A STUDY OF GUIDELINES FOR A SELF-CARE FACILITY AT PRESBYTERIAN HOSPITAL OF DALLAS

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CHAPTER I

INTRODUCTION

General Information

The demands made on hospitals for service to their communities are constantly changing. These demands are being brought about by the changing nature of the population, the rapid advances being made in medicine and the changing attitude of the public toward the hospitals.

In the years prior to the Second World War most hospital patients were bedridden and quite ill. A trip to the hospital was a serious matter and usually only considered if there was no other course of action. Because of this, little serious consideration was given to the attractiveness of hospital surroundings or to additional facilities to make the hospital stay a pleasant experience.

In the twenty-five years since the war many changes in hospital services have occurred. Perhaps the first major change was early ambulation following surgery. The hospitalized patient was able to be up and around and, as a result, he wanted more privacy, more attractive surroundings, and the basic conveniences such as toilet and lavatory in his room. Then came rapid strides in new therapeutic agents

and drugs. Frequently a patient being treated with the newer drugs showed rapid improvement and was soon able to be out of bed although requiring close observation.

During this same period of time the hospitals were changing. These hospitals became more concerned about what the patient wanted, and began to consider Mrs. Smith and Mr. Jones, not the "gall bladder" in bed two, or the "cardiac" in room four. Hospitals have also provided individual beds routinely, particularly since the Second World War, in addition to other luxuries such as television, telephones, personal showers, and private and semi-private room accommodations. In addition, the availability of Blue Cross, hospital insurance plans and other forms of prepayment contributed to increased utilization of hospital facilities and services.

This increased utilization has not been generally met with efficient planning and adequate control by hospitals. Too often the result is extravagance: the patient, his insurer, or the community pays for more facilities and services than are required, and an expensive hospital bed is used by someone who does not need it.

This study will concentrate on a concept known as self-care, one which holds promise for helping solve this problem of extravagance which far too many hospitals help perpetuate in the delivery of health services.

The Hospital Setting and History

Presbyterian Hospital of Dallas is a general, acute, short term hospital of 365 beds which is situated on a spacious seventy-one acre site within the city limits. It opened for admissions to the general public in May, 1966, and was the first new major general hospital to be constructed in Dallas, Texas, since 1927. It is a nonprofit corporation sponsored by the Presbyterian Church of the United States of America and chartered in 1958 under the laws of Texas to serve Dallas and surrounding communities.

The hospital is a teaching unit of the University of Texas Southwestern Medical School. More than 550 physicians are members of the medical staff of the hospital, all of whom are on the clinical staff of the Medical School.

Presbyterian Hospital offers diagnostic and treatment facilities for complete medical, surgical, obstetric and pediatric care. In addition, a comprehensive psychiatric program is provided, offering inpatient, outpatient, day, and night care. This program operates out of two locations: the inpatient and night care unit on the ninth floor, and the day care center, which is a separate two-story building on the hospital grounds. A stroke unit was dedicated in November, 1969, and offers the latest in design, facilities and treatment of patients disabled by cardiovascular diseases.

Conditions Which Prompted the Study

Since opening to the public in 1966, the hospital has experienced a steady increase in demands for services and facilities. The average monthly census has approached the total number of beds available in 1969 and 1970 (see Appendix A). During 1970, the hospital has maintained an occupancy rate approximating 90 per cent, with a length of patient stay averaging 6.6 days.

This hospital has been open to the public for only forty months, and yet, all too frequently, people seeking admission are turned away. Often this means that patients in need of hospitalization are required to seek other facilities or wait several days before being admitted.

Presbyterian Hospital of Dallas is currently engaged in a fund drive to raise four million dollars for an additional 120 medical-surgical beds in the main hospital. This addition is scheduled for completion in 1971. The administrative and professional staffs estimate that these beds will merely provide temporary relief from the existing bed availability problem. Therefore, the hospital has manifested an interest in the concept of self-care as a possible means of providing much needed relief from a serious bed shortage problem in the most expeditious manner possible.

Statement of the Problem

The problem is to determine guidelines for the optimal utilization of a self-care facility at Presbyterian Hospital of Dallas, Texas.

Objectives

The objectives of the study are:

1. To analyze the results of an inpatient survey to determine the eligibility of patients for admission to a self-care facility.

2. To discuss guidelines relating to services and nurse staffing requirements to meet the medical needs of patients admitted to a self-care facility.

3. To discuss guidelines relating to the evaluation and control of a self-care facility.

4. To recommend actions the hospital should take to implement the guidelines in order to obtain the optimal utilization of a self-care facility.

Criteria

Any proposed solution to the problem should:

1. Result in the proposal of attainable objectives for a self-care facility.

2. Result in the establishment of patient admission criteria which are acceptable to the administrative,

professional and nursing staffs of the hospital.

3. Result in procedures for estimating the percentage of eligible patients for admission to a self-care facility.

4. Result in the establishment of guidelines for services to meet the medical needs of patients admitted to a self-care facility.

5. Result in the establishment of guidelines for nurse staffing requirements to meet the medical needs of patients admitted to a self-care facility.

6. Result in the establishment of guidelines for the evaluation and control of a self-care facility.

Limitation

As a result of a decision by the administrator, no surveys were permitted of individual inpatients to ascertain their views of self-care.

Assumptions

For the purposes of this study, the following assumptions are made:

1. Presbyterian Hospital will continue to function as an acute, general, short-term hospital.

2. The costs of medical care, including personnel, equipment and facilities will continue to increase.

3. The high occupancy rate will continue.

Definitions

A guideline is an indication or outline of future policy or conduct.

A self-care facility refers to a facility for ambulatory and self-sufficient patients either requiring therapeutic or diagnostic services or convalescing. In this homelike atmosphere, provision is made for relaxation and recreation. Here the patient is instructed in self-care within the limits of his illness. No unnecessary dependency on the hospital is engendered since the patient remains responsible for ministering to his own personal needs.[1]

Ancillary services at Presbyterian Hospital, Dallas include radiology service (X-ray, to include therapy and radioactive iodine studies), laboratory service, electrocardiology-electroencephalogram service (ECG-EEG), physical therapy service (P.T.), inhalation therapy service (I.T.), and pulmonary physiological service.

Research Methodology

In order to determine guidelines for the optimal utilization of a self-care facility, the following methods were employed:

1. Key personnel of the administrative, professional and nursing staffs were questioned relative to establishing objectives for, and criteria for admission to a self-care facility.

2. A questionnaire designed to be completed by the nursing team leaders of each ward surveyed was developed as a means of determining the percentage of inpatients eligible for admission to a self-care facility based on established admission criteria. In addition, this questionnaire was designed to determine the nursing needs of these patients.

3. An additional questionnaire was developed for physicians using the established admission criteria. The purpose of this questionnaire was to determine the agreement between the physicians and nursing team leaders in the evaluation of patient eligibility for self-care.

4. Interviews were conducted with key personnel of the administrative, professional, and nursing staffs to determine guidelines relating to required services, staffing, evaluation and control of a self-care facility.

5. An in-depth study of all the available literature was made to ascertain the experiences reported by other hospitals operating self-care facilities which could be applied to Presbyterian Hospital.

Literature Review

As hospital usage goes up in volume, cost and complexity, there is increasing recognition of the need for discrimination in the levels of hospital care provided the patient. A concept known as progressive patient care provides this discrimination. Progressive patient care is the

systematic classification of patients according to their medical and nursing needs. It is recognized that as critically and seriously ill patients recover, the type and intensity of their medical and nursing needs lessen.[2]

Progressive patient care is no longer in its infancy. Since the early 1950's, when a small number of hospitals first established units of progressive patient care, this concept has spread throughout the country. Interest in progressive patient care has been enhanced by the dilemma in which hospitals find themselves because of continuing increases in the extent and complexity of patient care requirements, the scarcity of qualified personnel, and the constantly increasing costs of hospital operation. The concept shows promise of helping hospitals with their two most pressing problems: scarcity of trained personnel, and continuing improvement of services without unduly increasing costs.[3]

At least five elements are incorporated in the progressive patient care concept. The essentials of each may be considered as follows:

Intensive care: For critically and seriously ill patients who are unable to communicate their needs or who may require extensive nursing care and observation. Presbyterian Hospital provides this service and the one following.

Acute care: For acute patients (the classification for generally ill and non-ambulatory patients) who do not require the intensive care that is given in the intensive care unit, but who do require the exacting nursing procedures provided in acute care sections of the hospital.

