	40%	4.4	60%	1: 5.5	7.9	2.4	30%	5.6	70%
Specialized Services Treatment	PC Specialized Services	3	T14	ICF	Specialized Svcs	DBT Team	MDO, NGI	Coed	Both	40.5	1: 5.8	7.0	2.8	40%	4.2	60%	1: 5.5	7.4	2.2	30%	5.2	70%
Specialized Services Treatment	PC Specialized Services	1	T7	ICF	Specialized Svcs	Polydipsia	Mixed	M	Both	44.8	1: 5	9.0	3.6	40%	5.4	60%	1: 5.5	8.1	2.4	30%	5.7	70%
Specialized Services Treatment	PC Specialized Services	1	T8	ICF	Specialized Svcs	DBT Team	Mixed	M	Both	45.4	1: 5.7	8.0	3.2	40%	4.8	60%	1: 5.5	8.3	2.5	30%	5.8	70%
										174.4		31.4	12.6		18.8			31.7	9.5		22.2	
Specialized Services Treatment	LPS Specialized Services	4	A1	ICF	Specialized Svcs	DBT Unit	LPS	Coed	Dorm	29.9	1: 3.3	9.2	3.7	40%	5.5	60%	1: 3.0	10.0	3.0	30%	7.0	70%
Specialized Services Treatment	LPS Specialized Services	4	A10	ICF	Specialized Svcs	Polydipsia	LPS	M	Both	27.0	1: 3	8.9	3.6	40%	5.3	60%	1: 3.0	9.0	2.7	30%	6.3	70%
										56.9		18.1	7.3		10.8			19.0	5.7		13.3	
Specialized Services Treatment	Specialized Services: Sex Offender	3	T15	ICF	Specialized Svcs	Sex Offender	MDO, NGI	M	Both	44.9	1: 7.4	6.1	2.4	40%	3.7	60%	1: 7.5	6.0	1.8	30%	4.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	2	T17	ICF	Permanent Housing	Long Term IST	IST	F	Both	45.2	1: 6.7	6.7	2.7	40%	4.0	60%	1: 6.5	7.0	2.1	30%	4.9	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	T11	ICF	Permanent Housing	High behave acuity	MDO, NGI	Coed	Both	43.8	1: 7.1	6.2	2.5	40%	3.7	60%	1: 6.5	6.7	2.0	30%	4.7	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	2	T18	ICF	Permanent Housing	High behave acuity	MDO, NGI	M	Both	45.4	1: 5.8	7.8	3.1	40%	4.7	60%	1: 6.5	7.0	2.1	30%	4.9	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	1	T6	ICF	Permanent Housing	High behave acuity	MDO, NGI	Coed	Both	45.8	1: 6.9	6.6	2.6	40%	4.0	60%	1: 6.5	7.0	2.1	30%	4.9	70%
										135.0		20.6	8.2		12.4			20.8	6.2		14.5	
Lanterman-Petris-Short Treatment	LPS Permanent Housing	4	A7	ICF	Permanent Housing	High behave acuity	LPS	M	Dorm	35.0	1: 4.9	7.2	2.9	40%	4.3	60%	1: 5.0	7.0	2.1	30%	4.9	70%
Lanterman-Petris-Short Treatment	LPS Permanent Housing	4	A8	ICF	Permanent Housing	High behave acuity	LPS	M	Dorm	34.9	1: 4.8	7.3	2.9	40%	4.4	60%	1: 5.0	7.0	2.1	30%	4.9	70%
										69.9		14.5	5.8		8.7			14.0	4.2		9.8	
Discharge Preparation Units	Discharge Ready	3	T10 <sup>4</sup>	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Single	27.6	1: 5.4	5.1	2.0	40%	3.1	60%	1: 7.0	3.9	1.2	30%	2.8	70%
Discharge Preparation Units	Discharge Ready	3	T16	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Both	45.2	1: 7.4	6.1	2.4	40%	3.7	60%	1: 7.0	6.5	1.9	30%	4.5	70%
Discharge Preparation Units	Discharge Ready	1	T5	ICF	Pre-Discharge	Pre-Discharge	MDO, NGI	Coed	Both	45.5	1: 7.5	6.1	2.4	40%	3.7	60%	1: 7.0	6.5	2.0	30%	4.6	70%
Discharge Preparation Units	Discharge Ready	1	T9 <sup>4</sup>	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Single	27.8	1: 5.6	5.0	2.0	40%	3.0	60%	1: 7.0	4.0	1.2	30%	2.8	70%
										146.1		22.3	8.8		13.5			20.9	6.3		14.6	
										1178		227.6	92.5		135.2			230.8	72.1		158.7	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The percentage split for RNs and PTs is projected and not based on actual staff delivered since Napa's daily staffing sheets do not breakout staff delivered by classification on their "summary tab" view; which is what was used for the average roll-up. Napa communicated they operate closer to a 40/60 split.

<sup>4</sup> Units T1, T9 and T10 are outliers for their respective groups and were not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period.

▪ Units Q3 and Q4 were being used as swing space for the fire alarm sprinkler project during the data collection time period.

▪ Units M3, M5, and M6 - closed at time of data collection.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Napa																						
Unit Characteristics											PM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)	PT <sup>2,3</sup> (Projected)			Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)	PT <sup>2,3</sup> (Projected)		
Admissions	PC Standard Admissions	2	T1 <sup>4</sup>	ICF	Admissions	1 Admit, unlikelys	IST	M	Dorm	17.3	1: 3.3	5.3	2.1	40%	3.2	60%	1: 5.0	3.5	1.0	30%	2.4	70%
Admissions	PC Standard Admissions	2	T2	ICF	Admissions	2 Admit	MDO, NGI, IST	F	Dorm	28.5	1: 4.9	5.8	2.3	40%	3.5	60%	1: 5.0	5.7	1.7	30%	4.0	70%
Admissions	PC Standard Admissions	5	T3	ICF	Admissions	2 Admit, 1:15	IST	M	Both	28.7	1: 4.9	5.8	2.3	40%	3.5	60%	1: 5.0	5.7	1.7	30%	4.0	70%
Admissions	PC Standard Admissions	5	T4	ICF	Admissions	2 Admit, 1:15	IST	M	Dorm	28.8	1: 5.1	5.7	2.3	40%	3.4	60%	1: 5.0	5.8	1.7	30%	4.0	70%
										103.3		22.6	9.0		13.6			20.7	6.2		14.5	
Admissions	LPS Admissions/ 5150s	4	A9	Acute Certified	Admissions	High behave acuity with 5150s.	LPS	Coed	Both	9.8	1: 2.1	4.7	1.9	40%	2.8	60%	1: 2.0	4.9	1.5	30%	3.4	70%
Admissions	Hybrid Admissions	5	Q5	ICF	Hybrid Admission	Q5 & Q6 Double Unit. IST admit 1:15	IST	M	Both	29.2	1: 5.3	5.5	2.2	40%	3.3	60%	1: 5.5	5.3	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	5	Q6	ICF	Hybrid Admission	Q5 & Q6 Double Unit. IST admit 1:15	IST	M	Both	28.9	1: 6.6	4.4	1.8	40%	2.6	60%	1: 5.5	5.3	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	5	Q7	ICF	Hybrid Admission	Q7 & Q8 Double Unit. IST admit 1:15	IST	M	Both	29.3	1: 4.9	6.0	2.4	40%	3.6	60%	1: 5.5	5.3	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	5	Q8	ICF	Hybrid Admission	Q7 & Q8 Double Unit. IST admit 1:15	IST	M	Both	29.6	1: 7.4	4.0	1.6	40%	2.4	60%	1: 5.5	5.4	1.6	30%	3.8	70%
Admissions	Hybrid Admissions	3	T13	ICF	Hybrid Admission	1 Admit, 1:15	MDO, NGI	M	Both	41.4	1: 6.1	6.8	2.7	40%	4.1	60%	1: 5.5	7.5	2.3	30%	5.3	70%
										158.4		26.7	10.7		16.0			28.8	8.6		20.2	
Medical Treatment	Medical Unit	4	A3	Acute Certified	Specialized Svcs	Acute Medical	Any Commitments	Coed	Both	6.5	1: 1.9	3.5	1.8	50%	1.8	50%	1: 2.0	3.3	1.6	50%	1.6	50%
Medical Treatment	Skilled Nursing Facility	4	A4	SNF Certified	SNF		Any excluding CDCR	Coed	Both	27.2	1: 2.5	10.8	5.4	50%	5.4	50%	1: 2.5	10.9	5.4	50%	5.4	50%
Specialized Services Treatment	PC Geropsych	2	Q1	ICF	Specialized Svcs-Q1 & Q2 Double Unit	Geropsych	Mixed	Coed	Both	32.6	1: 6.0	5.4	2.2	40%	3.2	60%	1: 5.5	5.9	1.8	30%	4.1	70%
Specialized Services Treatment	PC Geropsych	2	Q11	ICF	Specialized Svcs	Geropsych	MDO, NGI	M	Both	49.5	1: 4.6	10.7	4.3	40%	6.4	60%	1: 5.5	9.0	2.7	30%	6.3	70%
Specialized Services Treatment	PC Geropsych	2	Q2	ICF	Specialized Svcs-Q1 & Q2 Double Unit	Geropsych	Mixed	Coed	Both	34.6	1: 6.0	5.8	2.3	40%	3.5	60%	1: 5.5	6.3	1.9	30%	4.4	70%
Specialized Services Treatment	PC Geropsych	5	Q9	ICF	Specialized Svcs	Geropsych	IST	M	Dorm	48.9	1: 5.5	8.9	3.6	40%	5.3	60%	1: 5.5	8.9	2.7	30%	6.2	70%
										165.6		30.8	12.4		18.4			30.1	9.0		21.1	
Specialized Services Treatment	LPS Geropsych	4	A2	ICF	Specialized Svcs	Geropsych	LPS	Coed	Both	34.4	1: 4.6	7.5	3.0	40%	4.5	60%	1: 4.5	7.6	2.3	30%	5.4	70%
Specialized Services Treatment	PC Specialized Services	3	T12	ICF	Specialized Svcs	Substance recovery	MDO, NGI	M	Both	43.7	1: 5.9	7.4	3.0	40%	4.4	60%	1: 5.5	7.9	2.4	30%	5.6	70%
Specialized Services Treatment	PC Specialized Services	3	T14	ICF	Specialized Svcs	DBT Team	MDO, NGI	Coed	Both	40.5	1: 5.7	7.1	2.8	40%	4.3	60%	1: 5.5	7.4	2.2	30%	5.2	70%
Specialized Services Treatment	PC Specialized Services	1	T7	ICF	Specialized Svcs	Polydipsia	Mixed	M	Both	44.8	1: 5.0	9.0	3.6	40%	5.4	60%	1: 5.5	8.1	2.4	30%	5.7	70%
Specialized Services Treatment	PC Specialized Services	1	T8	ICF	Specialized Svcs	DBT Team	Mixed	M	Both	45.4	1: 5.7	8.0	3.2	40%	4.8	60%	1: 5.5	8.3	2.5	30%	5.8	70%
										174.4		31.5	12.6		18.9			31.7	9.5		22.2	
Specialized Services Treatment	LPS Specialized Services	4	A1	ICF	Specialized Svcs	DBT Unit	LPS	Coed	Dorm	29.9	1: 3.3	9.2	3.7	40%	5.5	60%	1: 3.0	10.0	3.0	30%	7.0	70%
Specialized Services Treatment	LPS Specialized Services	4	A10	ICF	Specialized Svcs	Polydipsia	LPS	M	Both	27.0	1: 3.0	9.0	3.6	40%	5.4	60%	1: 3.0	9.0	2.7	30%	6.3	70%
										56.9		18.2	7.3		10.9			19.0	5.7		13.3	
Specialized Services Treatment	Specialized Services: Sex Offender	3	T15	ICF	Specialized Svcs	Sex Offender	MDO, NGI	M	Both	44.9	1: 7.5	6.0	2.4	40%	3.6	60%	1: 7.5	6.0	1.8	30%	4.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	2	T17	ICF	Permanent Housing	Long Term IST	IST	F	Both	45.2	1: 6.7	6.7	2.7	40%	4.0	60%	1: 6.5	7.0	2.1	30%	4.9	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	T11	ICF	Permanent Housing	High behave acuity	MDO, NGI	Coed	Both	43.8	1: 7.1	6.2	2.5	40%	3.7	60%	1: 6.5	6.7	2.0	30%	4.7	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	2	T18	ICF	Permanent Housing	High behave acuity	MDO, NGI	M	Both	45.4	1: 6.0	7.6	3.0	40%	4.6	60%	1: 6.5	7.0	2.1	30%	4.9	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	1	T6	ICF	Permanent Housing	High behave acuity	MDO, NGI	Coed	Both	45.8	1: 7.2	6.4	2.6	40%	3.8	60%	1: 6.5	7.0	2.1	30%	4.9	70%
										135.0		20.2	8.1		12.1			20.8	6.2		14.5	
Lanterman-Petris-Short Treatment	LPS Permanent Housing	4	A7	ICF	Permanent Housing	High behave acuity	LPS	M	Dorm	35.0	1: 5.6	6.3	2.5	40%	3.8	60%	1: 5.0	7.0	2.1	30%	4.9	70%
Lanterman-Petris-Short Treatment	LPS Permanent Housing	4	A8	ICF	Permanent Housing	High behave acuity	LPS	M	Dorm	34.9	1: 4.7	7.4	3.0	40%	4.4	60%	1: 5.0	7.0	2.1	30%	4.9	70%
										69.9		13.7	5.5		8.2			14.0	4.2		9.8	
Discharge Preparation Units	Discharge Ready	3	T10 <sup>4</sup>	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Single	27.6	1: 6.9	4.0	1.6	40%	2.4	60%	1: 7.5	3.7	1.1	30%	2.6	70%
Discharge Preparation Units	Discharge Ready	3	T16	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Both	45.2	1: 7.5	6.0	2.4	40%	3.6	60%	1: 7.5	6.0	1.8	30%	4.2	70%
Discharge Preparation Units	Discharge Ready	1	T5	ICF	Pre-Discharge	Pre-Discharge	MDO, NGI	Coed	Both	45.5	1: 7.5	6.1	2.4	40%	3.7	60%	1: 7.5	6.1	1.8	30%	4.2	70%
Discharge Preparation Units	Discharge Ready	1	T9 <sup>4</sup>	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Single	27.8	1: 7.0	4.0	1.6	40%	2.4	60%	1: 7.5	3.7	1.1	30%	2.6	70%
										146.1		20.1	8.0		12.1			19.5	5.8		13.6	
										1178		223.0	90.8		132.3			224.1	70.1		154.0	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The percentage split for RNs and PTs is projected and not based on actual staff delivered since Napa's daily staffing sheets do not breakout staff delivered by classification on their "summary tab" view; which is what was used for the average roll-up. Napa communicated they operate closer to a 40/6

<sup>4</sup> Units T1, T9 and T10 are outliers for their respective groups and were not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period.

