

WORKLOAD MANAGEMENT

HOME & COMMUNITY/RESIDENTIAL CARE

OVERVIEW

In May of 1988, the Continuing Care Division of the Ministry of Health requested the assistance of BCLTCA in developing a Workload Measurement Tool for long term care facilities. From this request, a committee representing BCLTCA, BC Pricare, BCHA, and Ministry of Health was formed. Ten facilities were chosen to participate and were represented by their Directors of Resident Care of Administrators in a working committee.

There was a consensus that the Juan de Fuca, New Brunswick, Ontario and British Columbia EC workload measurement tools be reviewed for relevancy. The committee found that parts of the tool were relevant, but that descriptors and indicators did not identify or describe:

- a) the resistive behavior
- b) cognitive impairment
- c) psycho-social needs

These have been included in the tool developed and have been used in EC and intermediate care facility. The staff in both facilities felt that the tool identified the care requirements of their respective residents appropriately.

There is an identified need in the continuing care industry to develop data that will objectively identify residents' care needs and to relate these resource requirement. The requirements can then be more appropriately addressed in strategic planning and budgeting.

GOAL

To develop a workload measurement tool for long term care.

OBJECTIVES

1. To identify commonalities in the daily care of residents and assign a time to the care functions performed.
2. To identify and assess each resident's care needs.
3. To identify which members of the Direct Care staff perform each task, i.e. professional/non-professional.
4. To identify resources needed for care and allocate these more appropriately.
5. To respond to changes in the demands for care or workload whether seasonal or a needs change by virtue of aging and disease progression.
6. To identify objective data that will assist in allocation of funds for staffing and care level assessment.
7. To identify care requirements of the resident which assist in appropriate placement of residents within facilities, i.e. unit or floors.
8. To relate the identified workload of each resident to assessed care levels in terms of professional/non-professional.

The above identified information can creatively assist governments, care providers, etc. in:

- the design of physical space in facilities
- area location of future facilities
- providing a base of information for determining alternate mode of care]
- providing data to assist in strategic planning in care for the elderly

WORKLOAD MANAGEMENT**SECTION:****WORKLOAD MANAGEMENT
OVERVIEW****SUBJECT:****MEASURED QUARTERLY**

UTILIZING THE WORKLOAD MEASUREMENT TOOL ACCOMPLISHES THE FOLLOWING:

- Assigns a time to the care functions performed
- Assesses each resident's care needs
- Identifies resources needed for care
- Assists with care level assessment – see care level guide (pg 1-4)
- Assists in strategic planning and trending

GUIDE TO WORKLOAD MEASUREMENT TOOL:

1. Nurse can manage 8-10, 000 measures of work on each shift
2. Care aide can manage 2200-2500 measures for cognitively well resident (GDS 1-4)
3. Care aide can manage 2200-2500 measures for moderate dementia (GDS 4-5)
4. Care aide can manage 2000-2300 for severe dementia-extended care-clinically complex (GDS 6-7)
5. Bathing included in the above measures.

CARE LEVEL GUIDE

Care Level	Workload	GDS	Validation
IC1	80 – 130	1	
IC2	130 – 220	2-3	
IC3	220 – 300	4+	
EC	300 +	4+	

****Note:** Care Levels are now derived from the Workload Measurement Tool System rather than from Long Term Care.

- Care Levels as per present system
- Workload is derived from Workload Measurement Tool (Form #810163)
- GDS is derived from the Global Deterioration Scale and Functional Assessment Staging (FAST) form #810100
- As admission to facility is IC3 or EC ***validation is required when the care level is lower than IC3***
i.e.
 - 406 – requires one staff manual transfer.
 - 611 – therapeutic communication (i.e. special communication tools).
 - 612 – extraordinary medical needs (i.e. alcoholism).
 - 613 – requires protection from injury (i.e. no home).
 - GDS 4+

WORKLOAD MEASUREMENT TOOL

NOTE

The totals in minutes reflect the amount of professional/non-professional time given in direct and indirect care per resident per 24 hour period in your facility.

When your times seem excessive, review such things as:

- a) elevator service
- b) toilets in rooms
- c) bathing facilities
- d) storied or ranch styled
- e) support services
- f) how meals are served
- g) security

These have a direct bearing on manpower requirements and are provided. In the times assigned to the indicators, we have allowed for the above except in unusual situations.

TABLE 1

GLOBAL DETERIORATION SCALE (GDS)

- **1. No subjective complaints of memory deficit.**
 - > No memory deficit evident on clinical interview.
- **2. Subjective complaints of memory deficit, most frequently in following areas:**
 - a) forgetting where one has placed familiar objects;
 - b) forgetting names one formerly knew well
 - > No objective evidence of memory deficit on clinical interview.
 - > No objective deficit in employment or social situations
 - > Appropriate concern with respect to symptomatology.