Self-care: This element of progressive patient care is described in the definitions section of this study.

Extended care: For patients requiring skilled prolonged medical and nursing care. Rehabilitation, occupational therapy, and physical therapy services may be needed for these patients.

Home care: For patients who can be adequately cared for in the home through the extension of certain hospital services.[4]

A small number of hospitals in the United States have made some effort to meet the need of patients in the self-care category. Some have set aside a few rooms in the main hospital for these patients while others have established facilities near the hospital where they and their relatives may stay. Different terms have been used to describe these facilities, such as: convalescent, pre-convalescent, self-care, minimal-care, supportive, selective-care, continuation, ancillary, pre-discharge, hostel and homeward-bound.[5] Self-care is the term used most often in the literature, and will be applied to the facility under

consideration in this study.

The Baptist Hospital of Winston Salem, North Carolina was one of the first hospitals to pioneer the self-care concept. In 1959, this hospital conducted a study which disclosed that one out of five patients was receiving and paying for complete hospital care that was not needed, although it was essential for him to be present at the hospital. These patients were hospitalized for diagnostic and surgical work-up, recovering from surgery or serious illness, or receiving treatment which did not require special and personalized hospital care. The patients could attend to their own personal needs, go to the cafeteria for their meals, walk to offices of physicians, treatment rooms and pharmacy, take their own medicine, and could in fact, do practically everything for themselves. Yet, they were occupying hospital beds, receiving full professional care, and paying bills so high they were burdensome. At the same time, the hospital had a long waiting list of patients waiting for admission.[6] The preceding conditions and the approximate 20 per cent inpatient eligibility for admission were typical of hospitals not operating self-care facilities.

The literature reveals that the success of any self-care facility depends on two important factors. First, patients will have to like the facility and accept it. Secondly, the physicians and nurses will have to be confident

that the self-care facility is a proper place for their patients and be willing to admit them to it.[7]

Several outstanding features which appealed to the majority of patients admitted to the self-care facility at the Rochester, Minnesota Hospital, another pioneer progressive patient care facility, included: (1) personal freedom to move around and provide for themselves; (2) an informal, relaxed and cheerful atmosphere; and (3) the morale and the encouragement in building of self-confidence. In addition, admission to the self-care facility allowed the patient to recuperate at a faster pace and reduced his cost of services. Patients voiced few complaints, most of which related to minor operating policies pertaining to such things as smoking privileges, visitation hours and card playing.[8]

Physicians reported satisfaction with the self-care concept in general. Two favorable features mentioned most frequently were: (1) an environment that promoted convalescence because it encouraged physical activity and the regaining of self-sufficiency under supervision; and (2) an environment that was psychologically favorable for convalescence.[9]

The main objections reported by the physicians were: (1) the long distance patients had to travel to the cafeteria; (2) nurses and aides with insufficient training and backgrounds occasionally being placed in charge; (3) an

ineligible patient occasionally being admitted to the unit; and (4) occasions when doctors were required to wait on patients who had left the facility and had failed to meet scheduled appointments.[10]

Hospital nurses commented on essentially the same advantages and disadvantages of self-care as reported by the physicians. The most significant benefit mentioned by the nurses was the remarkable reduction in the nursing hours required for patient care.[11]

Some administrators feel that complete acceptance of the self-care concept for their hospitals will create unwieldy administrative and service problems. The literature does not substantiate this premise. It was found that those hospitals which devote careful scrutiny of their self-care facilities realized: (1) reduced operating costs resulting from a more efficiently utilized staff; (2) administrative savings based on minimized record keeping; and (3) a reduction in the number of patients examined daily by staff physicians.[12]

A self-care facility releases valuable patient bed space and permits the hospital staff to increase its overall efficiency by allowing it to provide more care to needy patients. To operate efficiently and economically, however, the self-care facility requires a minimum of twelve patients, or ideally, sixteen to twenty patients.[13]

Research of the literature reveals relatively little concerning the methods of payment for self-care. Barnes Hospital, in St. Louis, Missouri, discovered that Blue Cross was the only hospitalization insurance which paid for the services received in a self-care facility. Other insurance companies considered this type of service as extravagant and likened the practice to the operation of a motel. A familiarization tour of the self-care facility was arranged by the hospital for the board presidents of several major insurance companies. The result was agreement by all these companies to pay for self-care services in Barnes Hospital. Medicare also pays for self-care at the hospital.[14]

A representative of the Texas Blue Cross-Blue Shield office stated that its policy would be to consider favorably payment for admission to a self-care facility if the hospital could guarantee proper utilization. He indicated that this meant not admitting patients who would be left to look after their own needs without the supervision of qualified nursing personnel.[15] The use of the term "minimal-care," in lieu of self-care, might better connote the philosophy of such a facility. In any event, a need exists for the education of insurance companies by the hospital if maximum endorsement of the self-care concept is to be realized.

Footnotes

[1]U.S., Department of Health, Education, and Welfare,

Public Health Service, Elements of Progressive Patient Care, Public Health Service, Publication No. 930-C-1 (Washington, D.C.: Government Printing Office, 1962), p. 2.

[2]Edward J. Thomas, "Progressive Patient Care--Planning and Research," New York State Journal of Medicine, LIX (July 15, 1959), 2778.

[3]Jack C. Haldeman and Faye G. Abdellah, "Concepts of Progressive Patient Care," Hospitals, XXXIII (June 1, 1959), 46.

[4]Elements of Progressive Patient Care, p. 2.

[5]J.S. Meredith, et al., 'Hostel' in Hospitals? (London: Oxford University Press, 1968), p. 1.

[6]Robert Walker, "Evaluation of a Minimal Care Center," Hospitals, XXXVIII (July 16, 1964), 76.

[7]Ibid.

[8]Madelyne Sturdavant and Harold C. Mickey, "An Experiment in Minimal Care," Hospitals, XL (March 1, 1966), 52.

[9]Ibid., p. 53.

[10]Ibid.

[11]Ibid., 54.

[12]Edwin E. Fairfield, "Personnel Can Be Saved by the Installation of Minimal Self-Care Units," Hospital Management, IC (March, 1965), 94.

[13]Sturdavant and Mickey, "An Experiment in Minimal Care," p. 54.

[14]Letter from Mr. Robert E. Frank, Director, Barnes Hospital, St. Louis, Missouri, April 9, 1970.

[15]Mr. Gene Aurne, Director of Public Relations for Blue Cross-Blue Shield, private interview, Dallas, Texas, February 14, 1970.

CHAPTER II

DISCUSSION

Objectives of a Self-Care Facility

Planning of a self-care facility must include the establishment of realistic objectives. These objectives should be determined by the hospital before any additional plans relative to admissions, services, staffing or evaluation of the facility are considered.

The administrator and his staff at Presbyterian Hospital desire a facility that will meet the medical needs of self-care patients, reduce the costs to these patients, minimize staffing requirements and provide more acute beds within the main hospital.[1] Therefore, to satisfy these requirements, the following objectives for a self-care facility are proposed:

The self-care facility at Presbyterian Hospital of Dallas, Texas should:

1. Be an area where patients are given care which does not require acute care facilities, but does require the use of techniques and facilities available in a hospital setting.

2. Provide the type and amount of nursing services

an individual patient needs at the lowest possible cost.

3. Provide an area in which a physical, emotional and social rehabilitative program can be carried out to its fullest extent before the patient returns home.

4. Provide teaching facilities and supervision of the patient learning to assume complete care of himself.

5. Provide facilities as homelike as possible and with a more relaxed atmosphere than the usual hospital inpatient unit.

6. Provide hospital facilities for self-care patients within a short distance of the self-care facility.

7. Provide sufficient beds to serve the patients in the hospital who are eligible for self-care.

Admission Criteria

In the selection of patients who would benefit from these objectives, it is necessary to consider the type patients who could be admitted to a self-care facility. The pamphlet, Elements of Progressive Patient Care, published by the U.S. Public Health Service, lists the following type patients as eligible for care in a self-care facility:

> Ambulatory patients who are convalescing or require diagnosis or therapy may be cared for in this unit. Examples of self-care patients include the physically self-sufficient requiring daily or more frequent specialized treatment such as radiation or physical therapy; the new diabetic who requires precise dietary

> management, frequent laboratory tests, and adjustment of insulin dosage, as well as instruction on diet and self-administration of insulin; the post-coronary patient who must learn, under close supervision, how much activity he can tolerate; and the convalescent rectal carcinoma patient who needs a few more days help in bowel training and colostomy management.[2]

The patient requiring regulation of diabetes is an example of one ideally treated in a self-care facility. He is expected to administer his own insulin injections, to work with the dietitian in learning to select proper foods in the cafeteria and to maintain daily physical exercise at a level approximating that normally experienced at home.