▪ Units Q3 and Q4 were being used as swing space for the fire alarm sprinkler project during the data collection time period.

▪ Units M3, M5, and M6 - closed at time of data collection.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Napa																						
Unit Characteristics											NOC Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)		Ratio	Total Staff Delivered	RNs <sup>3</sup> (Projected)		PT <sup>2,3</sup> (Projected)	
Admissions	PC Standard Admissions	2	T1 <sup>4</sup>	ICF	Admissions	1 Admit, unlikelys	IST	M	Dorm	17.3	1: 4.8	3.6	1.4	40%	2.2	60%	1: 8	2.2	0.6	30%	1.5	70%
Admissions	PC Standard Admissions	2	T2	ICF	Admissions	2 Admit	MDO, NGI, IST	F	Dorm	28.5	1: 6.8	4.2	1.7	40%	2.5	60%	1: 8	3.6	1.1	30%	2.5	70%
Admissions	PC Standard Admissions	5	T3	ICF	Admissions	2 Admit, 1:15	IST	M	Both	28.7	1: 6.8	4.2	1.7	40%	2.5	60%	1: 8	3.6	1.1	30%	2.5	70%
Admissions	PC Standard Admissions	5	T4	ICF	Admissions	2 Admit, 1:15	IST	M	Dorm	28.8	1: 6.5	4.4	1.8	40%	2.6	60%	1: 8	3.6	1.1	30%	2.5	70%
										103.3		16.4	6.6		9.8			12.9	3.9		9.0	
Admissions	LPS Admissions/ 5150s	4	A9	Acute Certified	Admissions	High behave acuity with 5150s.	LPS	Coed	Both	9.8	1: 2.3	4.2	1.7	40%	2.5	60%	1: 2.5	3.9	1.2	30%	2.7	70%
Admissions	Hybrid Admissions	5	Q5	ICF	Hybrid Admission	Q5 & Q6 Double Unit. IST admit 1:15	IST	M	Both	29.2	1: 10.1	2.9	1.2	40%	1.7	60%	1: 9.5	3.1	0.9	30%	2.2	70%
Admissions	Hybrid Admissions	5	Q6	ICF	Hybrid Admission	Q5 & Q6 Double Unit. IST admit 1:15	IST	M	Both	28.9	1: 9.6	3.0	1.2	40%	1.8	60%	1: 9.5	3.0	0.9	30%	2.1	70%
Admissions	Hybrid Admissions	5	Q7	ICF	Hybrid Admission	Q7 & Q8 Double Unit. IST admit 1:15	IST	M	Both	29.3	1: 9.2	3.2	1.3	40%	1.9	60%	1: 9.5	3.1	0.9	30%	2.2	70%
Admissions	Hybrid Admissions	5	Q8	ICF	Hybrid Admission	Q7 & Q8 Double Unit. IST admit 1:15	IST	M	Both	29.6	1: 11	2.7	1.1	40%	1.6	60%	1: 9.5	3.1	0.9	30%	2.2	70%
Admissions	Hybrid Admissions	3	T13	ICF	Hybrid Admission	1 Admit, 1:15	MDO, NGI	M	Both	41.4	1: 9.6	4.3	1.7	40%	2.6	60%	1: 9.5	4.4	1.3	30%	3.1	70%
										158.4		16.1	6.5		9.6			16.7	5.0		11.7	
Medical Treatment	Medical Unit	4	A3	Acute Certified	Specialized Svcs	Acute Medical	Any Commitments	Coed	Both	6.5	1: 1.9	3.5	1.8	50%	1.8	50%	1: 2.5	2.6	1.3	50%	1.3	50%
Medical Treatment	Skilled Nursing Facility	4	A4	SNF Certified	SNF		Any excluding CDCR	Coed	Both	27.2	1: 3.7	7.4	3.7	50%	3.7	50%	1: 4	6.8	3.4	50%	3.4	50%
Specialized Services Treatment	PC Geropsych	2	Q1	ICF	Specialized Svcs-Q1 & Q2 Double Unit	Geropsych	Mixed	Coed	Both	32.6	1: 9.6	3.4	1.4	40%	2.0	60%	1: 10	3.3	1.0	30%	2.3	70%
Specialized Services Treatment	PC Geropsych	2	Q11	ICF	Specialized Svcs	Geropsych	MDO, NGI	M	Both	49.5	1: 9.3	5.3	2.1	40%	3.2	60%	1: 10	5.0	1.5	30%	3.5	70%
Specialized Services Treatment	PC Geropsych	2	Q2	ICF	Specialized Svcs-Q1 & Q2 Double Unit	Geropsych	Mixed	Coed	Both	34.6	1: 11.9	2.9	1.2	40%	1.7	60%	1: 10	3.5	1.0	30%	2.4	70%
Specialized Services Treatment	PC Geropsych	5	Q9	ICF	Specialized Svcs	Geropsych	IST	M	Dorm	48.9	1: 10.6	4.6	1.8	40%	2.8	60%	1: 10	4.9	1.5	30%	3.4	70%
										165.6		16.2	6.5		9.7			16.6	5.0		11.6	
Specialized Services Treatment	LPS Geropsych	4	A2	ICF	Specialized Svcs	Geropsych	LPS	Coed	Both	34.4	1: 6.4	5.4	2.2	40%	3.2	60%	1: 6.5	5.3	1.6	30%	3.7	70%
Specialized Services Treatment	PC Specialized Services	3	T12	ICF	Specialized Svcs	Substance recovery	MDO, NGI	M	Both	43.7	1: 9.9	4.4	1.8	40%	2.6	60%	1: 9	4.9	1.5	30%	3.4	70%
Specialized Services Treatment	PC Specialized Services	3	T14	ICF	Specialized Svcs	DBT Team	MDO, NGI	Coed	Both	40.5	1: 8.6	4.7	1.9	40%	2.8	60%	1: 9	4.5	1.4	30%	3.2	70%
Specialized Services Treatment	PC Specialized Services	1	T7	ICF	Specialized Svcs	Polydipsia	Mixed	M	Both	44.8	1: 7.6	5.9	2.4	40%	3.5	60%	1: 9	5.0	1.5	30%	3.5	70%
Specialized Services Treatment	PC Specialized Services	1	T8	ICF	Specialized Svcs	DBT Team	Mixed	M	Both	45.4	1: 9.3	4.9	2.0	40%	2.9	60%	1: 9	5.0	1.5	30%	3.5	70%
										174.4		19.9	8.1		11.8			19.4	5.8		13.6	
Specialized Services Treatment	LPS Specialized Services	4	A1	ICF	Specialized Svcs	DBT Unit	LPS	Coed	Dorm	29.9	1: 4.9	6.1	2.4	40%	3.7	60%	1: 4.5	6.6	2.0	30%	4.7	70%
Specialized Services Treatment	LPS Specialized Services	4	A10	ICF	Specialized Svcs	Polydipsia	LPS	M	Both	27.0	1: 4	6.7	2.7	40%	4.0	60%	1: 4.5	6.0	1.8	30%	4.2	70%
										56.9		12.8	5.1		7.7			12.6	3.8		8.9	
Specialized Services Treatment	Specialized Services: Sex Offender	3	T15	ICF	Specialized Svcs	Sex Offender	MDO, NGI	M	Both	44.9	1: 14.5	3.1	1.2	40%	1.9	60%	1: 14	3.2	1.0	30%	2.2	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	2	T17	ICF	Permanent Housing	Long Term IST	IST	F	Both	45.2	1: 11	4.1	1.6	40%	2.5	60%	1: 12	3.8	1.1	30%	2.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	T11	ICF	Permanent Housing	High behave acuity	MDO, NGI	Coed	Both	43.8	1: 10.7	4.1	1.6	40%	2.5	60%	1: 11.5	3.8	1.1	30%	2.7	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	2	T18	ICF	Permanent Housing	High behave acuity	MDO, NGI	M	Both	45.4	1: 10.1	4.5	1.8	40%	2.7	60%	1: 11.5	3.9	1.2	30%	2.8	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	1	T6	ICF	Permanent Housing	High behave acuity	MDO, NGI	Coed	Both	45.8	1: 10.9	4.2	1.7	40%	2.5	60%	1: 11.5	4.0	1.2	30%	2.8	70%
										135.0		12.8	5.1		7.7			11.7	3.5		8.2	
Lanterman-Petris-Short Treatment	LPS Permanent Housing	4	A7	ICF	Permanent Housing	High behave acuity	LPS	M	Dorm	35.0	1: 10	3.5	1.4	40%	2.1	60%	1: 9	3.9	1.2	30%	2.7	70%
Lanterman-Petris-Short Treatment	LPS Permanent Housing	4	A8	ICF	Permanent Housing	High behave acuity	LPS	M	Dorm	34.9	1: 8.3	4.2	1.7	40%	2.5	60%	1: 9	3.9	1.2	30%	2.7	70%
										69.9		7.7	3.1		4.6			7.8	2.3		5.4	
Discharge Preparation Units	Discharge Ready	3	T10 <sup>4</sup>	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Single	27.6	1: 9.2	3.0	1.2	40%	1.8	60%	1: 12.5	2.2	0.7	30%	1.5	70%
Discharge Preparation Units	Discharge Ready	3	T16	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Both	45.2	1: 15.1	3.0	1.2	40%	1.8	60%	1: 12.5	3.6	1.1	30%	2.5	70%
Discharge Preparation Units	Discharge Ready	1	T5	ICF	Pre-Discharge	Pre-Discharge	MDO, NGI	Coed	Both	45.5	1: 12	3.8	1.5	40%	2.3	60%	1: 12.5	3.6	1.1	30%	2.5	70%
Discharge Preparation Units	Discharge Ready	1	T9 <sup>4</sup>	ICF	Discharge	Discharge Unit	MDO, NGI	Coed	Single	27.8	1: 9	3.1	1.2	40%	1.9	60%	1: 12.5	2.2	0.7	30%	1.6	70%
										146.1		12.9	5.1		7.8			11.7	3.5		8.2	
										1178		142.5	58.3		84.3			134.9	42.4		92.6	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> The percentage split for RNs and PTs is projected and not based on actual staff delivered since Napa's daily staffing sheets do not breakout staff delivered by classification on their "summary tab" view; which is what was used for the average roll-up. Napa communicated they operate closer to a 40/6

<sup>4</sup> Units T1, T9 and T10 are outliers for their respective groups and were not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period.

▪ Units Q3 and Q4 were being used as swing space for the fire alarm sprinkler project during the data collection time period.

▪ Units M3, M5, and M6 - closed at time of data collection.



Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Patton																							
Unit Characteristics											AM Shift												
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios						
											Ratio-Driven						Ratio-Driven						
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)		
Admissions	PC Standard Admissions	6	EB01	Acute	Admissions		MDO,NGI,LPS	M	Dorm	33.8	1: 5.3	6.4	2.1	33%	4.3	67%	1: 4.5	7.5	2.3	30%	5.3	70%	
Admissions	PC Standard Admissions	6	EB02	Acute	Admissions		IST	M	Dorm	32.8	1: 5.2	6.3	2.3	37%	4.0	63%	1: 4.5	7.3	2.2	30%	5.1	70%	
Admissions	PC Standard Admissions	6	EB12 <sup>3</sup>	Acute	Admissions	Admission: Non IST Females	MDO,NGI,LPS	F	Dorm	23.9	1: 3.7	6.4	2.4	38%	4.0	63%	1: 4.5	5.3	1.6	30%	3.7	70%	
Admissions	PC Standard Admissions	7	70	Acute	Admissions		IST	M	Dorm	49.6	1: 5.0	10.0	2.8	28%	7.2	72%	1: 4.5	11.0	3.3	30%	7.7	70%	
Admissions	PC Standard Admissions	7	71	Acute	Admissions		IST	Co-Ed	Dorm	48.8	1: 4.9	9.9	2.4	24%	7.5	76%	1: 4.5	10.8	3.3	30%	7.6	70%	
										188.9			39.0	12.0		27.0			42.0	12.6		29.4	
Admissions	Hybrid Admissions	6	EB09	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	43.2	1: 5.8	7.4	2.4	32%	5.0	68%	1: 5.5	7.9	2.4	30%	5.5	70%	
Admissions	Hybrid Admissions	7	72	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	49.7	1: 5.4	9.2	2.4	26%	6.8	74%	1: 5.5	9.0	2.7	30%	6.3	70%	
Admissions	Hybrid Admissions	7	73	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	M	Dorm	49.7	1: 4.6	10.8	3.1	29%	7.7	71%	1: 5.5	9.0	2.7	30%	6.3	70%	
Admissions	Hybrid Admissions	7	75	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	49.6	1: 5.3	9.4	2.2	23%	7.2	77%	1: 5.5	9.0	2.7	30%	6.3	70%	
Admissions	Hybrid Admissions	7	77	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	M	Dorm	49.8	1: 5.5	9.0	2.4	27%	6.6	73%	1: 5.5	9.1	2.7	30%	6.3	70%	
										242.0			45.8	12.5		33.3			44.0	13.2		30.8	
Medical Treatment	Medically Fragile	6	U05	ICF	Specialized Svcs	Medically Fragile	MDO,NGI,LPS	Co-Ed	Mixed	39.9	1: 3.8	10.4	3.5	34%	6.9	66%	1: 3.5	11.4	5.7	50%	5.7	50%	
Medical Treatment	Medically Fragile	6	EB11	Acute	Specialized Svcs	Medical/Geriatric/Isolation	IST,MDO,NGI	Co-Ed	Mixed	41.8	1: 3.6	11.6	4.7	41%	6.9	59%	1: 3.5	11.9	6.0	50%	6.0	50%	
										81.7			22.0	8.2		13.8			23.3	11.7		11.7	
Specialized Services Treatment	Specialized Services: High Behavior Acuity	6	U06	ICF	Specialized Svcs	Psychologically Fragile	MDO,NGI,LPS	Co-Ed	Mixed	42.2	1: 5.2	8.1	2.3	28%	5.8	72%	1: 4.5	9.4	2.8	30%	6.6	70%	
Specialized Services Treatment	Specialized Services: Sex Offender Treatment	4	35	ICF	Specialized Svcs	Sex Offender Treatment	MDO,NGI,LPS	M	Dorm	49.8	1: 7.3	6.8	2.3	34%	4.5	66%	1: 7.5	6.6	2.0	30%	4.6	70%	
Specialized Services Treatment	Specialized Services: Deaf, Hard of Hearing	6	EB10	Acute	Specialized Svcs	Deaf/Hard of Hearing	IST,MDO,NGI	Co-Ed	Mixed	12.8	1: 3.0	4.3	1.6	37%	2.7	63%	1: 3.0	4.3	1.3	30%	3.0	70%	
Specialized Services Treatment	Specialized Services: Monolingual	6	EB04	ICF	Specialized Svcs	Monolingual-Spanish	MDO,NGI,LPS	Co-Ed	Dorm	46.9	1: 5.0	9.3	1.5	16%	7.8	84%	1: 5.0	9.4	2.8	30%	6.6	70%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	4	34	ICF	Permanent Housing	Long Term IST	IST	M	Dorm	49.9	1: 6.8	7.3	1.9	26%	5.4	74%	1: 6.5	7.7	2.3	30%	5.4	70%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	7	74	ICF	Permanent Housing	Long Term IST	IST	Co-Ed	Dorm	49.7	1: 7.0	7.1	1.7	24%	5.4	76%	1: 6.5	7.6	2.3	30%	5.4	70%	
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	7	76	ICF	Permanent Housing	Long Term IST	IST	Co-Ed	Dorm	49.2	1: 6.5	7.6	2.2	29%	5.4	71%	1: 6.5	7.6	2.3	30%	5.3	70%	
										148.8			22.0	5.8		16.2			22.9	6.9		16.0	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N20	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Dorm	49.4	1: 5.4	9.1	2.4	26%	6.7	74%	1: 6.5	7.6	2.3	30%	5.3	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N21	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Mixed	49.6	1: 5.8	8.6	2.8	33%	5.8	67%	1: 6.5	7.6	2.3	30%	5.3	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N22	ICF	Permanent Housing	Long Term	MDO,NGI	M	Dorm	49.9	1: 6.2	8.1	2.2	27%	5.9	73%	1: 6.5	7.7	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N23	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Mixed	49.8	1: 5.8	8.6	1.7	20%	6.9	80%	1: 6.5	7.7	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N24	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Mixed	50.0	1: 6.8	7.4	1.8	24%	5.6	76%	1: 6.5	7.7	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N25	ICF	Permanent Housing	Long Term	MDO,NGI	Co-Ed	Dorm	49.7	1: 6.7	7.4	1.5	20%	5.9	80%	1: 6.5	7.6	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N26	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.6	1: 6.0	8.3	1.8	22%	6.5	78%	1: 6.5	7.6	2.3	30%	5.3	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N27	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.7	1: 6.5	7.7	1.7	22%	6.0	78%	1: 6.5	7.6	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	30	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.9	1: 5.3	9.4	1.8	19%	7.6	81%	1: 6.5	7.7	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	31	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.9	1: 6.3	7.9	1.7	22%	6.2	78%	1: 6.5	7.7	2.3	30%	5.4	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	32	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	F	Dorm	49.6	1: 5.5	9.0	2.2	24%	6.8	76%	1: 6.5	7.6	2.3	30%	5.3	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	33	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.5	1: 5.0	9.9	1.9	19%	8.0	81%	1: 6.5	7.6	2.3	30%	5.3	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	36	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	F	Dorm	49.2	1: 6.4	7.7	1.5	19%	6.2	81%	1: 6.5	7.6	2.3	30%	5.3	70%	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	37	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.6	1: 5.5	9.0	1.8	20%	7.2	80%	1: 6.5	7.6	2.3	30%	5.3	70%	
										695.4			118.1	26.8		91.3			107.0	32.1		74.9	
										1508.5			275.4	73.0		202.4			268.9	85.3		183.5	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> Unit EB12 is an outlier and was not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period. Patton did not have any closed units.

- No closed units during the data collection time period.



Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Patton																						
Unit Characteristics											PM Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven						Ratio-Driven					
											Ratio	Total Staff Delivered	RN (Actual)		PT <sup>2</sup> (Actual)		Ratio	Total Staff Delivered	RN (Projected)		PT (Projected)	
Admissions	PC Standard Admissions	6	EB01	Acute	Admissions		MDO,NGI,LPS	M	Dorm	33.8	1: 5.5	6.2	2.2	35%	4.0	65%	1: 5.0	6.8	2.0	30%	4.7	70%
Admissions	PC Standard Admissions	6	EB02	Acute	Admissions		IST	M	Dorm	32.8	1: 5.1	6.4	2.4	38%	4.0	63%	1: 5.0	6.6	2.0	30%	4.6	70%
Admissions	PC Standard Admissions	6	EB12 <sup>3</sup>	Acute	Admissions	Admission: Non IST Females	MDO,NGI,LPS	F	Dorm	23.9	1: 3.8	6.3	2.6	41%	3.7	59%	1: 5.0	4.8	1.4	30%	3.3	70%
Admissions	PC Standard Admissions	7	70	Acute	Admissions		IST	M	Dorm	49.6	1: 5.0	9.9	3.2	32%	6.7	68%	1: 5.0	9.9	3.0	30%	6.9	70%
Admissions	PC Standard Admissions	7	71	Acute	Admissions		IST	Co-Ed	Dorm	48.8	1: 5.0	9.8	2.7	28%	7.1	72%	1: 5.0	9.8	2.9	30%	6.8	70%
										188.9		38.6	13.1		25.5			37.8	11.3		26.4	
Admissions	Hybrid Admissions	6	EB09	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	43.2	1: 5.8	7.4	2.2	30%	5.2	70%	1: 5.5	7.9	2.4	30%	5.5	70%
Admissions	Hybrid Admissions	7	72	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	49.7	1: 5.1	9.8	3.1	32%	6.7	68%	1: 5.5	9.0	2.7	30%	6.3	70%
Admissions	Hybrid Admissions	7	73	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	M	Dorm	49.7	1: 4.6	10.8	2.8	26%	8.0	74%	1: 5.5	9.0	2.7	30%	6.3	70%
Admissions	Hybrid Admissions	7	75	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	49.6	1: 5.3	9.3	3.0	32%	6.3	68%	1: 5.5	9.0	2.7	30%	6.3	70%
Admissions	Hybrid Admissions	7	77	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	M	Dorm	49.8	1: 5.6	8.9	2.3	26%	6.6	74%	1: 5.5	9.1	2.7	30%	6.3	70%
										242.0		46.2	13.4		32.8			44.0	13.2		30.8	
Medical Treatment	Medically Fragile	6	U05	ICF	Specialized Svcs	Medically Fragile	MDO,NGI,LPS	Co-Ed	Mixed	39.9	1: 4.0	10.1	3.3	33%	6.8	67%	1: 4.0	10.0	5.0	50%	5.0	50%
Medical Treatment	Medically Fragile	6	EB11	Acute	Specialized Svcs	Medical/Geriatric/Isolation	IST,MDO,NGI	Co-Ed	Mixed	41.8	1: 3.7	11.4	4.5	39%	6.9	61%	1: 4.0	10.5	5.2	50%	5.2	50%
										81.7		21.5	7.8		13.7			20.4	10.2		10.2	
Specialized Services Treatment	Specialized Services: High Behavior Acuity	6	U06	ICF	Specialized Svcs	Psychologically Fragile	MDO,NGI,LPS	Co-Ed	Mixed	42.2	1: 5.3	8.0	2.1	26%	5.9	74%	1: 4.5	9.4	2.8	30%	6.6	70%
Specialized Services Treatment	Specialized Services: Sex Offender Treatment	4	35	ICF	Specialized Svcs	Sex Offender Treatment	MDO,NGI,LPS	M	Dorm	49.8	1: 7.4	6.7	1.8	27%	4.9	73%	1: 7.5	6.6	2.0	30%	4.6	70%
Specialized Services Treatment	Specialized Services: Deaf, Hard of Hearing	6	EB10	Acute	Specialized Svcs	Deaf/Hard of Hearing	IST,MDO,NGI	Co-Ed	Mixed	12.8	1: 3.2	4.0	1.4	35%	2.6	65%	1: 3.0	4.3	1.3	30%	3.0	70%
Specialized Services Treatment	Specialized Services: Monolingual	6	EB04	ICF	Specialized Svcs	Monolingual-Spanish	MDO,NGI,LPS	Co-Ed	Dorm	46.9	1: 5.4	8.7	1.5	17%	7.2	83%	1: 5.5	8.5	2.6	30%	6.0	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	4	34	ICF	Permanent Housing	Long Term IST	IST	M	Dorm	49.9	1: 6.9	7.2	1.8	25%	5.4	75%	1: 6.5	7.7	2.3	30%	5.4	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	7	74	ICF	Permanent Housing	Long Term IST	IST	Co-Ed	Dorm	49.7	1: 7.0	7.1	2.1	30%	5.0	70%	1: 6.5	7.6	2.3	30%	5.4	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	7	76	ICF	Permanent Housing	Long Term IST	IST	Co-Ed	Dorm	49.2	1: 6.6	7.5	2.9	39%	4.6	61%	1: 6.5	7.6	2.3	30%	5.3	70%
										148.8		21.8	6.8		15.0			22.9	6.9		16.0	
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N20	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Dorm	49.4	1: 5.4	9.2	2.3	25%	6.9	75%	1: 6.5	7.6	2.3	30%	5.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N21	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Mixed	49.6	1: 6.5	7.6	1.6	21%	6.0	79%	1: 6.5	7.6	2.3	30%	5.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N22	ICF	Permanent Housing	Long Term	MDO,NGI	M	Dorm	49.9	1: 6.2	8.0	2.3	29%	5.7	71%	1: 6.5	7.7	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N23	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Mixed	49.8	1: 6.3	7.9	2.3	29%	5.6	71%	1: 6.5	7.7	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N24	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Mixed	50.0	1: 6.8	7.4	1.9	26%	5.5	74%	1: 6.5	7.7	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N25	ICF	Permanent Housing	Long Term	MDO,NGI	Co-Ed	Dorm	49.7	1: 6.7	7.4	2.0	27%	5.4	73%	1: 6.5	7.6	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N26	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.6	1: 6.3	7.9	2.3	29%	5.6	71%	1: 6.5	7.6	2.3	30%	5.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N27	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.7	1: 6.0	8.3	2.3	28%	6.0	72%	1: 6.5	7.6	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	30	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.9	1: 5.4	9.3	1.9	20%	7.4	80%	1: 6.5	7.7	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	31	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.9	1: 6.3	7.9	1.9	24%	6.0	76%	1: 6.5	7.7	2.3	30%	5.4	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	32	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	F	Dorm	49.6	1: 6.1	8.1	2.1	26%	6.0	74%	1: 6.5	7.6	2.3	30%	5.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	33	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.5	1: 5.4	9.1	2.3	25%	6.8	75%	1: 6.5	7.6	2.3	30%	5.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	36	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	F	Dorm	49.2	1: 7.6	6.5	1.3	20%	5.2	80%	1: 6.5	7.6	2.3	30%	5.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	37	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.6	1: 6.1	8.1	1.8	22%	6.3	78%	1: 6.5	7.6	2.3	30%	5.3	70%
										695.4		112.7	28.3		84.4			107.0	32.1		74.9	
										1508.5		268.2	76.2		192.0			260.9	82.4		178.5	

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> Unit EB12 is an outlier and was not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period. Patton did not have any closed units.