MILD

- **3. Earliest clear-cut deficits.**
 - > Manifestations in more than one of the following areas:
 - a) patient may have gotten lost when travelling to an unfamiliar location.
 - b) co-workers become aware of patient's relatively poor performance.
 - c) Work and name finding deficit become evident to intimates.
 - d) patient may read a passage or book & retain relatively little material.
 - e) patient may demonstrate decreased facility remembering names upon introduction to new people
 - f) patient may have lost or misplace an object of value.
 - g) concentration deficit may be evident on clinical testing.
 - > Objective evidence of memory deficit obtained only with an intensive interview.
 - > Decreased performance in demanding employment & social settings.
 - > Denial begins to become manifest in patient.
 - > Mild to moderate anxiety frequently accompanies symptoms.

- **4. Clear-cut deficit on careful clinical interview.**
 - > Deficit manifest in following areas:
 - a) decreased knowledge of current & recent events.
 - b) may exhibit some deficit in memory of one's personal history.
 - c) concentration deficit elicited on serial subtractions.
 - d) decreased ability to travel, handle finances, etc.
 - > Frequently no deficit in following areas:
 - a) orientation to time & place.
 - b) recognition of familiar persons & faces.
 - c) ability to travel to familiar locations.
 - > Inability to perform complex tasks.
 - > Denial is dominant defense mechanism.
 - > Flattening of affect & withdrawal from challenging situations occur.

MODERATE

- **5. Patient can no longer survive without some assistance.**
 - > Patient is unable during interview to recall a major relevant aspect of their current life, i.e.:
 - a) their address or telephone number for many years.
 - b) the names of close members of their family (such as grandchildren)
 - c) the name of high school or college from which they graduated.
 - > Frequently some disorientation to time (date, day of the week, season, etc.) or to place.
 - > An educated person may have difficulty counting back from 40 by 4's or from 20 by 2's.
 - > Persons at this stage retain knowledge of many major facts regarding themselves & others.
 - > They invariable know their own names & generally know their spouse & children's names.
 - > They require no assistance with toileting or eating, but may have difficulty choosing the proper clothing to wear.

MODERATE SEVERE

- **6.** May occasionally forget the name of the spouse upon whom they are entirely dependent for survival.
 - > Will be largely unaware of all recent events & experiences in their lives.
 - > Retain some knowledge of their surroundings; the year, the season, etc.
 - > May have difficulty counting by 1's from 10, both backward & sometimes forward.
 - > Will require some assistance with activities of daily living;
 - a) delusional behavior, i.e., patients may accuse their spouse of being an imposter; may talk to imaginary figures in the environment, or to their own reflection in the mirror.
 - b) Obsessive symptoms, i.e., person may continually repeat simple cleaning activities.
 - c) Anxiety symptoms, agitation, & even previously non-existent violent behavior may occur.
 - d) Cognitive abulia, i.e., loss of willpower because an individual cannot carry a thought long enough to determine a purposeful course of action.

SEVERE

- **7. All verbal abilities are lost over the course of this stage.**
 - > Early in this stage words & phrases are spoken but speech is very circumscribed.
 - > Later there is no speech at all – only grunting.
 - > Incontinent of urine; requires assistance toileting & feeding.
 - > Basic psychomotor skills (i.e. ability to walk) are lost with the progression of this stage.
 - > The brain appears to no longer be able to tell the body what to do.
 - > Generalized & cortical neurologic signs & symptoms are frequently present.

FUNCTIONAL ASSESSMENT STAGING (FAST)

(Check highest consecutive level of disability.)

1. No difficulty, either subjectively or objectively.
2. Complains of forgetting location of objects. Subjective work difficulties.
3. Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity.*
4. Decreased ability to perform complex tasks, i.e., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty marketing, etc.*
5. Requires assistance in choosing proper clothing to wear for the day, season, or occasion, i.e., patient may wear the same clothing repeatedly, unless supervised.*
6.
 - a) Improperly putting on clothes without assistance or cuing (i.e., may put street clothes on over night clothes, or put shoes on the wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*
 - b) Unable to bathe properly (i.e. difficulty adjusting bath water temperature – occasionally or more frequently over the past weeks.*
 - c) Inability to handle mechanics of toileting (i.e., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*
 - d) Urinary incontinence (occasionally or more frequently over the past weeks).*
 - e) Fecal incontinence (occasionally or more frequently over the past weeks).*

FUNCTIONAL ASSESSMENT STAGING (FAST)

- 7. a) Ability to speak limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.
- b) Speech ability limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).
- c) Ambulatory ability lost (cannot walk without personal assistance).
- d) Cannot sit up without assistance (i.e., the individual will fall over is there are no lateral rests (arms) on the chair).
- e) Loss of ability to smile.
- f) Loss of ability to hold up head independently.

* *Scored primarily on the basis of information obtained from a knowledgeable informant &/or caregiver.*