A patient with rheumatoid arthritis offers another example of one suitably treated in this facility. Such a patient is normally admitted with acutely inflamed joints which require that he receive some degree of physical assistance for a few days. Except for those who are totally bedridden, such patients have been judged ideal for the self-care facility since salicylate therapy can be easily managed. As the patient's acute symptoms subside, he can participate more actively and effectively in physical and occupational therapy activities.[3]

Admission is not limited by diagnosis, but by the patient's ability to assume responsibility toward meeting his own medical needs. The most important single difference between progressive patient care and traditional hospital organization is that each patient is assigned to the

unit which can best serve his needs at the time, rather than to the unit which fits his diagnosis and economic status. Therefore, it is essential to establish criteria for admission to each unit. These criteria must be thoroughly understood by the members of the medical staff who have the ultimate responsibility of requesting admission to, and transfer between units. The nursing staff must also be thoroughly familiar with the criteria since the nurse plays an important role in advising the physician concerning the condition of the patient.[4]

The criteria for admission to a self-care facility, in addition to conditions or requirements which would deny admission to the facility (see Appendix B), were agreed upon by key members of the administrative, professional and nursing staffs. These criteria were used as a basis for preparing a questionnaire to be completed by nursing team leaders for the purpose of surveying inpatients to determine eligibility for admission to such a facility. This questionnaire will be discussed in the section concerning inpatient survey procedures.

These admission criteria were developed based on the philosophy that the self-care facility should be a place where patients truly require only minimal nursing care attention. In addition, this facility should contain only patients whose medical and mental conditions do not prove

offensive to, or threaten the health of other patients.

Survey of Patient Population

How does a hospital contemplating a partial or complete progressive patient care program determine the number of beds required for each of the patient care units? In an attempt to answer this question, the U.S. Public Health Service conducted a two year study at Manchester, Connecticut General Hospital. An analysis of the results shows that such a bed requirement determination can be made based on patient utilization experience of the hospital under its traditional pattern of care.

The Manchester Study was conducted in two phases. Phase I involved a review of hospitalized patients using established admission criteria. The purpose of this phase was to determine which unit of the hospital patients would be assigned to if the hospital were organized in accordance with the progressive patient care concept (intensive care, acute care, self-care, or extended care).

Phase II involved the application of statistical theories used in operations research to compute the number of beds needed for each patient care unit. It was found that the number of self-care beds required was somewhat arbitrary. Since this segment of the patient census was largely elective, the laws of probability which affected

the other census were not operative and administrative policy could dominate.[5]

The reason for this arbitrary allocation of self-care beds becomes more apparent when it is recognized that the percentage of patients eligible for self-care in hospitals with the same total census will probably differ. This is because of variations in factors such as: (1) socioeconomic characteristics of the hospital's clientele; (2) the range of clinical services within the hospital; (3) the proportion of patients within each clinical service; (4) adequacy of the supply of beds within the hospital; and (5) the variations in interpretations of the need for a self-care facility.

Each such factor will exert an influence to either lower or increase the use of a self-care facility and, of course, there will be wide variations among hospitals as to which factors exert the strongest influence and in which direction. Therefore, a reliable estimate of the census of patients who are eligible for admission to a self-care facility can be made only from an actual survey of inpatients and their nursing needs within the individual hospital.[6]

A survey questionnaire to be completed by nursing team leaders was designed as a means of determining the percentage of inpatients at Presbyterian Hospital who would be eligible for admission to a self-care facility (see

Appendix C). By a decision of the administrator, this questionnaire was used by the nurse to survey all inpatients except those in the intensive care, obstetrical, neuropsychiatric and stroke wards, all which have relatively few patients eligible for self-care. The wards that were surveyed, and the specialties represented, are shown in Appendix D.

The survey was conducted on April 22, 1970. A general meeting of nursing team leaders was called on April 21 by the chief of nursing services, and at that time the purpose of the study was discussed, and the research methodology explained to the group. The questionnaire was explained in detail and the nurses were given sufficient time to ask questions and contribute suggestions. The nurses were then instructed to evaluate as eligible for self-care only those patients on their wards who could meet the established criteria for admission.

Analysis of the results of the survey (see Annex E) reveals that 16.7 per cent of the patients surveyed on that day were evaluated by the nursing team leaders as eligible for admission to a self-care facility. Further analysis reveals that the eligible patients had certain nursing needs. Some patients were evaluated by the nurses as having only one nursing need, while others were evaluated as having as many as five. These five areas of nursing needs, and the

individual percentages of the total responses (51), are listed in Table 1. These nursing needs will be discussed further in the section pertaining to services provided in a self-care facility.

TABLE 1

NURSING NEEDS OF ELIGIBLE SELF-CARE PATIENTS

Nursing Needs	Per Cent of Total Responses
Assistance or supervision in taking medications.	44
Assistance or instruction with tests or diagnostic measures.	12
Assistance or instruction with special treatments.	16
Instructions for home care.	20
Assistance or instruction with diet.	8

Source: Inpatient survey for self-care eligibility conducted by nursing team leaders at Presbyterian Hospital of Dallas on April 22, 1970.

The nurses were also requested to indicate on the questionnaire those patients eligible for self-care who had relatives residing or staying in the city of Dallas during the patients' episode of hospitalization. A mean average of 85 per cent of eligible patients were reported to be in this category. The implications of this statistic will be discussed in the section pertaining to services.

A questionnaire for physicians was also designed for the purpose of determining the extent of agreement between the nursing team leaders and physicians in the evaluation of

inpatient self-care eligibility (see Appendix F). This questionnaire was given to the physicians of the thirty-eight patients evaluated as eligible for self-care by the nursing team leaders on the day of the survey. The physicians were asked to evaluate the patients' eligibility for self-care based on the same admission criteria as applied by the nurses. The results of this survey reveal that 68 per cent of the physicians concurred in the evaluation of the nurses. A total of 16 per cent of the physicians disagreed with the nurses, and 16 per cent failed to respond (see Table 2).

TABLE 2

AGREEMENT OF PHYSICIANS AND NURSING TEAM LEADERS IN EVALUATION OF SELF-CARE ELIGIBILITY

Ward	Eligible Patients (Head Nurse)	Eligible Patients (Physician)	Ineligible Patients (Physician)	No Response
2E	6	6	0	0
3E	9	6	3	0
3W	3	2	0	1
4E	1	0	0	1
4W	2	2	0	0
5E	9	5	3	1
5W	6	3	0	3
6E	0	0	0	0
6W	2	2	0	0
Total 9	38	26	6	6

Source: Inpatient survey for self-care eligibility conducted by selected physicians at Presbyterian Hospital of Dallas on April 22, 1970.

Analysis of these results reveals that there is a significant difference of opinion between the nurses and physicians concerning eligibility for admission to a self-care facility. This situation could no doubt be improved or corrected if a thorough indoctrination of the philosophy of self-care is conducted for the medical and nursing staffs prior to the establishment of a self-care facility at the hospital.

The survey conducted on April 22 should not be interpreted as a conclusive estimation of patients eligible for admission to a self-care facility. The hospital should conduct surveys over a prolonged period of time in order to arrive at a valid estimation. These one day surveys should be spaced over this prolonged period in such a manner that the risk of surveying the same patients more than once is kept to an absolute minimum. This could be accomplished if the surveys are not conducted any more frequently than every seven days considering the fact that the average length of patient stay at Presbyterian Hospital is 6.6 days.

The result of 16.7 per cent eligibility, although not conclusive, can be considered for tentative planning purposes as far as this study is concerned. It is probable that approximately 20 per cent of the patient population of the hospital will be considered eligible for self-care at the conclusion of any survey conducted for this purpose.

This prediction is based on an extensive review of the literature which reveals that approximately one in five, or 20 per cent, of all patients in hospitals in the same category as Presbyterian Hospital are eligible for admission to a self-care facility.

Therefore, based on this inconclusive result of 16.7 per cent, a rough estimation of self-care beds required to support the nine wards can be shown. A total number of 279 patients could be accommodated in these nine wards. Multiplying these 279 patients by 16.7 per cent results in forty-seven required beds.