- No closed units during the data collection time period.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Methodology Test: Actual Staff Delivered versus System-Wide Grouping Ratio Staffing Levels

DSH-Patton																						
Unit Characteristics											NOC Shift											
Category	System-Wide Grouping	Program	Unit	CDPH Licensure	Type of Unit (General)	Type of Unit (Detail)	Commitment Type	Gender	Room Type	Census (6mo Avg)	Based on Actual Staff Delivered <sup>1</sup>						Based on Proposed System-Wide Grouping Ratios					
											Ratio-Driven				Ratio-Driven				Ratio	Total Staff Delivered	RN (Projected)	PT (Projected)
											Ratio	Total Staff Delivered	RN (Actual)	PT <sup>2</sup> (Actual)	Ratio	Total Staff Delivered	RN (Projected)	PT (Projected)				
Admissions	PC Standard Admissions	6	EB01	Acute	Admissions		MDO,NGI,LPS	M	Dorm	33.8	1: 9.9	3.4	1.6	47%	1.8	53%	1: 8.0	4.2	1.3	30%	3.0	70%
Admissions	PC Standard Admissions	6	EB02	Acute	Admissions		IST	M	Dorm	32.8	1: 9.6	3.4	1	29%	2.4	71%	1: 8.0	4.1	1.2	30%	2.9	70%
Admissions	PC Standard Admissions	6	EB12 <sup>3</sup>	Acute	Admissions	Admission: Non IST Females	MDO,NGI,LPS	F	Dorm	23.9	1: 5.8	4.1	0.9	22%	3.2	78%	1: 8.0	3.0	0.9	30%	2.1	70%
Admissions	PC Standard Admissions	7	70	Acute	Admissions		IST	M	Dorm	49.6	1: 8.3	6.0	1.8	30%	4.2	70%	1: 8.0	6.2	1.9	30%	4.3	70%
Admissions	PC Standard Admissions	7	71	Acute	Admissions		IST	Co-Ed	Dorm	48.8	1: 8.4	5.8	1.5	26%	4.3	74%	1: 8.0	6.1	1.8	30%	4.3	70%
										188.9		22.7	6.8	15.9			23.6	7.1		16.5		
Admissions	Hybrid Admissions	6	EB09	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	43.2	1: 9.8	4.4	1.2	27%	3.2	73%	1: 9.5	4.5	1.4	30%	3.2	70%
Admissions	Hybrid Admissions	7	72	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	49.7	1: 9.6	5.2	1.7	33%	3.5	67%	1: 9.5	5.2	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	7	73	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	M	Dorm	49.7	1: 7.4	6.7	1.5	22%	5.2	78%	1: 9.5	5.2	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	7	75	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	Co-Ed	Dorm	49.6	1: 9	5.5	1.3	24%	4.2	76%	1: 9.5	5.2	1.6	30%	3.7	70%
Admissions	Hybrid Admissions	7	77	Acute	Admissions/Hybrid	7-Direct Admission (per month)/Med LOS	IST	M	Dorm	49.8	1: 10	5.0	1.4	28%	3.6	72%	1: 9.5	5.2	1.6	30%	3.7	70%
										242.0		26.8	7.1	19.7			25.5	7.6		17.8		
Medical Treatment	Medically Fragile	6	U05	ICF	Specialized Svcs	Medically Fragile	MDO,NGI,LPS	Co-Ed	Mixed	39.9	1: 5.1	7.8	2.8	36%	5	64%	1: 5.0	8.0	4.0	50%	4.0	50%
Medical Treatment	Medically Fragile	6	EB11	Acute	Specialized Svcs	Medical/Geriatric/Isolation	IST,MDO,NGI	Co-Ed	Mixed	41.8	1: 5	8.3	2.4	29%	5.9	71%	1: 5.0	8.4	4.2	50%	4.2	50%
										81.7		16.1	5.2	10.9			16.3	8.2		8.2		
Specialized Services Treatment	Specialized Services: High Behavior Acuity	6	U06	ICF	Specialized Svcs	Psychologically Fragile	MDO,NGI,LPS	Co-Ed	Mixed	42.2	1: 7.4	5.7	1.4	25%	4.3	75%	1: 7.5	5.6	1.7	30%	3.9	70%
Specialized Services Treatment	Specialized Services: Sex Offender Treatment	4	35	ICF	Specialized Svcs	Sex Offender Treatment	MDO,NGI,LPS	M	Dorm	49.8	1: 13.8	3.6	1.3	36%	2.3	64%	1: 14.0	3.6	1.1	30%	2.5	70%
Specialized Services Treatment	Specialized Services: Deaf, Hard of Hearing	6	EB10	Acute	Specialized Svcs	Deaf/Hard of Hearing	IST,MDO,NGI	Co-Ed	Mixed	12.8	1: 5.8	2.2	0.5	23%	1.7	77%	1: 6.0	2.1	0.6	30%	1.5	70%
Specialized Services Treatment	Specialized Services: Monolingual	6	EB04	ICF	Specialized Svcs	Monolingual-Spanish	MDO,NGI,LPS	Co-Ed	Dorm	46.9	1: 7.9	5.9	1.3	22%	4.6	78%	1: 8.0	5.9	1.8	30%	4.1	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	4	34	ICF	Permanent Housing	Long Term IST	IST	M	Dorm	49.9	1: 13.1	3.8	1.3	34%	2.5	66%	1: 12.0	4.2	1.2	30%	2.9	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	7	74	ICF	Permanent Housing	Long Term IST	IST	Co-Ed	Dorm	49.7	1: 12.4	4.0	1.5	38%	2.5	63%	1: 12.0	4.1	1.2	30%	2.9	70%
Incompetent to Stand Trial Treatment	IST Permanent Housing-Dorm, Mixed	7	76	ICF	Permanent Housing	Long Term IST	IST	Co-Ed	Dorm	49.2	1: 10.9	4.5	1.6	36%	2.9	64%	1: 12.0	4.1	1.2	30%	2.9	70%
										148.8		12.3	4.4	7.9			12.4	3.7		8.7		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N20	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Dorm	49.4	1: 9.9	5.0	1.5	30%	3.5	70%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N21	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Mixed	49.6	1: 11	4.5	1.5	33%	3.0	67%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N22	ICF	Permanent Housing	Long Term	MDO,NGI	M	Dorm	49.9	1: 10	5.0	1.6	32%	3.4	68%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N23	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Mixed	49.8	1: 10.2	4.9	1.7	35%	3.2	65%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N24	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	Co-Ed	Mixed	50.0	1: 11.9	4.2	1.4	33%	2.8	67%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N25	ICF	Permanent Housing	Long Term	MDO,NGI	Co-Ed	Dorm	49.7	1: 11.6	4.3	1.6	37%	2.7	63%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N26	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.6	1: 9.7	5.1	1.4	27%	3.7	73%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	5	N27	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.7	1: 10.6	4.7	1.4	30%	3.3	70%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	30	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.9	1: 9.6	5.2	1.9	37%	3.3	63%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	31	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.9	1: 12.8	3.9	1.9	49%	2.0	51%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	32	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	F	Dorm	49.6	1: 9.7	5.1	1.5	29%	3.6	71%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	33	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.5	1: 9	5.5	1.4	25%	4.1	75%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	36	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	F	Dorm	49.2	1: 14.1	3.5	1.3	37%	2.2	63%	1: 11.5	4.3	1.3	30%	3.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	4	37	ICF	Permanent Housing	Long Term	MDO,NGI,LPS	M	Dorm	49.6	1: 11	4.5	1.3	29%	3.2	71%	1: 11.5	4.3	1.3	30%	3.0	70%
										695.4		65.4	21.4	44			60.5	18.1		42.3		
										1508.5		160.7	49.4	111.3			155.5	49.9		105.6		

<sup>1</sup> Actual staff delivered is based on daily staffing sheets (6-month average: January 2015 - June 2015).

<sup>2</sup> Psychiatric Technician (PT) staff delivered numbers include licensed vocational nurses, psychiatric technician assistants and pre-licensed psychiatric technicians.

<sup>3</sup> Unit EB12 is an outlier and was not included in ratio averages.

Data only includes units with staffing allocations during the data collection time period. Patton did not have any closed units.

- No closed units during the data collection time period.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Proposed DSH Unit Categorization and System-Wide Ratios  
Ratio-Driven Staffing Calculations

DSH-Atascadero																												
Unit Characteristics								AM Shift							PM Shift							NOC Shift						
Category	System-Wide Grouping	Unit	Program	CDPH Licensure	Gender	Room Type	Operational Capacity	Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios						
								Ratio-Driven							Ratio-Driven							Ratio-Driven						
								Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %
Admissions	PC Standard Admissions	6	3	Acute	M	Single	32	1: 4.5	7.1	2.1	30%	1.0	4.0	70%	1: 5	6.4	1.9	30%	1.0	3.5	70%	1: 8	4.0	1.2	30%	1.0	1.8	70%
Admissions	PC Standard Admissions	8	6	Acute	M	Single	30	1: 4.5	6.7	2.0	30%	1.0	3.7	70%	1: 5	6.0	1.8	30%	1.0	3.2	70%	1: 8	3.8	1.1	30%	1.0	1.6	70%
Admissions	PC Standard Admissions	12	1	Acute	M	Single	32	1: 4.5	7.1	2.1	30%	1.0	4.0	70%	1: 5	6.4	1.9	30%	1.0	3.5	70%	1: 8	4.0	1.2	30%	1.0	1.8	70%
Admissions	PC Standard Admissions	13	5	Acute	M	Single	32	1: 4.5	7.1	2.1	30%	1.0	4.0	70%	1: 5	6.4	1.9	30%	1.0	3.5	70%	1: 8	4.0	1.2	30%	1.0	1.8	70%
Admissions	PC Standard Admissions	21	1	Acute	M	Single	32	1: 4.5	7.1	2.1	30%	1.0	4.0	70%	1: 5	6.4	1.9	30%	1.0	3.5	70%	1: 8	4.0	1.2	30%	1.0	1.8	70%
Admissions	PC Standard Admissions	23	7	Acute	M	Single	32	1: 4.5	7.1	2.1	30%	1.0	4.0	70%	1: 5	6.4	1.9	30%	1.0	3.5	70%	1: 8	4.0	1.2	30%	1.0	1.8	70%
Medical Treatment	Medical Unit	1	6	Acute	M	Single	22	1: 2	11.0	5.5	50%	1.0	4.5	50%	1: 2	11.0	5.5	50%	1.0	4.5	50%	1: 2.5	8.8	4.4	50%	1.0	3.4	50%
Specialized Services Treatment	High Aggression/ETU/ETP	4	6	Acute	M	Single	14	1: 1.5	9.3	3.7	40%	1.0	4.6	60%	1: 1.5	9.3	3.7	40%	1.0	4.6	60%	1: 3	4.7	1.9	40%	1.0	1.8	60%
Specialized Services Treatment	High Aggression/ETU/ETP	29	4	ETP	M	Single	13	1: 1.5	8.7	3.5	40%	1.0	4.2	60%	1: 1.5	8.7	3.5	40%	1.0	4.2	60%	1: 3	4.3	1.7	40%	1.0	1.6	60%
Incompetent to Stand Trial (IST) Treatment	IST Permanent Housing-Single	11	1	ICF	M	Single	33	1: 5.5	6.0	1.8	30%	1.0	3.2	70%	1: 6.5	5.1	1.5	30%	1.0	2.6	70%	1: 9.5	3.5	1.0	30%	1.0	1.4	70%
Incompetent to Stand Trial (IST) Treatment	IST Permanent Housing-Single	20	1	ICF	M	Single	35	1: 5.5	6.4	1.9	30%	1.0	3.5	70%	1: 6.5	5.4	1.6	30%	1.0	2.8	70%	1: 9.5	3.7	1.1	30%	1.0	1.6	70%
Incompetent to Stand Trial (IST) Treatment	IST Permanent Housing-Dorm, Mixed	9	1	ICF	M	Mixed	40	1: 6.5	6.2	1.8	30%	1.0	3.3	70%	1: 6.5	6.2	1.8	30%	1.0	3.3	70%	1: 12	3.3	1.0	30%	1.0	1.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	3	7	ICF	M	Mixed	22	1: 6.5	3.4	1.0	30%	1.0	1.4	70%	1: 6.5	3.4	1.0	30%	1.0	1.4	70%	1: 11.5	1.9	0.6	30%	1.0	0.3	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	16	3	ICF	M	Dorm	43	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	17	3	ICF	M	Dorm	43	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	18	6	ICF	M	Dorm	43	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	19	6	ICF	M	Dorm	43	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	24	7	ICF	M	Dorm	16	1: 6.5	2.5	0.7	30%	1.0	0.7	70%	1: 6.5	2.5	0.7	30%	1.0	0.7	70%	1: 11.5	1.4	0.4	30%	1.0	0.0	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	25	7	ICF	M	Dorm	42	1: 6.5	6.5	1.9	30%	1.0	3.5	70%	1: 6.5	6.5	1.9	30%	1.0	3.5	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	26	7	ICF	M	Dorm	43	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 6.5	6.6	2.0	30%	1.0	3.6	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	27	7	ICF	M	Mixed	41	1: 6.5	6.3	1.9	30%	1.0	3.4	70%	1: 6.5	6.3	1.9	30%	1.0	3.4	70%	1: 11.5	3.6	1.1	30%	1.0	1.5	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	28	7	ICF	M	Mixed	42	1: 6.5	6.5	1.9	30%	1.0	3.5	70%	1: 6.5	6.5	1.9	30%	1.0	3.5	70%	1: 11.5	3.7	1.1	30%	1.0	1.6	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	2	3	ICF	M	Single	33	1: 5.5	6.0	1.8	30%	1.0	3.2	70%	1: 6.5	5.1	1.5	30%	1.0	2.6	70%	1: 10.5	3.1	0.9	30%	1.0	1.2	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	5	1	ICF	M	Single	32	1: 5.5	5.8	1.7	30%	1.0	3.1	70%	1: 6.5	4.9	1.5	30%	1.0	2.4	70%	1: 10.5	3.0	0.9	30%	1.0	1.1	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	7	3	ICF	M	Single	33	1: 5.5	6.0	1.8	30%	1.0	3.2	70%	1: 6.5	5.1	1.5	30%	1.0	2.6	70%	1: 10.5	3.1	0.9	30%	1.0	1.2	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	10	6	ICF	M	Single	31	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 6.5	4.8	1.4	30%	1.0	2.3	70%	1: 10.5	3.0	0.9	30%	1.0	1.1	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	14	3	ICF	M	Single	37	1: 5.5	6.7	2.0	30%	1.0	3.7	70%	1: 6.5	5.7	1.7	30%	1.0	3.0	70%	1: 10.5	3.5	1.1	30%	1.0	1.5	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	15	3	ICF	M	Single	32	1: 5.5	5.8	1.7	30%	1.0	3.1	70%	1: 6.5	4.9	1.5	30%	1.0	2.4	70%	1: 10.5	3.0	0.9	30%	1.0	1.1	70%
Multi-Commitment Treatment	MDO, NGI Permanent Housing-Single	22	1	ICF	M	Single	35	1: 5.5	6.4	1.9	30%	1.0	3.5	70%	1: 6.5	5.4	1.6	30%	1.0	2.8	70%	1: 10.5	3.3	1.0	30%	1.0	1.3	70%
CDCR (Coleman) Treatment	CDCR Permanent Housing	30	5	ICF	M	Dorm	46	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 6	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.0	1.2	30%	1.0	1.8	70%
CDCR (Coleman) Treatment	CDCR Permanent Housing	31	5	ICF	M	Dorm	46	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 6	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.0	1.2	30%	1.0	1.8	70%
CDCR (Coleman) Treatment	CDCR Permanent Housing	32	5	ICF	M	Dorm	46	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 6	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.0	1.2	30%	1.0	1.8	70%
CDCR (Coleman) Treatment	CDCR Permanent Housing	33	5	ICF	M	Dorm	46	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 6	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.0	1.2	30%	1.0	1.8	70%
CDCR (Coleman) Treatment	CDCR Permanent Housing	34	5	ICF	M	Dorm	46	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 6	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.0	1.2	30%	1.0	1.8	70%
		34					1188		232.1	73.6		34.0	124.5			215.9	68.8		34.0	113.2			127.1	40.8		34.0	52.3	

\* Data as of August 2018 Net Bed Capacity Report with hospital confirmation as of September 2018.