The 120 bed planned expansion is expected to add medical-surgical patients to the inpatient census in the same mix as now included in the nine wards which were surveyed. Multiplying 120 total patients by 16.7 per cent eligibility results in nineteen beds required to support the planned expansion phase. Therefore, based on the one day survey the estimated total number of beds required to support the present hospital configuration and the planned 120 bed expansion phase is sixty-six (forty-seven and nineteen).

Services

The services to be provided in a self-care facility depend in large measure on the types of patients who will be admitted. The patients, both adult and children, at Presbyterian Hospital who were eligible for admission can be

classified into six general categories as follows:

1. Diabetics: Those patients needing instruction in diet management, self-administration of insulin injections, and checking of urine.

2. Other medical convalescents: Those patients following acute and chronic medical episodes who can be admitted to the facility the last few days prior to discharge in order that the physician and nurse can observe them in a more normal homelike atmosphere and provide instructions for home care.

3. Pre-operatives: Those patients needing diagnostic "work-ups" which may require one or two days prior to scheduled surgery.

4. Minor surgical cases: Those patients who would be ambulatory immediately after minor surgical procedures.

5. Post-operatives: Those patients normally admitted to a facility two or three days after surgery in order that they can be observed and assisted prior to discharge.

6. Diagnostic cases: Those patients needing diagnostic studies requiring more than one day, and therefore not practical on an outpatient basis.

An analysis of these patients' nursing needs reveals that they require nursing services which are chiefly educational and supervisory in nature (see Table 1, p. 23),

and which will encourage them to learn to take care of themselves. The nursing services provided, therefore, should be predicated on the philosophy that in self-care, nursing procedures are to be kept at a minimum.

Only in an emergency should any bedside nursing be required. In general, this minimal type of nursing care consists of patient observation, assistance and instruction, the giving of medication, routine bedside care and occasional ambulation of patients. It does not include constant treatment or observation of vital signs.

Many patients admitted to a self-care facility will no doubt believe that self-care involves a lack of qualified nursing attention. The dissemination of a patient orientation booklet would serve to dispel these beliefs, and to orient the patients as to what nursing services will be provided them.

One very important type of nursing service which should be provided the patients is that of assisting them in taking medications. This nursing need can often be met by allowing the patients to pick up the medication at the pharmacy and to keep it at their bedsides. Under the guidance of the nurse, the individual patient prepares and takes his own medication, and keeps his own record. This ability of the patient to take his own medication safely is one of the main prerequisites for discharge from the hospital.

In addition to assisting with oral medications, the nurse may be required to instruct and assist the diabetic patient in the self-injection of insulin. This assistance provided in the self-care facility will help guarantee that he can take care of his own medication needs once he returns home.

Patients should also be given assistance or instruction relating to tests or other diagnostic procedures which they might require. Certain procedures performed by the ancillary services at Presbyterian Hospital such as X-rays, physical therapy and pulmonary physiology tests will require self-care patients to go to the main hospital at appointed times. The nurse will be responsible for assisting these patients by arranging their schedules and for insuring that they know what is expected of them.

The chiefs of the ancillary services were questioned about any changes in operating procedures which would be required to support a self-care facility. The consensus of opinion among these key personnel was that a self-care facility should not require any significant changes in present ancillary service procedures. Some procedures such as laboratory collections and inhalation therapy treatments will be performed in the patients' rooms, while others such as X-ray and electroencephalograms must be performed within the main hospital.

Certain treatments and diagnostic procedures can actually be performed in the self-care facility if the patients are ambulatory immediately after the completion of them. A small treatment room available within the facility will permit physicians to visit their patients for these purposes. Such procedures performed within the self-care facility at Barnes Hospital, St. Louis, Missouri are cited as guidelines (see Appendix G). The role of the nurse is to assist in physically preparing the patient for these procedures, and to prepare him mentally by explaining the procedures and the necessity for them.

The need to prepare patients to adjust from the hospital to the home or community is an important factor in their hospitilization. The transfer to the self-care facility prior to discharge minimizes this problem because the patients have the opportunity to adjust gradually from complete dependency to self-sufficiency.

The nursing procedures provided should encourage and assist patients in their transition from the hospital to home. The patients are given instructions, assistance and counseling of a nature designed to achieve self-sufficiency as quickly as possible. In addition, they should be permitted so far as possible to follow a homelike routine, with no fixed bedtime or arising hours except as may be required by appointments for diagnostic or therapeutic procedures.

There also should be no need to restrict either children or adults as visitors, or to limit visiting hours.

One service which can do much to ease the patient's transition from the hospital to home is communal dining. Properly utilized, this service can play an important role in the therapy of the patient, because mealtime should be a cheerful and enjoyable experience for him. Being able to move from the all too familiar sickroom in which he has been confined to a different location for meals is a psychological boost for the patient, since it makes him feel that this is a milestone in his recovery.

Ambulatory dining has the further advantage of encouraging the passive, ungregarious, and inarticulate patient to assume at least some role in a community activity. It places him in a realistic atmosphere where he is in competition with others, and where he must rely on his own resources if he is to succeed in gaining self-confidence.[7]

One of the major functions of the hospital dietary department relating to the self-care patient is aiding him through nutritional education which helps him adjust to his home environment. Here the cafeteria can serve as a tool by enabling the dietitian to provide instruction and assistance to the patient as he goes through the cafeteria line. A nutritional education training program can be developed by a teaching dietitian for patients on modified diets

requiring instructions, for food service personnel engaged in serving and checking trays, and for food service supervisors assigned to assist ambulant patients in the line.[8]

Dietary instruction implies a multitude of practices. It usually connotes direct communication between a dietitian and a patient for whom a physician has ordered a modified diet. The anticipated impact on such a modified diet instruction program on the hospital can perhaps be better appreciated when it is recognized that as many as 80 per cent of self-care patients may require this service.[9] Dietary instruction may also refer simply to the printed sheet of nutritional directions given to the patient prior to discharge, or it may involve the informal instruction of the patient and, perhaps, his family. Regardless of the method of presentation, its purpose is generally the same--to teach the patient how to provide for his own dietary needs.[10]

Easy access to the hospital cafeteria is desirable for both patients and staff. If this is impractical, a small, separate cafeteria should be made a part of the unit. In this event, adequate seating space for patients, guests, and staff would be required, in addition to policies regarding meal hours, dress, collections from guests, and the methods of serving modified diets.

The chief dietitian at Presbyterian Hospital stated

that in her opinion a self-care facility could easily be supported by the present food service department. In addition, the acquisition of food service equipment required to support the projected 120-bed expansion phase in the main hospital should easily serve up to an additional 100 self-care beds as well.

The dietition also stated that the self-care facility would present many welcome opportunities for the food service staff to implement unique nutritional programs which would be to the advantage of the patients. One concept recommended for adoption is known as the five meal plan: for the early risers, a continental breakfast of sweet rolls, toast, cold cereal, fruit and beverages would be served. Brunch is served around 11:00 A.M. for those patients whose X-rays and laboratory tests have been completed. For those who do not want to wait until 5:00 P.M. dinner, an afternoon snack of fruit, cookies, jello or custard is available at 1:30 P.M. Bedtime snacks are available after visiting hours. This plan allows for a more flexible morning schedule and more eating activities for the patient to look forward to during the day.

Another dietary service recommended by the dietition for self-care patients and their guests is a small minimal dietary kitchen for preparation of a light breakfast and between meal snacks with a small dining room adjacent to

this facility. These conveniences would meet both the recreational and instructional needs of the patients.[11]

The surroundings of a self-care facility should permit patients to be in an excellent frame of mind so as to facilitate more rapid and complete recovery. Time should pass quickly, for there are many ways for patients to occupy the hours not used in going to the hospital for examinations, treatment or conferences with physicians. Simple recreational opportunities such as a lounge and game room will permit patients to visit with friends, to relax, or to enjoy television.[12]

The women's hospital auxiliary at Presbyterian Hospital can play an important role in the services provided in the self-care facility. Volunteers can be assigned to the facility for purposes of assisting the staff in operating the lounge and game rooms, escorting patients to and from the hospital, or providing information and assistance to patients and their visitors.

In planning services which should be provided to self-care patients, it is important to consider the role of the patients' families. A family member is often of help to the patient in preparing him for studies, assisting him with his medications and providing the nuances of comfort readily available at home but not usually recognized or provided by the hospital or its workers. In addition, the opportunity

of the doctors and nurses to observe the interchange between the patient and his family over the course of several days of stressful probing and testing reveals attitudes and behavior that are highly relevant to diagnosis, prognosis, and treatment.[13]

Since one of the proposed objectives of the self-care unit is to provide surroundings as homelike as possible, it is advisable to plan a facility which will permit patients' family members to remain with them during the period of hospitalization. In most cases it should be possible for a family member to occupy a room with a patient, and at a charge considerably below the rate charged for a private room in the main hospital. If this were possible, it is probable that a significant number of the out-of-town family members reported as temporarily staying in Dallas, as well as some members living in the city, would elect to share a room with the patients.

The self-care facility can also be a place where children in the hospital can be taken care of by a parent. As pediatricians are well aware, the hospitilization of a child is often a traumatic experience for him, as well as an expensive one for the parents. In an effort to counteract both the emotional and economic disadvantages of admitting the child to the hospital, children can be admitted to the facility who meet the admission criteria

and who can be cared for by a parent.

The vast majority of needs of the children in the facility can be met by the parent. The collection of urine, for example, is much easier for the mother to do correctly than it is for the nurse. Parents have also been very successful in "ambulating" a child after surgery, or getting a "chest case" to cough. With careful instructions, they can also accurately observe and record the effects of drugs and other therapy.

In summary, there are important advantages of admitting children to the self-care facility. These are:

(1) By keeping the parent and child together, the trauma of mother-child separation is eliminated.

(2) The twenty-four hour availability of the parent provides an excellent opportunity to teach the parent much about the child's condition, and allows her to try her newly acquired child care skills under careful supervision.

(3) The physicians and nurses can observe parent-child interaction, making appropriate suggestions regarding management when indicated.[14]

In providing services to the self-care patient, it should be kept in mind that the needs of non-acute patients differ from those who are acutely ill. The individual teaching and professional guidance offered here are of greater importance to the patient than bedside care. The

ambulatory patient, whether recovering from a severe illness or undergoing diagnostic procedures, needs understanding and support, preparation for return to home, and above all, assistance in understanding himself and his illness. The staffing patterns for nursing services that are established by the hospital to provide these services will be critical to the success of the self-care concept.

Staffing Requirements

One significant advantage to patients admitted to the self-care facility is a reduction in their cost of hospitilization. This is achieved primarily through a reduction of direct nursing hours per patient and nursing personnel required to provide these hours. Presbyterian Hospital is presently providing approximately 4.2 hours of direct nursing care per day to patients in the intermediate care areas of the hospital. The nursing personnel required to provide these hours on each thirty-one patient ward are as follows: three professional nurses, two licensed vocational nurses, two aides, and one orderly on the day and evening shifts; and two professional nurses, one licensed vocational nurse and one aide on the night shift.[15]

The hours required per day for each self-care patient should be considerably lower than the 4.2 hours now provided for patients in the intermediate care areas. The number of hours provided should actually decrease as

the patient passes from intensive, to intermediate, and finally to self-care. An example of comparisons of required hours of care per day as revealed in a study of nineteen Massachusetts hospitals conducted in 1968, is shown in Table 3.

TABLE 3

PATIENT MIXTURE AND AVERAGE REQUIRED HOURS PER PATIENT DAY BY LEVEL OF DEPENDENCY

Dependency	Required Hours of Care Per Day
Intensive care	4.47
Intermediate care	3.27
Self-care	2.79

Source: David H. Harris, "Staff Requirements," Hospitals, XLIV (April 16, 1970), 65.

Much of the success of a self-care facility as an element of hospitilization permitting fewer hours of nursing care will depend on the validity of the assumption that staffing of nursing personnel can be light. Dr. Jack C. Haldeman, one of the recognized experts in the field of progressive patient care, has the following to say about staffing requirements for a self-care facility:

> The unit's staffing requirements will depend on the services to be provided and on the patient census. In one hospital where the average number of patients in the unit is twenty-six, the following pattern has been found adequate: one professional nurse plus one licensed vocational nurse or nurse's aide for the day shift; one professional nurse plus one licensed vocational nurse or nurse's aide for the evening shift;

> and either a professional nurse or a licensed vocational nurse for the night shift. A clerk could be assigned to this unit to assist in arranging patients' schedules or to remind them of appointments.[16]

In addition to services provided and the patient census which Dr. Haldeman mentions, other possible factors will determine differences in nurse staff patterns. These include the utilization of nonprofessional nursing personnel, the size of the facility, the type of patient cared for, and the layout of the facility. One hospital, for example, might decide it advisable to staff the self-care facility with only one professional nurse without regard to the number of beds, while another might religiously follow Dr. Haldeman's staffing recommendations.[17]

Two examples will serve to illustrate individual hospital approaches to nurse staff requirements. One administrator reports that the staffing pattern in his hospital's forty bed self-care facility is as follows: a professional nurse is on duty during the day shift, a professional nurse or a licensed vocational nurse during the evenings, and a licensed vocational nurse at night. In addition, a ward clerk is on duty from 7:00 A.M. to 3:00 P.M., and a nurse's aide from 3:00 P.M. to 8:30 P.M.[18] Another hospital with eighty beds has a nurses' station manned twenty-four hours by only a professional nurse, a licensed vocational nurse, and an aide.[19]

Specific requirements for additional nurses, if any, on the intermediate care wards would be dictated by the nursing needs of patients occupying the vacated beds. The fact that Presbyterian Hospital is providing approximately 4.2 hours of direct nursing care per day to patients in the intermediate care areas of the hospital as opposed to an average of 3.27 hours given by nineteen Massachusetts hospitals as shown in Table 3 would seem to indicate that the present staffing patterns would be adequate to accommodate patients occupying vacated beds in the intermediate care wards.

The self-care facility should be under the supervision of a professional nurse at all times; however, a professional nurse may not be required to be physically in constant attendance. For safety reasons it should also be staffed with at least one person on each of the three shifts. It seems highly desirable that a professional nurse, preferably of head nurse capability and perhaps rank, should be placed in the unit during the day shift. With a less trained person, it is questionable whether the unit could achieve all its objectives.[20] In addition, without properly qualified personnel, it is doubtful whether Medicare, Blue Cross and other types of hospital insurance would pay for admission to a self-care facility.

Since the key to progressive patient care is service

on each unit to fit the needs of patients assigned there, it is essential that the staff for each unit be carefully selected and given any special training which may be necessary. The fact that requirements on the several units differ provides an opportunity to utilize differing preferences and abilities among the nursing staff. For example, a nurse who likes technical procedures and is not easily flustered by the pressures of emergencies would probably serve well on the intensive care unit, while the nurse with demonstrated abilities in health teaching and counseling would probably be more effective in the self-care facility.[21]

There are usually no easy answers as to what constitutes adequate staffing. Yet, from a legal protection standpoint the hospital administrator may well ask certain key questions. These questions should center on such key areas as the observable level of patient care, staffing patterns at comparable facilities, special responsibilities of staff and the potential risks to patients in the area under study, and adequate education, training and experience of assigned personnel.

These are some of the factors that will affect a decision on staffing. However, it can never be assumed that a legal challenge will not be made, based on alleged inadequacy of personnel. Administration need not satisfy everybody; to meet the legal standards imposed in the cases,

it must be able to justify the staffing patterns used in a reasonable manner.

The professional nurse in the self-care facility will have a minimum of technical procedures to perform, but her human relations skills may be used to the maximum. Elements of the teacher, counselor, confidante, hostess, as well as nurse are all important in the makeup of the person working in this facility.[22] Skills in these areas and knowledge of good public health practices and of the community's health resources should be given high priority in selecting a nurse for the self-care facility.

A good self-care nurse must also be alert and observant. Many of the patients will need little supervision, while others will need to be kept in sight. Most patients need to be reminded of appointments or medications, and sometimes, they must be reminded to prepare for mealtime. Some patients need to be checked if they are absent from the patient group for more than a few minutes. Naturally, patients frequently go to their rooms to rest or nap, but the nurse must be sure that withdrawal from the group is for some normal reason.[23]

The self-care nurse works alone much of the time. Emergencies seldom occur, but minor problems requiring mature judgments do frequently happen. The nurse must be a good judge of human nature, adept at handling patients who

are not quite well but many times would like to act as though they were.