\* Closed Units: none

\* Reflects unit status that will be achieved with the activation of Unit 29 as an ETP unit. Displays Unit 3 and Unit 24 as open since they were part of the Unit 29 ETP staffing package.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Proposed DSH Unit Categorization and System-Wide Ratios  
Ratio-Driven Staffing Calculations

DSH-Coalinga																												
Unit Characteristics								AM Shift							PM Shift							NOC Shift						
Category	System-Wide Grouping	Unit	Program	CDPH Licensure	Gender	Room Type	Operational Capacity	Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios						
								Ratio-Driven							Ratio-Driven							Ratio-Driven						
								Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %
Medical Treatment	Medical Unit	MA-1	1	Acute	M	Single	19	1: 2	9.5	4.8	50%	1.0	3.8	50%	1: 2	9.5	4.8	50%	1.0	3.8	50%	1: 2.5	7.6	3.8	50%	1.0	2.8	50%
Medical Treatment	Medical Unit	MA-2	1	Acute	M	Single	21	1: 2	10.5	5.3	50%	1.0	4.3	50%	1: 2	10.5	5.3	50%	1.0	4.3	50%	1: 2.5	8.4	4.2	50%	1.0	3.2	50%
Medical Treatment	Medically Fragile/Geropsych	6	3	ICF	M	Mixed	50	1: 4.5	11.1	5.6	50%	1.0	4.6	50%	1: 5	10.0	5.0	50%	1.0	4.0	50%	1: 7.5	6.7	3.3	50%	1.0	2.3	50%
Specialized Services Treatment	PC Specialized Services: Intermediate Care High Behavior Acuity	17	6	ICF	M	Mixed	40	1: 4.5	8.9	2.7	30%	1.0	5.2	70%	1: 4.5	8.9	2.7	30%	1.0	5.2	70%	1: 7.5	5.3	1.6	30%	1.0	2.7	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	22	7	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	23	7	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	25	8	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	26	8	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	27	8	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	28	8	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	24	7	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
Mentally Disordered Offender (MDO) Treatment	MDO Permanent Housing-Single, Mixed	20	6	ICF	M	Mixed	45	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 5	9.0	2.7	30%	1.0	5.3	70%	1: 10	4.5	1.4	30%	1.0	2.2	70%
CDCR (Coleman) Treatment	CDCR Permanent Housing	21	7	ICF	M	Mixed	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	5	3	ICF	M	Mixed	40	1: 6	6.7	2.0	30%	1.0	3.7	70%	1: 6.5	6.2	1.8	30%	1.0	3.3	70%	1: 13.5	3.0	0.9	30%	1.0	1.1	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	9	4	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	1	2	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	2	2	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	8	3	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	13	5	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	14	5	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	16	5	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	18	6	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Permanent Housing	10	4	ICF	M	Mixed	50	1: 6	8.3	2.5	30%	1.0	4.8	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 13.5	3.7	1.1	30%	1.0	1.6	70%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	3	2	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	4	2	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	7	3	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	11	4	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	12	4	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	15	5	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
Sexually Violent Predator (SVP) Treatment	SVP Residential Recovery Unit	19	6	RRU	M	Mixed	50	1: 13	3.8	0.8	20%	1.0	2.1	80%	1: 17	2.9	0.6	20%	1.0	1.4	80%	1: 20	2.5	0.5	20%	1.0	1.0	80%
		30					1380		229.7	72.4		30.0	127.2			215.2	68.5		30.0	116.7			122.1	39.4		30.0	52.7	

\* Data as of August 2018 Net Bed Capacity Report with hospital confirmation as of September 2018.

\* Closed Units: MA-3 and MA-4

\* Reflects unit status that will be achieved with the activation of 40 MDO beds. Displays Units 20, 22, 23, 24, 25, 26, 27 and 28 with an operational capacity of 45 beds.

229.7215.2122.1567.0

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Proposed DSH Unit Categorization and System-Wide Ratios  
Ratio-Driven Staffing Calculations

DSH-Metro																																
Unit Characteristics								AM Shift							PM Shift							NOC Shift										
Category	System-Wide Grouping	Unit	Program	CDPH Licensure	Gender	Room Type	Operational Capacity	Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios										
								Ratio-Driven							Ratio-Driven							Ratio-Driven										
								Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %				
Medical Treatment	Skilled Nursing Facility	419	6	SNF	Co-Ed	Mixed	34	1: 2.5	13.6	6.8	50%	1.0	5.8	50%	1: 2.5	13.6	6.8	50%	1.0	5.8	50%	1: 4	8.5	4.3	50%	1.0	3.3	50%				
Medical Treatment	Skilled Nursing Facility	418	6	SNF	Co-Ed	Mixed	34	1: 2.5	13.6	6.8	50%	1.0	5.8	50%	1: 2.5	13.6	6.8	50%	1.0	5.8	50%	1: 4	8.5	4.3	50%	1.0	3.3	50%				
Medical Treatment	Medically Fragile/Geropsych	420	6	Acute	Co-Ed	Mixed	32	1: 4.5	7.1	3.6	50%	1.0	2.6	50%	1: 5	6.4	3.2	50%	1.0	2.2	50%	1: 7.5	4.3	2.1	50%	1.0	1.1	50%				
Specialized Services Treatment	LPS Specialized Services: Acute Psychiatric	410	4	Acute Cert	Co-Ed	Dorm	46	1: 3	15.3	4.6	30%	1.0	9.7	70%	1: 3	15.3	4.6	30%	1.0	9.7	70%	1: 4.5	10.2	3.1	30%	1.0	6.2	70%				
Specialized Services Treatment	LPS Specialized Services: DBT	101	TBD	Acute	TBD	Dorm	16	1: 3	5.3	1.6	30%	1.0	2.7	70%	1: 3	5.3	1.6	30%	1.0	2.7	70%	1: 4.5	3.6	1.1	30%	1.0	1.5	70%				
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	401	3	Acute	M	Dorm	54	1: 5.5	9.8	2.9	30%	1.0	5.9	70%	1: 5.5	9.8	2.9	30%	1.0	5.9	70%	1: 9.5	5.7	1.7	30%	1.0	3.0	70%				
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	403	5	Acute	F	Dorm	54	1: 5.5	9.8	2.9	30%	1.0	5.9	70%	1: 5.5	9.8	2.9	30%	1.0	5.9	70%	1: 9.5	5.7	1.7	30%	1.0	3.0	70%				
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	405	5	Acute	M	Dorm	54	1: 5.5	9.8	2.9	30%	1.0	5.9	70%	1: 5.5	9.8	2.9	30%	1.0	5.9	70%	1: 9.5	5.7	1.7	30%	1.0	3.0	70%				
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	411	5	Acute	M	Dorm	53	1: 5.5	9.6	2.9	30%	1.0	5.7	70%	1: 5.5	9.6	2.9	30%	1.0	5.7	70%	1: 9.5	5.6	1.7	30%	1.0	2.9	70%				
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	413	5	Acute	M	Dorm	53	1: 5.5	9.6	2.9	30%	1.0	5.7	70%	1: 5.5	9.6	2.9	30%	1.0	5.7	70%	1: 9.5	5.6	1.7	30%	1.0	2.9	70%				
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	415	3	Acute	M	Dorm	53	1: 5.5	9.6	2.9	30%	1.0	5.7	70%	1: 5.5	9.6	2.9	30%	1.0	5.7	70%	1: 9.5	5.6	1.7	30%	1.0	2.9	70%				
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	407	3	Acute	M	Dorm	54	1: 6	9.0	2.7	30%	1.0	5.3	70%	1: 6	9.0	2.7	30%	1.0	5.3	70%	1: 11.5	4.7	1.4	30%	1.0	2.3	70%				
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	409	3	Acute	M	Dorm	53	1: 6	8.8	2.7	30%	1.0	5.2	70%	1: 6	8.8	2.7	30%	1.0	5.2	70%	1: 11.5	4.6	1.4	30%	1.0	2.2	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	408	4	Acute	Co-Ed	Dorm	48	1: 5	9.6	2.9	30%	1.0	5.7	70%	1: 5	9.6	2.9	30%	1.0	5.7	70%	1: 9	5.3	1.6	30%	1.0	2.7	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	404	2	Acute	Co-Ed	Dorm	48	1: 5	9.6	2.9	30%	1.0	5.7	70%	1: 5	9.6	2.9	30%	1.0	5.7	70%	1: 9	5.3	1.6	30%	1.0	2.7	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	102	TBD	Acute	TBD	Dorm	28	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 9	3.1	0.9	30%	1.0	1.2	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	105	TBD	Acute	TBD	Dorm	28	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 9	3.1	0.9	30%	1.0	1.2	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	106	TBD	Acute	TBD	Dorm	28	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 9	3.1	0.9	30%	1.0	1.2	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	107	TBD	Acute	TBD	Dorm	28	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 9	3.1	0.9	30%	1.0	1.2	70%				
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	108	TBD	Acute	TBD	Dorm	28	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 5	5.6	1.7	30%	1.0	2.9	70%	1: 9	3.1	0.9	30%	1.0	1.2	70%				
Closed	IST Admission to Discharge	416	n/a	Acute	n/a	Dorm	0	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 9.5	0.0	0.0	30%	0.0	0.0	70%				
Closed	IST Admission to Discharge	412	n/a	Acute	n/a	Dorm	0	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 9.5	0.0	0.0	30%	0.0	0.0	70%				
Closed	IST Admission to Discharge	414	n/a	Acute	n/a	Dorm	0	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 9.5	0.0	0.0	30%	0.0	0.0	70%				
Closed	IST Admission to Discharge	406	n/a	Acute	n/a	Dorm	0	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 9.5	0.0	0.0	30%	0.0	0.0	70%				
Closed	IST Admission to Discharge	402	n/a	Acute	n/a	Dorm	0	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 5.5	0.0	0.0	30%	0.0	0.0	70%	1: 9.5	0.0	0.0	30%	0.0	0.0	70%				
		20					826		178.4	60.4		20.0	98.0			177.7	60.0		20.0	97.6			104.4	35.6		20.0	48.8					
								178.4							177.7							104.4							460.4			

\* Data as of August 2018 Net Bed Capacity Report with hospital confirmation as of September 2018.

\* Closed Units: SNF Unit 417; CT-W Units 402, 406, 412, 414, and 416.

\* Reflects unit status achieved with the re-occupation of the 100s Building and transfer of LPS patients from CT-W.



Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Proposed DSH Unit Categorization and System-Wide Ratios  
Ratio-Driven Staffing Calculations