Evaluation of Self-Care Utilization

It would be extremely useful for the hospital to form an overall control committee to evaluate the utilization of the self-care facility. Operational questions such as eligibility for admission, transfer, and length of stay (generally not to exceed seven days) can usually be resolved at the attending physician and nursing supervisor level. If such questions cannot be resolved at this level, they may require solution by the control committee. Instances of repeated misuse of the facility are reported to the control committee which may act on the disputes, refer them to the executive committee of the board of trustees, or to the hospital joint conference committee for final action.[24]

The control committee should also function to evaluate the overall utilization of the facility, develop policy, plan future development, and maintain liaison among the administrative, professional and nursing staffs. Problems of patient care should be documented and reported at the various committee meetings by a physician or nurse.

The control committee could be called the self-care control committee, ambulatory care committee or some other appropriate name, and consist of such key hospital staff members as the assistant administrator, director of nursing

services, head nurse of the self-care facility, a social worker and an internist. Some hospitals assign overall responsibilities for the facility directly to existing committees such as the committee on professional services or the utilization committee.

Summary

Presbyterian Hospital of Dallas is faced with a high occupancy rate and shortage of acute beds for its patients. In an attempt to obtain relief from these critical problems, the administrator requested that this study be made to determine guidelines for the optimal utilization of a self-care facility at the hospital.

Before the hospital develops any definitive plans for a self-care facility, serious consideration must be given to what objectives must be established for this innovative type of hospitalization element. Basically, these objectives must lead to the creation of a facility that meets the unique medical needs of the patients, permits a reduction in their costs of care, minimizes staffing requirements and frees much needed acute beds within the hospital. Objectives to meet these goals were proposed for consideration by the hospital in the planning of a self-care facility.

The patients admitted to this facility must be selected based on their ability to assume responsibility toward meeting their own physical needs; those selected

should not require more than minimal nursing care procedures. In order to insure that only such eligible patients are admitted to the facility, criteria were established by which patients could be evaluated by the hospital for admission. In addition, procedures were established for use by the hospital for purposes of surveying the patient population to determine an accurate estimate of the percentage of patients eligible for a self-care facility.

The services the hospital must provide in the self-care facility will depend in large measure on the types of patients admitted. The services discussed in this study were predicated on the philosophy that the patients in the facility will require nursing and medical services which are chiefly educational and supervisory in nature, and which will encourage the patients to take care of their own needs within the limits of their capabilities. Other services facilitating patient recovery were discussed, such as those which can be provided by the food service department.

The successful operation of a self-care facility will depend in large measure on the ability of the hospital to staff it with a minimum of personnel. Different nurse staff patterns were discussed that would permit the facility to operate with a sharp reduction of direct nursing hours as compared to those now provided, and without a lessening of the required services. The desirable qualifications of

nurses elected for this facility were also discussed.

In order to insure proper utilization of the self-care facility, the hospital must employ proper evaluation and control procedures. At least two procedures were discussed for consideration by the hospital in exercising these supervisory functions.

Footnotes

[1]Mr. Rod Bell, Administrator, Presbyterian Hospital of Dallas, private interview, Dallas, Texas, April 18, 1970.

[2]U.S., Department of Health, Education, and Welfare, Public Health Service, Elements of Progressive Patient Care, Public Health Service Publication No. 930-C-1 (Washington, D.C.: Government Printing Office, 1962), p. 34.

[3]W.J. Coggins, "The Hospital Ambulatory Unit--Report of an Experience," New England Journal of Medicine, CCLXXII (April 22, 1965), 839.

[4]Jack C. Haldeman and Faye G. Abdellah, "Concepts of Progressive Patient Care," Hospitals, XXXIII (June 1, 1959), 45.

[5]U.S., Department of Health, Education, and Welfare, Public Health Service, The Progressive Patient Care Hospital: Estimating Bed Needs, Public Health Service Publication No. 930-C-2 (Washington, D.C.: Government Printing Office, 1963), pp. 1: 10.

[6]Madelyne Sturdavant and Harold C. Mickey, "An Experiment in Minimal Care," Hospitals, XL (February 16, 1966), 77.

[7]David A. Gee, and David A. Barnett, "Dining Out Makes Patients Feel Better," Modern Hospital, XCI (August, 1958), 98-102.

[8]Elements of Progressive Patient Care, pp. 35; 37.

[9]John R. Griffith, James H. Sullivan, and Lewis E. Weeks, The McPherson Experiment (Ann Arbor, Michigan: The University of Michigan Press, 1967), p. 144.

[10]Anne Claire Donovan and Burton Meyer, "Dietary Service in Progressive Patient Care," Journal of American Dietitic Association, XXXVIII (September, 1960), 449.

[11]Miss Doris Wilson, Chief Dietitian, Presbyterian Hospital, private interview held at Dallas, Texas, April 21, 1970.

[12]Robert Walker, "Reducing the Cost of Hospital Care--North Carolina Baptist Hospital's New Facility," Southern Hospitals, XXIX (March, 1961), 26.

[13]W.J. Coggins, "The Hospital Ambulant Unit--Report of an Experience," New England Journal of Medicine, CCLXXII (April 22, 1965), 840.

[14]Vernon L. James and Warren E. Wheeler, "The Care-by-Parent Unit," Pediatrics, XLIII (April, 1969), 493.

[15]Miss Sarah Miller, Assistant Director of Nursing Services, Presbyterian Hospital, private interview held at Dallas, Texas, April 16, 1970.

[16]Elements of Progressive Patient Care, p. 35.

[17]Faye G. Abdellah, Burton Meyer, and Helen Roberts, "Nursing Patterns Vary in Progressive Care," Modern Hospital, XCV (August, 1960), 87.

[18]Robert M. Jones, "Minimal Care Unit and Beds at Low Cost," Modern Hospital, CII (March, 1964), 103.

[19]Robert Walker, "Evaluation of a Minimal Care Center," Hospitals, XXXVIII (July 16, 1964), 77.

[20]John R. Griffith, James Sullivan, and Lewis E. Weeks, The McPherson Experiment (Ann Arbor, Michigan: The University of Michigan Press, 1967), p. 191.

[21]Jack C. Haldeman and Faye G. Haldeman, "Concepts of Progressive Patient Care," Hospitals, XXXIII (May 16, 1959), 46.

[22]Griffith, Sullivan and Weeds, The McPherson Experiment, p. 53.

[23]Ibid., p. 173.

[24]H.J. Lockward, Lane Giddings and Edward Thoms,

"Progressive Patient Care--A Preliminary Report," Journal of American Medical Association, CLXXII (January, 1960), 133.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The conclusions of the study provide the required guidelines for a self-care facility at Presbyterian Hospital. These guidelines are:

1. Proposal of attainable objectives for a self-care facility. The self-care facility must be separate from acute care areas. Nursing services should be provided at the lowest possible cost. Such services should also encourage the patient to prepare himself for return home and be provided in homelike surroundings with a relaxed atmosphere.

2. Establishment of acceptable patient admission criteria. Self-care patients must be able and willing to provide for their own needs, cooperate with nursing personnel, and not require close nursing care procedures. Also, they must not have any medical conditions which pose a threat or prove offensive to other self-care patients.

3. Establishment of procedures for estimating the percentage of eligible patients for admission to a self-care facility. To accomplish this purpose a survey questionnaire for completion by nursing team leaders was designed and utilized at the hospital. A questionnaire was also designed

for physicians to determine the extent of agreement between them and nursing team leaders in evaluation of self-care eligibility. Analysis of these results reveals that a thorough indoctrination program for the hospital staff is necessary prior to initiation of the self-care concept.

4. Provision of required services for self-care patients. The needs of self-care patients are chiefly educational and supervisory in nature. The services provided should be based on nursing procedures which are kept to a minimum, but which do involve family members when possible. Few modifications of services presently provided will be required if the concept of self-care is initiated.

5. Establishment of nurse staffing requirements. These should result in a substantial reduction in the 4.2 hours of direct nursing care per day presently provided to patients in the intermediate care areas. Personnel can conceivably be reduced to a level requiring only a professional nurse, licensed vocational nurse and an aide on duty during any one shift. The staff for this facility must be carefully selected and trained.

6. Establishment of procedures for the evaluation and control of the self-care facility. Operational questions which cannot be resolved at the physician and nursing supervisor level can be submitted to a special control committee, or to existing hospital committees for resolution.