DSH-Napa																												
Unit Characteristics								AM Shift							PM Shift							NOC Shift						
Category	System-Wide Grouping	Unit	Program	CDPH Licensure	Gender	Room Type	Operational Capacity	Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios						
								Ratio-Driven							Ratio-Driven							Ratio-Driven						
								Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %
Admissions	PC Standard Admissions	T1	2	ICF	F	Dorm	35	1: 4.5	7.8	2.3	30%	1.0	4.4	70%	1: 5	7.0	2.1	30%	1.0	3.9	70%	1: 8	4.4	1.3	30%	1.0	2.1	70%
Admissions	PC Standard Admissions	T2	2	ICF	F	Dorm	35	1: 4.5	7.8	2.3	30%	1.0	4.4	70%	1: 5	7.0	2.1	30%	1.0	3.9	70%	1: 8	4.4	1.3	30%	1.0	2.1	70%
Admissions	PC Standard Admissions	T3	5	ICF	M	Mixed	33	1: 4.5	7.3	2.2	30%	1.0	4.1	70%	1: 5	6.6	2.0	30%	1.0	3.6	70%	1: 8	4.1	1.2	30%	1.0	1.9	70%
Admissions	PC Standard Admissions	T4	5	ICF	M	Dorm	33	1: 4.5	7.3	2.2	30%	1.0	4.1	70%	1: 5	6.6	2.0	30%	1.0	3.6	70%	1: 8	4.1	1.2	30%	1.0	1.9	70%
Admissions	Hybrid Admissions	A9	4	Acute Cert	Co-Ed	Mixed	20	1: 5.5	3.6	1.1	30%	1.0	1.5	70%	1: 5.5	3.6	1.1	30%	1.0	1.5	70%	1: 9.5	3.0	0.9	30%	1.0	1.1	70%
Admissions	Hybrid Admissions	Q5	5	ICF	M	Mixed	31	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 9.5	3.3	1.0	30%	1.0	1.3	70%
Admissions	Hybrid Admissions	Q6	5	ICF	M	Mixed	31	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 9.5	3.3	1.0	30%	1.0	1.3	70%
Admissions	Hybrid Admissions	Q7	5	ICF	M	Mixed	31	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 9.5	3.3	1.0	30%	1.0	1.3	70%
Admissions	Hybrid Admissions	Q8	5	ICF	M	Mixed	31	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 5.5	5.6	1.7	30%	1.0	2.9	70%	1: 9.5	3.3	1.0	30%	1.0	1.3	70%
Admissions	Hybrid Admissions	Q9	5	ICF	M	Mixed	52	1: 5.5	9.5	2.8	30%	1.0	5.6	70%	1: 5.5	9.5	2.8	30%	1.0	5.6	70%	1: 9.5	5.5	1.6	30%	1.0	2.8	70%
Admissions	Hybrid Admissions	T13	3	ICF	M	Mixed	44	1: 5.5	8.0	2.4	30%	1.0	4.6	70%	1: 5.5	8.0	2.4	30%	1.0	4.6	70%	1: 9.5	4.6	1.4	30%	1.0	2.2	70%
Medical Treatment	Medical Unit	A3	4	Acute Cert	Co-Ed	Mixed	15	1: 2	7.5	3.8	50%	1.0	2.8	50%	1: 2	7.5	3.8	50%	1.0	2.8	50%	1: 2.5	6.0	3.0	50%	1.0	2.0	50%
Medical Treatment	Skilled Nursing Facility	A4	4	SNF	Co-Ed	Mixed	29	1: 2.5	11.6	5.8	50%	1.0	4.8	50%	1: 2.5	11.6	5.8	50%	1.0	4.8	50%	1: 4	7.3	3.6	50%	1.0	2.6	50%
Medical Treatment	Medically Fragile/Geropsych	Q1	2	ICF	Co-Ed	Mixed	34	1: 4.5	7.6	3.8	50%	1.0	2.8	50%	1: 5	6.8	3.4	50%	1.0	2.4	50%	1: 7.5	4.5	2.3	50%	1.0	1.3	50%
Medical Treatment	Medically Fragile/Geropsych	Q11	5	ICF	M	Dorm	52	1: 4.5	11.6	5.8	50%	1.0	4.8	50%	1: 5	10.4	5.2	50%	1.0	4.2	50%	1: 7.5	6.9	3.5	50%	1.0	2.5	50%
Medical Treatment	Medically Fragile/Geropsych	Q2	2	ICF	Co-Ed	Mixed	34	1: 4.5	7.6	3.8	50%	1.0	2.8	50%	1: 5	6.8	3.4	50%	1.0	2.4	50%	1: 7.5	4.5	2.3	50%	1.0	1.3	50%
Medical Treatment	Medically Fragile/Geropsych	Q3	2	ICF	M	Mixed	28	1: 4.5	6.2	3.1	50%	1.0	2.1	50%	1: 5	5.6	2.8	50%	1.0	1.8	50%	1: 7.5	3.7	1.9	50%	1.0	0.9	50%
Medical Treatment	Medically Fragile/Geropsych	Q4	2	ICF	M	Mixed	28	1: 4.5	6.2	3.1	50%	1.0	2.1	50%	1: 5	5.6	2.8	50%	1.0	1.8	50%	1: 7.5	3.7	1.9	50%	1.0	0.9	50%
Medical Treatment	Medically Fragile/Geropsych	A2	4	ICF	Co-Ed	Mixed	37	1: 4.5	8.2	4.1	50%	1.0	3.1	50%	1: 5	7.4	3.7	50%	1.0	2.7	50%	1: 7.5	4.9	2.5	50%	1.0	1.5	50%
Specialized Services Treatment	PC Specialized Services: DBT	T14	3	ICF	Co-Ed	Mixed	41	1: 5.5	7.5	2.2	30%	1.0	4.2	70%	1: 5.5	7.5	2.2	30%	1.0	4.2	70%	1: 9	4.6	1.4	30%	1.0	2.2	70%
Specialized Services Treatment	PC Specialized Services: DBT	T8	1	ICF	M	Mixed	46	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 5.5	8.4	2.5	30%	1.0	4.9	70%	1: 9	5.1	1.5	30%	1.0	2.6	70%
Specialized Services Treatment	PC Specialized Services: Polydipsia	T7	1	ICF	M	Mixed	44	1: 5.5	8.0	2.4	30%	1.0	4.6	70%	1: 5.5	8.0	2.4	30%	1.0	4.6	70%	1: 9	4.9	1.5	30%	1.0	2.4	70%
Specialized Services Treatment	PC Specialized Services: Substance Abuse	T12	3	ICF	M	Mixed	43	1: 5.5	7.8	2.3	30%	1.0	4.5	70%	1: 5.5	7.8	2.3	30%	1.0	4.5	70%	1: 9	4.8	1.4	30%	1.0	2.3	70%
Specialized Services Treatment	LPS Specialized Services: DBT	A1	4	ICF	Co-Ed	Dorm	30	1: 3	10.0	3.0	30%	1.0	6.0	70%	1: 3	10.0	3.0	30%	1.0	6.0	70%	1: 4.5	6.7	2.0	30%	1.0	3.7	70%
Specialized Services Treatment	LPS Specialized Services: Polydipsia	A10	4	ICF	M	Mixed	30	1: 3	10.0	3.0	30%	1.0	6.0	70%	1: 3	10.0	3.0	30%	1.0	6.0	70%	1: 4.5	6.7	2.0	30%	1.0	3.7	70%
Specialized Services Treatment	PC Specialized Services: Intermediate Care High Behavior Acuity	T18	1	ICF	M	Mixed	46	1: 4.5	10.2	3.1	30%	1.0	6.2	70%	1: 4.5	10.2	3.1	30%	1.0	6.2	70%	1: 7.5	6.1	1.8	30%	1.0	3.3	70%
Specialized Services Treatment	PC Specialized Services: Intermediate Care High Behavior Acuity	T6	1	ICF	Co-Ed	Mixed	46	1: 4.5	10.2	3.1	30%	1.0	6.2	70%	1: 4.5	10.2	3.1	30%	1.0	6.2	70%	1: 7.5	6.1	1.8	30%	1.0	3.3	70%
Specialized Services Treatment	Specialized Services: Sex Offender Treatment	T15	3	ICF	M	Mixed	45	1: 7.5	6.0	1.8	30%	1.0	3.2	70%	1: 7.5	6.0	1.8	30%	1.0	3.2	70%	1: 14	3.2	1.0	30%	1.0	1.3	70%
Incompetent to Stand Trial (IST) Treatment	IST Permanent Housing-Dorm, Mixed	T17	2	ICF	Co-Ed	Mixed	46	1: 6.5	7.1	2.1	30%	1.0	4.0	70%	1: 6.5	7.1	2.1	30%	1.0	4.0	70%	1: 12	3.8	1.2	30%	1.0	1.7	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	T11	3	ICF	Co-Ed	Mixed	44	1: 6.5	6.8	2.0	30%	1.0	3.7	70%	1: 6.5	6.8	2.0	30%	1.0	3.7	70%	1: 11.5	3.8	1.1	30%	1.0	1.7	70%
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	T5	1	ICF	Co-Ed	Mixed	46	1: 6.5	7.1	2.1	30%	1.0	4.0	70%	1: 6.5	7.1	2.1	30%	1.0	4.0	70%	1: 11.5	4.0	1.2	30%	1.0	1.8	70%
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	A7	4	ICF	M	Dorm	37	1: 5	7.4	2.2	30%	1.0	4.2	70%	1: 5	7.4	2.2	30%	1.0	4.2	70%	1: 9	4.1	1.2	30%	1.0	1.9	70%
Lanterman-Petris Short (LPS) Treatment	LPS Permanent Housing	A8	4	ICF	M	Dorm	36	1: 5	7.2	2.2	30%	1.0	4.0	70%	1: 5	7.2	2.2	30%	1.0	4.0	70%	1: 9	4.0	1.2	30%	1.0	1.8	70%
Discharge Preparation Units	Discharge Ready	T10	1	ICF	Co-Ed	Single	28	1: 7	4.0	1.2	30%	1.0	1.8	70%	1: 7.5	3.7	1.1	30%	1.0	1.6	70%	1: 12.5	3.0	0.9	30%	1.0	1.1	70%
Discharge Preparation Units	Discharge Ready	T16	3	ICF	Co-Ed	Mixed	45	1: 7	6.4	1.9	30%	1.0	3.5	70%	1: 7.5	6.0	1.8	30%	1.0	3.2	70%	1: 12.5	3.6	1.1	30%	1.0	1.5	70%
Discharge Preparation Units	Discharge Ready	T9	1	ICF	Co-Ed	Single	28	1: 7	4.0	1.2	30%	1.0	1.8	70%	1: 7.5	3.7	1.1	30%	1.0	1.6	70%	1: 12.5	3.0	0.9	30%	1.0	1.1	70%
		36					1314		268.3	93.8		36.0	138.5			259.6	90.2		36.0	133.4			162.3	57.0		36.0	69.3	

\* Data as of August 2018 Net Bed Capacity Report with hospital confirmation as of September 2018.

\* Closed Units: None

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Proposed DSH Unit Categorization and System-Wide Ratios  
Ratio-Driven Staffing Calculations

DSH-Patton																														
Unit Characteristics								AM Shift							PM Shift							NOC Shift								
Category	System-Wide Grouping	Unit	Program	CDPH Licensure	Gender	Room Type	Operational Capacity	Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios							Based on Proposed System-Wide Grouping Ratios								
								Ratio-Driven							Ratio-Driven							Ratio-Driven								
								Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %	Ratio	Total Staff Delivered	RN		Sr PT (SL)	PT	Sr PT & PT %		
Medical Treatment	Medically Fragile/Geropsych	EB11	6	Acute	Co-Ed	Mixed	43	1: 4.5	9.6	4.8	50%	1.0	3.8	50%	1: 5	8.6	4.3	50%	1.0	3.3	50%	1: 7.5	5.7	2.9	50%	1.0	1.9	50%		
Medical Treatment	Medically Fragile/Geropsych	U05	6	ICF	Co-Ed	Mixed	37	1: 4.5	8.2	4.1	50%	1.0	3.1	50%	1: 5	7.4	3.7	50%	1.0	2.7	50%	1: 7.5	4.9	2.5	50%	1.0	1.5	50%		
Specialized Services Treatment	PC Specialized Services: Psychologically fragile	U06	6	ICF	F	Mixed	43	1: 5.5	7.8	2.3	30%	1.0	4.5	70%	1: 5.5	7.8	2.3	30%	1.0	4.5	70%	1: 9.0	4.8	1.4	30%	1.0	2.3	70%		
Specialized Services Treatment	Specialized Services: Sex Offender Treatment	EB09	6	Acute	Co-Ed	Dorm	44	1: 6	7.3	2.2	30%	1.0	4.1	70%	1: 6	7.3	2.2	30%	1.0	4.1	70%	1: 12.0	3.7	1.1	30%	1.0	1.6	70%		
Specialized Services Treatment	Specialized Services: Deaf, Hard of Hearing	EB10	6	Acute	Co-Ed	Mixed	17	1: 3	5.7	1.7	30%	1.0	3.0	70%	1: 3	5.7	1.7	30%	1.0	3.0	70%	1: 6.0	3.0	0.9	30%	1.0	1.1	70%		
Specialized Services Treatment	Specialized Services: Monolingual	EB04	6	ICF	Co-Ed	Dorm	47	1: 5	9.4	2.8	30%	1.0	5.6	70%	1: 5.5	8.5	2.6	30%	1.0	5.0	70%	1: 8.0	5.9	1.8	30%	1.0	3.1	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	70	7	Acute	M	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	71	7	Acute	M	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	72	7	Acute	M	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	73	7	Acute	M	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	74	7	ICF	Co-Ed	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	75	7	Acute	Co-Ed	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	76	7	ICF	M	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	77	7	Acute	M	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Admission to Discharge	33	4	ICF	F	Dorm	50	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 5.5	9.1	2.7	30%	1.0	5.4	70%	1: 9.5	5.3	1.6	30%	1.0	2.7	70%		
Incompetent to Stand Trial (IST) Treatment	IST Permanent Housing-Dorm, Mixed	34	4	ICF	F	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 12.0	4.2	1.3	30%	1.0	1.9	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	EB12	6	Acute	M	Dorm	24	1: 6	4.0	1.2	30%	1.0	1.8	70%	1: 6	4.0	1.2	30%	1.0	1.8	70%	1: 11.5	3.0	0.9	30%	1.0	1.1	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	EB01	6	Acute	M	Dorm	34	1: 6	5.7	1.7	30%	1.0	3.0	70%	1: 6	5.7	1.7	30%	1.0	3.0	70%	1: 11.5	3.0	0.9	30%	1.0	1.1	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	EB02	6	Acute	M	Dorm	33	1: 6	5.5	1.7	30%	1.0	2.9	70%	1: 6	5.5	1.7	30%	1.0	2.9	70%	1: 11.5	3.0	0.9	30%	1.0	1.1	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N20	5	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N21	5	ICF	M	Mixed	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N22	5	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N23	5	ICF	M	Mixed	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N24	5	ICF	M	Mixed	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N25	5	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N26	5	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	N27	5	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	30	4	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	31	4	ICF	F	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	32	4	ICF	F	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	35	4	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	36	4	ICF	F	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
Multi-Commitment Treatment	MDO, NGI, LPS Permanent Housing-Dorm, Mixed	37	4	ICF	M	Dorm	50	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 6.5	7.7	2.3	30%	1.0	4.4	70%	1: 11.5	4.3	1.3	30%	1.0	2.0	70%		
		33					1522		260.4	81.7		33.0	145.7			257.7	80.5		33.0	144.2			149.3	46.9		33.0	69.4			
								260.4							257.7							149.3							667.4	

\* Data as of August 2018 Net Bed Capacity Report with hospital confirmation as of September 2018.