Recommendations

It is recommended that:

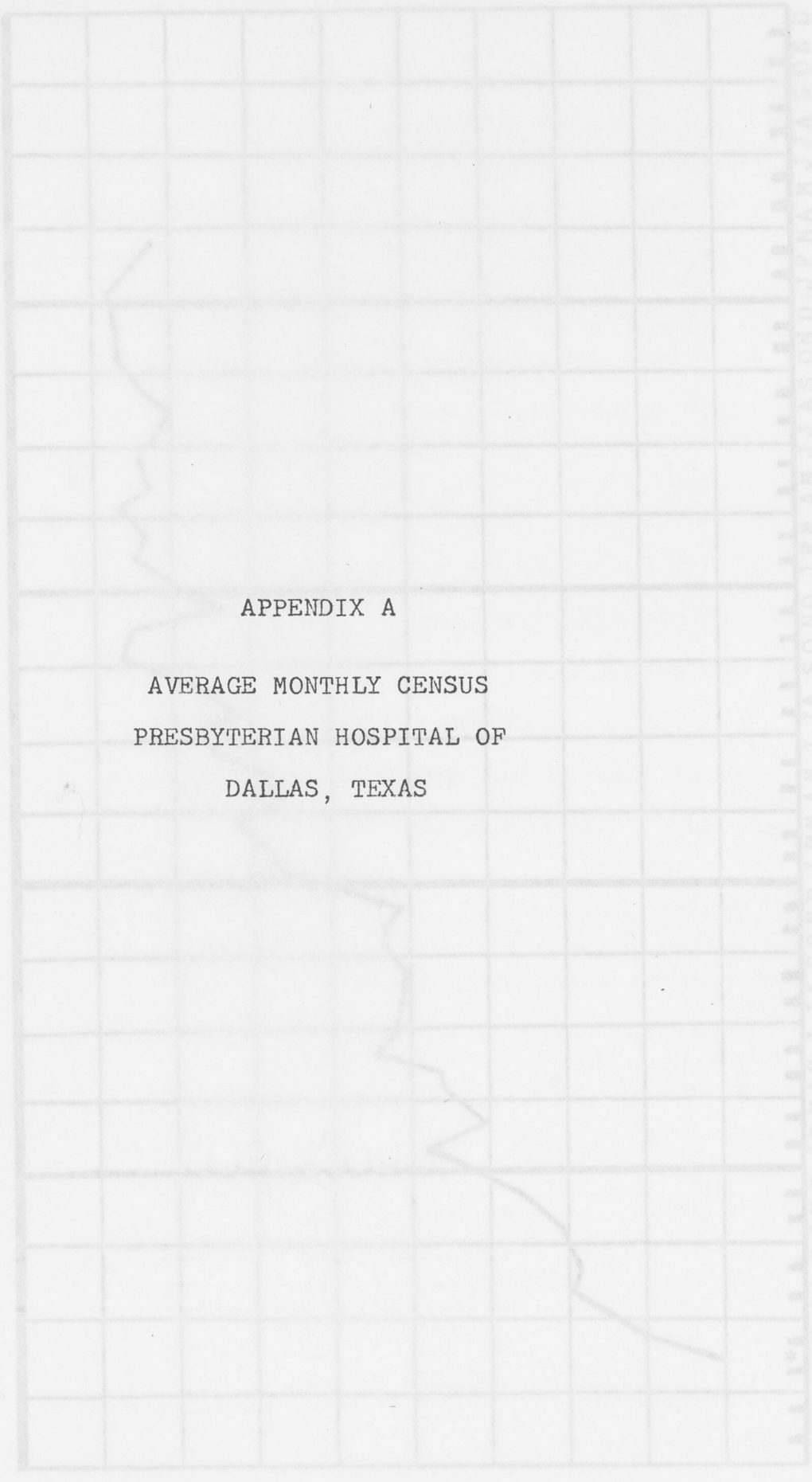
1. Before plans are made to construct a self-care facility at Presbyterian Hospital, independent surveys of patients be conducted over a period of not less than ninety days to determine more accurately the services and number of beds required.

2. Upon completion of these surveys, studies be made to determine the optimal location, design, and equipment requirements of the facility.

3. Before implementation of the self-care concept, the hospital initiate a thorough staff orientation and inservice education program.

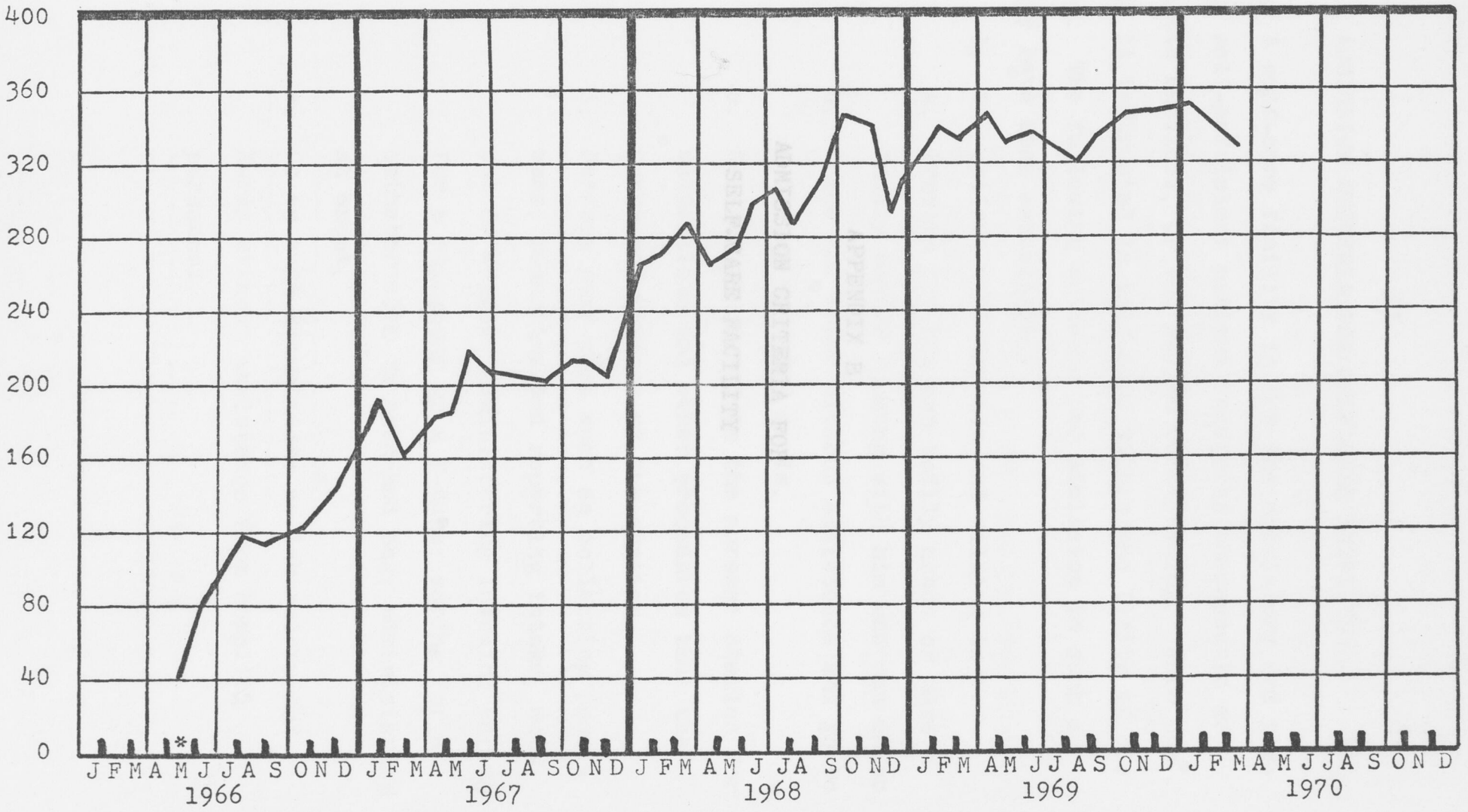
APPENDIX A

AVERAGE MONTHLY CENSUS
PRESBYTERIAN HOSPITAL OF
DALLAS, TEXAS



AVERAGE MONTHLY CENSUS

PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS



Source: Presbyterian Hospital of Dallas monthly statistical reports.