\* Closed Units: None

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Position Assessment and Need

Current Position Authority			
Atascadero	7A	Off Unit	Available Resources
Registered Nurse	294.5	17.0	277.5
Senior Psychiatric Technician	75.9	1.0	74.9
Psychiatric Technician	692.7	40.5	652.2
Psychiatric Technician Assistant	3.0	-	3.0
Licensed Vocational Nurse	3.0	-	3.0
Total	1,069.1	58.5	1,010.6

Coalinga	7A	Off Unit	Available Resources
Registered Nurse	240.1	26.0	214.1
Senior Psychiatric Technician	85.0	5.0	80.0
Psychiatric Technician	703.2	75.0	628.2
Psychiatric Technician Assistant	38.0	1.0	37.0
Licensed Vocational Nurse	17.8	16.0	1.8
Total	1,084.1	123.0	961.1

Metropolitan	7A	Off Unit	Available Resources
Registered Nurse	175.6	23.0	152.6
Senior Psychiatric Technician	49.1	3.0	46.1
Psychiatric Technician	302.5	16.0	286.5
Psychiatric Technician Assistant	65.0	7.0	58.0
Licensed Vocational Nurse	20.0	-	20.0
Total	612.2	49.0	563.2

Proposed Position Authority							
Atascadero	AM	PM	NOC	Sub-Total	Relief	Total	
Registered Nurse - Ratio-Driven	73.6	68.8	40.8	183.2	136.5	319.7	
Senior Psychiatric Technician - Ratio-Driven	34.0	34.0	34.0	102.0	76.0	178.0	
Psychiatric Technician - Ratio-Driven	124.5	113.2	52.3	289.9	216.0	505.9	
Total - Ratio-Driven Positions	232.1	215.9	127.1	575.1	428.5	1,003.6	
Psychiatric Technician - Medication Room				31.0	50.1	81.1	
Supervising Registered Nurse - Afterhours Supervision				3.0	4.9	7.9	
Total - Additional Unit-Based Positions	-	-	-	34.0	55.0	89.0	

Coalinga	AM	PM	NOC	Sub-Total	Relief	Total	
Registered Nurse - Ratio-Driven	72.4	68.5	39.4	180.4	134.4	314.8	
Senior Psychiatric Technician - Ratio-Driven	30.0	30.0	30.0	90.0	67.1	157.1	
Psychiatric Technician - Ratio-Driven	127.2	116.7	52.7	296.7	221.0	517.7	
Total - Ratio-Driven Positions	229.7	215.2	122.1	567.0	422.5	989.5	
Psychiatric Technician - Medication Room				17.0	27.5	44.5	
Supervising Registered Nurse - Afterhours Supervision				3.0	4.9	7.9	
Total - Additional Unit-Based Positions	-	-	-	20.0	32.4	52.4	

Metropolitan	AM	PM	NOC	Sub-Total	Relief	Total	
Registered Nurse - Ratio-Driven	60.4	60.0	35.6	156.0	116.2	272.2	
Senior Psychiatric Technician - Ratio-Driven	20.0	20.0	20.0	60.0	44.7	104.7	
Psychiatric Technician - Ratio-Driven	98.0	97.6	48.8	244.4	182.1	426.5	
Total - Ratio-Driven Positions	178.4	177.7	104.4	460.4	343.0	803.4	
Psychiatric Technician - Medication Room				16.0	25.9	41.9	
Supervising Registered Nurse - Afterhours Supervision				3.0	4.9	7.9	
Total - Additional Unit-Based Positions	-	-	-	19.0	30.8	49.8	

Position Need			
Atascadero	Current Positions	Proposed Positions	Position Need
Registered Nurse - Ratio-Driven	277.5	319.7	42.2
Senior Psychiatric Technician - Ratio-Driven	74.9	178.0	103.1
Psychiatric Technician <sup>1</sup> - Ratio-Driven	658.2	505.9	(152.3)
Total - Ratio-Driven Positions	1,010.6	1,003.6	(7.0)
Psychiatric Technician - Medication Room	-	81.1	81.1
Supervising Registered Nurse - Afterhours Supervision	-	7.9	7.9
Total - Additional Unit-Based Positions	-	89.0	89.0

Coalinga	Current Positions	Proposed Positions	Position Need
Registered Nurse - Ratio-Driven	214.1	314.8	100.7
Senior Psychiatric Technician - Ratio-Driven	80.0	157.1	77.1
Psychiatric Technician <sup>1</sup> - Ratio-Driven	667.0	517.7	(149.3)
Total - Ratio-Driven Positions	961.1	989.5	28.4
Psychiatric Technician - Medication Room	-	44.5	44.5
Supervising Registered Nurse - Afterhours Supervision	-	7.9	7.9
Total - Additional Unit-Based Positions	-	52.4	52.4

Metropolitan	Current Positions	Proposed Positions	Position Need
Registered Nurse - Ratio-Driven	152.6	272.2	119.6
Senior Psychiatric Technician - Ratio-Driven	46.1	104.7	58.6
Psychiatric Technician <sup>1</sup> - Ratio-Driven	364.5	426.5	62.0
Total - Ratio-Driven Positions	563.2	803.4	240.2
Psychiatric Technician - Medication Room	-	41.9	41.9
Supervising Registered Nurse - Afterhours Supervision	-	7.9	7.9
Total - Additional Unit-Based Positions	-	49.8	49.8

<sup>1</sup> Psychiatric technician current positions include licensed vocational nurses, psychiatric technicians and psychiatric technician assistants since these classifications may be used interchangeably on the units.

Department of State Hospitals  
24-Hour Care Nursing Services Staffing Study  
Position Assessment and Need

Current Position Authority

Napa	7A	Off Unit	Available Resources
Registered Nurse	391.0	20.0	371.0
Senior Psychiatric Technician	68.0	11.0	57.0
Psychiatric Technician	403.8	68.0	335.8
Psychiatric Technician Assistant	188.1	27.0	161.1
Licensed Vocational Nurse	40.0	2.0	38.0
Total	1,090.9	128.0	962.9

Patton	7A	Off Unit	Available Resources
Registered Nurse	360.7	42.5	318.2
Senior Psychiatric Technician	89.0	6.0	83.0
Psychiatric Technician	692.2	73.5	618.7
Psychiatric Technician Assistant	22.0	-	22.0
Licensed Vocational Nurse	47.0	1.0	46.0
Total	1,210.9	123.0	1,087.9

DSH Total	7A	Off Unit	Available Resources
Registered Nurse	1,461.9	128.5	1,333.4
Senior Psychiatric Technician	367.0	26.0	341.0
Psychiatric Technician	2,794.4	273.0	2,521.4
Psychiatric Technician Assistant	316.1	35.0	281.1
Licensed Vocational Nurse	127.8	19.0	108.8
Total	5,067.2	481.5	4,585.7

Proposed Position Authority

Napa	AM	PM	NOC	Sub-Total	Relief	Total
Registered Nurse - Ratio-Driven	93.8	90.2	57.0	241.0	179.6	420.6
Senior Psychiatric Technician - Ratio-Driven	36.0	36.0	36.0	108.0	80.5	188.5
Psychiatric Technician - Ratio-Driven	138.5	133.4	69.3	341.2	254.2	595.4
Total - Ratio-Driven Positions	268.3	259.6	162.3	690.3	514.3	1,204.6
Psychiatric Technician - Medication Room				31.0	50.1	81.1
Supervising Registered Nurse - Afterhours Supervision				4.0	6.5	10.5
Total - Additional Unit-Based Positions	-	-	-	35.0	56.6	91.6

Patton	AM	PM	NOC	Sub-Total	Relief	Total
Registered Nurse - Ratio-Driven	81.7	80.5	46.9	209.1	155.8	364.9
Senior Psychiatric Technician - Ratio-Driven	33.0	33.0	33.0	99.0	73.8	172.8
Psychiatric Technician - Ratio-Driven	145.7	144.2	69.4	359.3	267.7	627.0
Total - Ratio-Driven Positions	260.4	257.7	149.3	667.4	497.3	1,164.7
Psychiatric Technician - Medication Room				33.0	53.4	86.4
Supervising Registered Nurse - Afterhours Supervision				4.0	6.5	10.5
Total - Additional Unit-Based Positions	-	-	-	37.0	59.9	96.9

DSH Total	AM	PM	NOC	Sub-Total	Relief	Total
Registered Nurse - Ratio-Driven	381.9	368.0	219.7	969.7	722.5	1,692.2
Senior Psychiatric Technician - Ratio-Driven	153.0	153.0	153.0	459.0	342.1	801.1
Psychiatric Technician - Ratio-Driven	633.9	605.1	292.5	1,531.6	1,141.0	2,672.6
Total - Ratio-Driven Positions	1,168.8	1,126.1	665.3	2,960.2	2,205.6	5,165.8
Psychiatric Technician - Medication Room	-	-	-	128.0	207.0	335.0
Supervising Registered Nurse - Afterhours Supervision	-	-	-	17.0	27.5	44.5
Total - Additional Unit-Based Positions	-	-	-	145.0	234.5	379.5

Position Need

Napa	Current Positions	Proposed Positions	Position Need
Registered Nurse - Ratio-Driven	371.0	420.6	49.6
Senior Psychiatric Technician - Ratio-Driven	57.0	188.5	131.5
Psychiatric Technician <sup>1</sup> - Ratio-Driven	534.9	595.4	60.5
Total - Ratio-Driven Positions	962.9	1,204.6	241.7
Psychiatric Technician - Medication Room	-	81.1	81.1
Supervising Registered Nurse - Afterhours Supervision	-	10.5	10.5
Total - Additional Unit-Based Positions	-	91.6	91.6

Patton	Current Positions	Proposed Positions	Position Need
Registered Nurse - Ratio-Driven	318.2	364.9	46.7
Senior Psychiatric Technician - Ratio-Driven	83.0	172.8	89.8
Psychiatric Technician <sup>1</sup> - Ratio-Driven	686.7	627.0	(59.7)
Total - Ratio-Driven Positions	1,087.9	1,164.7	76.8
Psychiatric Technician - Medication Room	-	86.4	86.4
Supervising Registered Nurse - Afterhours Supervision	-	10.5	10.5
Total - Additional Unit-Based Positions	-	96.9	96.9

DSH Total	Current Positions	Proposed Positions	Position Need
Registered Nurse - Ratio-Driven	1,333.4	1,692.2	358.8
Senior Psychiatric Technician - Ratio-Driven	341.0	801.1	460.1
Psychiatric Technician <sup>1</sup> - Ratio-Driven	2,911.3	2,672.6	(238.7)
Total - Ratio-Driven Positions	4,585.7	5,165.8	580.1
Psychiatric Technician - Medication Room	-	335.0	335.0
Supervising Registered Nurse - Afterhours Supervision	-	44.5	44.5
Total - Additional Unit-Based Positions	-	379.5	379.5

<sup>1</sup> Psychiatric technician current positions include licensed vocational nurses, psychiatric technicians and psychiatric technician assistants since these classifications may be used interchangeably on the units.

## Appendix L

### Department of State Hospitals 24-Hour Care Nursing Services Staffing Study Relief Factor Assessment

A relief factor is essential for identifying the number of full-time-equivalent (FTE) staff necessary to fill a post. To calculate an accurate relief factor, variables that identify when an employee is away from their duties and requires coverage must be assessed. These variables include how long and how often posts need to be filled, regular days off for staff, and the use of paid and unpaid leave types. DSH currently applies a relief factor of 1.76 when calculating staffing needs of 24-hour functions. This relief factor has not been updated for multiple years. To assess the adequacy of DSH's current relief factor, leave usage data for fiscal year 2017-18 was compiled. Leave data was specific to psychiatric technician and registered nurse positions, as these classifications account for the majority (81 percent<sup>1</sup>) of all nursing classifications staffed at the hospitals.

Using the Management Information Retrieval System (MIRS), leave usage totals were retrieved for the following leave types:

- Annual Leave
- Bereavement Leave
- Compensating Time Off (CTO)
- Holiday Informal Time Off
- Personal Leave Day
- Military Leave
- Sick Leave
- Industrial Disability Leave (IDL)
- Vacation
- Administrative Time Off
- Continuing Medical Education
- Holiday Credit
- Jury Duty
- Personal Leave Programs
- Paid Educational Leave
- Personal Holiday
- Professional Training
- Non-Industrial Disability Insurance (NDI)

The relief factor assessment consisted of 4,417 employee records. Dock leave was also retrieved, but excluded since the relief factor assessment in this report is for budgetary, not scheduling purposes. When dock leave is used the dollars associated with the position are still available to be used to cover the absence of the incumbent using dock. Adjustments were also made to CTO leave data to only account for one-third of CTO usage since CTO earned in lieu of overtime pay is earned at a rate of 1.5 hours for every one hour worked. From a budgetary perspective only one-third (0.5 hours) is an additional cost to the department since the other two-thirds (one hour) nets out. Certain IDL and NDI leave data records were also adjusted for budgetary purposes to account for IDL and NDI pay that is not full pay. All data was compiled to identify the overall average time-away-from-post and used to calculate

---

<sup>1</sup> As of 2017-18 DSH Position Report data registered nurses and psychiatric technicians accounted for 81 percent of nursing classifications.



## Appendix L

the total coverage needed for each position annually. A weighted average was applied to the data which resulted in 263.6 hours<sup>2</sup> of usage annually per employee record.

### Disability Leave

MIRS data was also used to obtain NDI and IDL usage for FY 2017-18. NDI is an employer-paid disability insurance program utilized by qualifying employees/classifications who are unable to work due to a non-work-related injury<sup>3</sup>. IDL is for employees who are temporarily disabled due to a work-related injury and are eligible to receive IDL for up to 52 weeks in lieu of temporary disability benefits. IDL is captured in MIRS as IDL full and IDL 2/3. A weighted average was applied to the data which resulted in 56.0 hours of usage annually per employee record (based on 4,417 total records).

### Workers' Compensation

Workers' compensation data is collected and maintained locally at each hospital in their own site-specific Workers Compensation Claims Management System (WCCMS) database. Because of this a survey was sent to all five hospitals to ascertain the amount of workers' compensation used in FY 2017-18 for registered nurses and psychiatric technicians. A weighted average was applied to the data which resulted in 27.5 hours of usage annually per employee record (based on 4,417 total records).

### Professional and Education Leave

MIRS leave usage data from FY 2017-18 was obtained for continuing medical education (CME), educational leave, professional leave, paid educational leave and professional training and development leave to take into account leave generated by professional and education requirements. However, analysis of the data and discussions with DSH-Labor Relations revealed that these leave usage categories are often used interchangeably at the local hospital level and that not all professional and education leave is recorded in MIRS. For example, when continuing education credits are offered on-site the employee may be away from their post but the time away is handled in the same manner as other on-site hospital provided trainings in which no leave transactions are entered in MIRS because the employee is granted permission to attend as part of their normal workday. To account for this and ensure the updated relief factor includes adequate relief, the professional and education leave hours required by licensing, negotiated through the collective bargaining process and allocated per bargaining contract were deemed a more reliable holistic source than the MIRS data and therefore used within this study. This resulted in 16 hours (32 hours every two years) to be allocated for continuing education and 16 hours (two days per year) to be allocated for professional training and development (PDD).

### Hospital Trainings

---

<sup>2</sup> Does not include disability leave, workers' compensation leave, education leave, or in-hospital training leave detailed in the paragraphs to follow.

<sup>3</sup> In comparison to NDI, State Disability Insurance (SDI) is an employee-paid disability insurance program paid to qualifying employees for non-work-related illness or injury; however, because SDI is not employer-paid, it is not tracked in MIRS.

## **Appendix L**

Annual staff training data was collected through a survey provided to each hospital in order to document all annual on-going required hospital-specific and standard trainings. Each hospital was asked to quantify time spent on mandatory hospital-specific and licensure related trainings for registered nurses and psychiatric technicians. The analysis resulted in an average system-wide standard annual training time of 28 hours.

## Appendix L

### Department of State Hospitals

#### 24-Hour Care Nursing Services Staffing Study

#### Relief Factor Assessment - Calculations: 7-day-per-week, 8-hour shift

	System-wide		Atascadero		Coalinga		Metropolitan		Napa		Patton	
	Hours	Days	Hours	Days	Hours	Days	Hours	Days	Hours	Days	Hours	Days
Average Annual Leave Usage												
Annual Leave	66.94	8.37	86.7	10.8	86.3	10.8	39.0	4.9	37.2	4.6	73.6	9.2
Administrative Time Off	0.60	0.08	0.5	0.1	0.5	0.1	0.1	0.0	1.5	0.2	0.3	0.0
Bereavement Leave	3.73	0.47	2.4	0.3	2.7	0.3	4.1	0.5	3.5	0.4	5.4	0.7
Compensating Time Off	11.31	1.41	18.2	2.3	6.9	0.9	7.2	0.9	15.2	1.9	8.5	1.1
Holiday Credit	48.82	6.10	34.0	4.3	66.3	8.3	57.3	7.2	51.0	6.4	41.1	5.1
Holiday Informal Time Off	3.37	0.42	3.2	0.4	3.0	0.4	4.0	0.5	3.6	0.5	3.3	0.4
Jury Duty	1.01	0.13	0.5	0.1	0.6	0.1	1.6	0.2	0.6	0.1	1.7	0.2
Personal Leave Day	0.05	0.01	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0
Personal Leave Program 2010	0.01	0.00	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Personal Leave Program 2012	0.01	0.00	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Military Leave	0.00	0.00	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Personal Holiday	7.29	0.91	7.1	0.9	7.7	1.0	7.0	0.9	7.2	0.9	7.4	0.9
Personal Leave Program 1992	0.07	0.01	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Workers' Comp Leave <sup>I</sup>	27.48	3.43	3.8	0.5	21.5	2.7	8.9	1.1	15.8	2.0	66.4	8.3
NDI/IDL Disability Leave <sup>II</sup>	55.99	7.00	59.9	7.5	32.3	4.0	32.8	4.1	87.9	11.0	57.7	7.2
Sick Leave	50.43	6.30	45.9	5.7	34.9	4.4	60.9	7.6	62.6	7.8	51.2	6.4
Vacation	69.95	8.74	67.2	8.4	44.8	5.6	90.5	11.3	76.4	9.6	76.0	9.5
<b>Total Average Annual Leave Usage</b>	<b>347.04</b>	<b>43.38</b>	<b>329.6</b>	<b>41.2</b>	<b>307.4</b>	<b>38.4</b>	<b>313.6</b>	<b>39.2</b>	<b>362.7</b>	<b>45.3</b>	<b>392.9</b>	<b>49.1</b>
Annual Training												
In-hospital training <sup>III</sup>	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5
Allocated Training <sup>IV</sup>	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0
Professional Development Days	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0
<b>Total Annual Training Hours</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>
Coverage Required												
Hours in a Basic Shift	8.0		8.0		8.0		8.0		8.0		8.0	
Shifts per Day	1.0		1.0		1.0		1.0		1.0		1.0	
Days per Week	7.0		7.0		7.0		7.0		7.0		7.0	
<b>Total Coverage Required</b>	<b>2922</b>	<b>365</b>	<b>2922</b>	<b>365</b>	<b>2922</b>	<b>365</b>	<b>2922</b>	<b>365</b>	<b>2922</b>	<b>365</b>	<b>2922</b>	<b>365</b>
<b>Total Estimated Leave (Leave Usage + Training)</b>	<b>407.0</b>	<b>50.9</b>	<b>389.6</b>	<b>48.7</b>	<b>367.4</b>	<b>45.9</b>	<b>373.6</b>	<b>46.7</b>	<b>422.7</b>	<b>52.8</b>	<b>452.9</b>	<b>56.6</b>
<b>Total Time Paid (Per Year and Per Employee)</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>
<b>Net Time Worked (Per Year and Per Employee)</b>	<b>1673.0</b>	<b>209.1</b>	<b>1690.4</b>	<b>211.3</b>	<b>1712.6</b>	<b>214.1</b>	<b>1706.4</b>	<b>213.3</b>	<b>1657.3</b>	<b>207.2</b>	<b>1627.1</b>	<b>203.4</b>
Relief Calculation												
<b>Net Time Worked/Total Coverage Required</b>	<b>1.75</b>	<b>1.75</b>	<b>1.73</b>	<b>1.73</b>	<b>1.71</b>	<b>1.71</b>	<b>1.71</b>	<b>1.71</b>	<b>1.76</b>	<b>1.76</b>	<b>1.80</b>	<b>1.80</b>

I - Workers' Compensation Leave has been adjusted to only reflect temporary disability (TD) leave

II - NDI/IDL disability leave includes non-industrial disability leave (NDI) and industrial disability leave (IDL) extracted from MIRS

III - In-Hospital Training includes standard DSH required trainings and required trainings specific to each hospital

IV - Allocated Training includes leave hours required by licensure and allocated per the collective bargaining unit process

## Appendix L

### Department of State Hospitals

#### 24-Hour Care Nursing Services Staffing Study

#### Relief Factor Assessment - Calculations: 7-day-per-week, 12-hour shift

	System-wide		Atascadero		Coalinga		Metropolitan		Napa		Patton	
	Hours	Days	Hours	Days	Hours	Days	Hours	Days	Hours	Days	Hours	Days
Average Annual Leave Usage												
Annual Leave	66.94	8.37	86.7	10.8	86.3	10.8	39.0	4.9	37.2	4.6	73.6	9.2
Administrative Time Off	0.60	0.08	0.5	0.1	0.5	0.1	0.1	0.0	1.5	0.2	0.3	0.0
Bereavement Leave	3.73	0.47	2.4	0.3	2.7	0.3	4.1	0.5	3.5	0.4	5.4	0.7
Compensating Time Off	11.31	1.41	18.2	2.3	6.9	0.9	7.2	0.9	15.2	1.9	8.5	1.1
Holiday Credit	48.82	6.10	34.0	4.3	66.3	8.3	57.3	7.2	51.0	6.4	41.1	5.1
Holiday Informal Time Off	3.37	0.42	3.2	0.4	3.0	0.4	4.0	0.5	3.6	0.5	3.3	0.4
Jury Duty	1.01	0.13	0.5	0.1	0.6	0.1	1.6	0.2	0.6	0.1	1.7	0.2
Personal Leave Day	0.05	0.01	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0
Personal Leave Program 2010	0.01	0.00	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Personal Leave Program 2012	0.01	0.00	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Military Leave	0.00	0.00	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Personal Holiday	7.29	0.91	7.1	0.9	7.7	1.0	7.0	0.9	7.2	0.9	7.4	0.9
Personal Leave Program 1992	0.07	0.01	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Workers' Comp Leave <sup>I</sup>	27.48	3.43	3.8	0.5	21.5	2.7	8.9	1.1	15.8	2.0	66.4	8.3
NDI/IDL Disability Leave <sup>II</sup>	55.99	7.00	59.9	7.5	32.3	4.0	32.8	4.1	87.9	11.0	57.7	7.2
Sick Leave	50.43	6.30	45.9	5.7	34.9	4.4	60.9	7.6	62.6	7.8	51.2	6.4
Vacation	69.95	8.74	67.2	8.4	44.8	5.6	90.5	11.3	76.4	9.6	76.0	9.5
<b>Total Average Annual Leave Usage</b>	<b>347.04</b>	<b>43.38</b>	<b>329.6</b>	<b>41.2</b>	<b>307.4</b>	<b>38.4</b>	<b>313.6</b>	<b>39.2</b>	<b>362.7</b>	<b>45.3</b>	<b>392.9</b>	<b>49.1</b>
Annual Training												
In-hospital training <sup>III</sup>	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5
Allocated Training <sup>IV</sup>	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0
Professional Development Days	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0
<b>Total Annual Training Hours</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>	<b>60.0</b>	<b>7.5</b>
Coverage Required												
Hours in a Basic Shift	12.0		12.0		12.0		12.0		12.0		12.0	
Shifts per Day	1.0		1.0		1.0		1.0		1.0		1.0	
Days per Week	7.0		7.0		7.0		7.0		7.0		7.0	
<b>Total Coverage Required</b>	<b>4383</b>	<b>548</b>	<b>4383</b>	<b>548</b>	<b>4383</b>	<b>548</b>	<b>4383</b>	<b>548</b>	<b>4383</b>	<b>548</b>	<b>4383</b>	<b>548</b>
<b>Total Estimated Leave (Leave Usage + Training)</b>	<b>407.0</b>	<b>50.9</b>	<b>389.6</b>	<b>48.7</b>	<b>367.4</b>	<b>45.9</b>	<b>373.6</b>	<b>46.7</b>	<b>422.7</b>	<b>52.8</b>	<b>452.9</b>	<b>56.6</b>
<b>Total Time Paid (Per Year and Per Employee)</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>	<b>2080.0</b>	<b>260.0</b>
<b>Net Time Worked (Per Year and Per Employee)</b>	<b>1673.0</b>	<b>209.1</b>	<b>1690.4</b>	<b>211.3</b>	<b>1712.6</b>	<b>214.1</b>	<b>1706.4</b>	<b>213.3</b>	<b>1657.3</b>	<b>207.2</b>	<b>1627.1</b>	<b>203.4</b>
Relief Calculation												
<b>Net Time Worked/Total Coverage Required</b>	<b>2.62</b>	<b>2.62</b>	<b>2.59</b>	<b>2.59</b>	<b>2.56</b>	<b>2.56</b>	<b>2.57</b>	<b>2.57</b>	<b>2.64</b>	<b>2.64</b>	<b>2.69</b>	<b>2.69</b>

I - Workers' Compensation Leave has been adjusted to only reflect temporary disability (TD) leave

II - NDI/IDL disability leave includes non-industrial disability leave (NDI) and industrial disability leave (IDL) extracted from MIRS

III - In-Hospital Training includes standard DSH required trainings and required trainings specific to each hospital

IV - Allocated Training includes leave hours required by licensure and allocated per the collective bargaining unit process

Appendix M.1

Department of State Hospitals  
24-Hour Care Nursing Services  
Medication Pass Psychiatric Technician Phase-In Plan

			DSH-Atascadero		DSH-Coalinga		DSH-Metro		DSH-Napa		DSH-Patton		Total		
			24%		13%		13%		24%		26%		100%		
			of total positions		of total positions		of total positions		of total positions		of total positions		of total positions		
			Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	
FY 2019-20	Jul-19	12													9-months of funding
	Aug-19	11													
	Sep-19	10													
	Oct-19	9	12.7	17.0	7.0	9.3	6.6	8.8	12.7	17.0	13.5	18.0	52.5	70.0	6-months of funding
	Nov-19	8													
	Dec-19	7													
	Jan-20	6	6.7	13.3	3.7	7.3	3.4	6.9	6.7	13.3	7.1	14.2	27.5	55.0	3-months of funding
	Feb-20	5													
	Mar-20	4													
	Apr-20	3	3.6	14.5	2.0	8.0	1.9	7.5	3.6	14.5	3.9	15.5	15.0	60.0	FY 2019-20 Total
May-20	2														
Jun-20	1														
FY 2019-20 Total			23.0	44.8	12.6	24.6	11.9	23.1	23.0	44.8	24.5	47.7	95.0	185.0	
			23.0		12.6		11.9		23.0		24.5		95.0		
			Partial 20-21	Full 21-22	Partial 20-21	Full 21-22	Partial 20-21	Full 21-22	Partial 20-21	Full 21-22	Partial 20-21	Full 21-22	Partial 20-21	Full 21-22	
FY 2020-21	Jul-20	12													9-months of funding
	Aug-20	11													
	Sep-20	10													
	Oct-20	9	5.4	7.3	3.0	4.0	2.8	3.8	5.4	7.3	5.8	7.7	22.5	30.0	6-months of funding
	Nov-20	8													
	Dec-20	7													
	Jan-21	6	3.6	7.3	2.0	4.0	1.9	3.8	3.6	7.3	3.9	7.7	15.0	30.0	3-months of funding
	Feb-21	5													
	Mar-21	4													
	Apr-21	3	1.8	7.3	1.0	4.0	0.9	3.8	1.8	7.3	1.9	7.7	7.5	30.0	FY 2020-21 Total
May-21	2														
Jun-21	1														
FY 2020-21 Total			10.9	21.8	6.0	12.0	5.6	11.3	10.9	21.8	11.6	23.2	45.0	90.0	
			55.7		30.5		28.8		55.7		59.3		230.0		← (full: 185 + partial: 45)
FY 2021-22			Full 21-22	Full 22-23	Full 21-22	Full 22-23	Full 21-22	Full 22-23	Full 21-22	Full 22-23	Full 21-22	Full 22-23	Full 21-22	Full 22-23	
	Jul-21	12	14.5	14.5	8.0	8.0	7.5	7.5	14.5	14.5	15.5	15.5	60.0	60.0	12-months of funding
	FY 2021-22 Total		81.1		44.5		41.9		81.1		86.4		335.0		← (full: 185 + full: 90 + 60)
Total Request			81.1		44.5		41.9		81.1		86.4		335.0		



Appendix M.2

Department of State Hospitals  
24-Hour Care Nursing Services  
Afterhours Supervising Registered Nurse Phase-In Plan

			DSH-Atascadero		DSH-Coalinga		DSH-Metro		DSH-Napa		DSH-Patton		Total	
			18% of total positions		18% of total positions		18% of total positions		24% of total positions		24% of total positions		100% of total positions	
			Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21	Partial 19-20	Full 20-21
FY 2019-20	Jul-19	12												
	Aug-19	11												
	Sep-19	10												
	Oct-19	9												
	Nov-19	8												
	Dec-19	7												
	Jan-20	6	3.9	7.9	3.9	7.9	3.9	7.9	5.2	10.5	5.2	10.5	22.3	44.5
	Feb-20	5												
	Mar-20	4												
	Apr-20	3												
	May-20	2												
	Jun-20	1												
Total Request				7.9		7.9		7.9		10.5		10.5		44.5
FY 2020-21 Total														

6-months of funding