APPENDIX B

ADMISSION CRITERIA FOR SELF-CARE FACILITY

ADMISSION CRITERIA FOR SELF-CARE FACILITY

A self-care facility is for the ambulatory and physically self-sufficient patient requiring therapeutic or diagnostic services, or who may be convalescing. Here the patient is instructed in self-care within the limits of his illness. The following criteria for admission to such a facility have been established:

1. The patient must be able and willing to:
    a. Provide for his own bodily needs or have a family member rooming with him who can do so.
    b. Bathe and dress without assistance and go to a dining room for meals.
    c. Go when scheduled to the nurses' station for medications and other procedures that the nurse can perform at the station.
    d. Perform self-care such as collecting specimens; measuring and reporting intake, output or weight; administering insulin; caring for a colostomy or a T-tube; caring for a catheter with an attached bag; administering an enema.
    e. Go to such departments as laboratory and X-ray without assistance from hospital personnel.

f. Cooperate in carrying out diet, insulin self-administration, and other instructions as necessary.

2. A patient with any of the following conditions or requirements cannot be admitted even though he meets the criteria above:

a. Temperature, pulse and respiration or blood pressure required every five minutes to every two hours.

b. Hemorrhage

c. Levophed/Aramine

d. Unconsciousness

e. Disorientation

f. Bathing by nurse

g. Limited mobility

h. Feeding by nurse

i. Oxygen (inhalation therapy using room air is no restriction provided the patient does not require the assistance of a nurse to do so)

j. Suction

k. Infusion or transfusion

l. Pacemaker or respirator

m. Isolation

n. Close nursing care or observation

APPENDIX C

INPATIENT SURVEY QUESTIONNAIRE FOR DETERMINING ELIGIBILITY FOR ADMISSION TO A SELF-CARE FACILITY

(Nursing Team Leader)

INPATIENT SURVEY QUESTIONNAIRE FOR DETERMINING ELIGIBILITY FOR ADMISSION TO A SELF-CARE FACILITY

(Nursing Team Leader)

Name of nurse completing questionnaire _____

Date _____ Patient's name _____

Ward _____ Chart number _____ Sex _____

1. Based on the admission criteria is this patient's condition today such that his capacity for self-care and his nursing needs would permit safe and adequate care in our proposed self-care facility?

   _____ Yes _____ No

2. If the answer to the above question is Yes:

   a. What would this patient's nursing needs be in a self-care facility? (Answer all which apply).

      1. _____ Assistance or supervision in taking medicine.
      2. _____ Assistance or instruction with tests or other diagnostic measures.
      3. _____ Assistance or instruction with special treatment.
      4. _____ Instructions for home care.
      5. _____ Assistance or instruction with diet.

   b. Does this patient have relatives staying in town?

      _____ Yes _____ No

APPENDIX D

WARDS SURVEYED AND SPECIALTIES REPRESENTED

WARDS SURVEYED AND

SPECIALTIES REPRESENTED

Ward	Specialties
2E	Primarily GYN (D and C and hysterectomy)
3E	Medicine
3W	Medicine
4E	Orthopedic surgery and neurosurgery
4W	Urological surgery with some orthopedic surgery
5E	Ear, nose, throat, oral, dental, plastic, colon and rectal surgery
5W	Medicine, with some general surgery
6E	General surgery
6W	Ophthalmological surgery

APPENDIX E

RESULTS OF INPATIENT SURVEY
CONDUCTED BY NURSING TEAM LEADERS
TO DETERMINE SELF-CARE ELIGIBILITY

RESULTS OF INPATIENT SURVEY

CONDUCTED BY NURSING TEAM LEADERS

TO DETERMINE SELF-CARE ELIGIBILITY

22 April		
Ward	Yes	No
2E	6	17
3E	9	23
3W	3	28
4E	1	28
4W	2	29
5E	9	16
5W	6	25
6E	0	31
6W	2	31
Total	38	228

Source: Inpatient survey conducted by nursing team leaders at Presbyterian Hospital on April 22, 1970.

Note: YES refers to number of patients on ward rated as eligible for self-care. NO refers to patients rated as ineligible for self-care.

APPENDIX F

INPATIENT SURVEY QUESTIONNAIRE FOR DETERMINING ELIGIBILITY FOR ADMISSION TO A SELF-CARE FACILITY

(Physician)

INPATIENT SURVEY QUESTIONNAIRE FOR DETERMINING ELIGIBILITY FOR ADMISSION TO A SELF-CARE FACILITY

(Physician)

Purpose: The purpose of this questionnaire is to solicit your opinion concerning the eligibility of a certain number of your patients for admission to a self-care facility. These selected patients have been evaluated as eligible for self-care by the nursing team leader on this ward.

A self-care facility is for the ambulatory and physically self-sufficient patient requiring therapeutic and diagnostic services, or who may be convalescing. Here the patient is instructed in self-care within the limits of his illness.

The nursing team leader will provide you a copy of the criteria for admission to a self-care facility prior to your completion of this questionnaire.

Name of patient _____ Ward_____

Name of physician completing questionnaire _____

Considering the medical condition of this patient RIGHT NOW, and the criteria for admission to a self-care facility, could he be cared for safely and adequately in such a facility TODAY?

_____ Yes _____ No

APPENDIX G

GUIDELINES FOR DIAGNOSTIC PROCEDURES AND TREATMENTS ACCEPTABLE FOR SELF-CARE FACILITY

GUIDELINES FOR DIAGNOSTIC PROCEDURES AND TREATMENTS ACCEPTABLE FOR THE SELF-CARE FACILITY AT BARNES HOSPITAL

Objective: To clarify the diagnostic procedures and treatments that may be performed on patients admitted to the self-care facility.

I. Treatments Performed Within the Self-Care Facility
   - A. IPPB (done by inhalation therapy department or patient)
   - B. Intra-venous and intra-muscular injections
   - C. Injection or aspiration of joints
   - D. Neck and pelvic traction
   - E. Nerve block
   - F. Paracentesis
   - G. Removal of sutures and dressings
   - H. Thoracentesis

II. Diagnostic Procedures Performed Within the Self-Care Facility
   - A. Allergy and diagnostic skin testing
   - B. Biopsy (cervical, endometrial, skin)
   - C. Bone marrow aspiration
   - D. Caloric hot and cold
   - E. Lumbar puncture
   - F. Physical examinations

G. Proctoscopic examinations (biopsy if necessary)

H. Vaginal examinations and pap smears

III. Treatments Performed Away from the Self-Care Facility

A. Minor surgery (local anesthesia only)

B. Phlebotomy

C. Radioactive therapy

D. Rehabilitation treatments

IV. Diagnostic Procedures Performed Away from the Self-Care Facility

A. Allergy and diagnostic skin testing

B. Basal metabolism tests

C. B.S.P. (doctor injects dye)

D. Bone marrow aspiration

E. Catheterizations for urine culture

F. E.E.G.

G. EKG

1. Vectocardiograms

2. Masters single and double

H. Electro-myograms

I. Eye

1. Tonograms

2. Photo coagulations with laser beam

J. Ear, nose and throat

1. Audiograms

2. Sinus washings
3. Hot and cold calorics

K. Glucose and lactose tolerance

L. Gastro-enterology procedures
1. Esophogoscopy with dilation
2. Gastroscopy
3. Gastro-cine
4. Gastric aspiration either by cytology or gastro-enterology department

M. Laboratory tests

N. Pneumogynograms

O. Pulmonary function with or without isoprel
1. May or may not have blood gases

P. Scans (brain, liver, thyroid)

Q. X-rays
1. Angiograms
2. Any part of the anatomical structure
3. Barium enema
4. Cysto and fulgeration (local anesthesia)
5. Echograms
6. Esophagrams
7. Gallbladder
8. I.V. Cholangiograms
9. I.V. Pyelograms and retrograde
10. Laminograms of any specific area

11. Mammograms
12. Orthograms
13. Small bowel
14. Uretergrams
15. Upper G.I.

R. Tubal insufflation

V. Treatments Which May Not Be Done On Self-Care Patients

A. Any surgery under general anesthesia
B. Electric shock therapy
C. Indwelling catheter
D. Pre-operative medications (intra-muscular or sub-cutaneous)

VI. Diagnostic Procedures Which May Not Be Done On Shelf-Care Patients

A. Biopsy (kidney, liver)
B. Bronchoscopy
C. Cardiac catheterizations
D. Cystoscopy and fulgeration (general anesthesia)
E. Myelograms
F. Pneumo-encephalograms

VII. Questionable

A. Patient on kidney dialysis

Source: Letter from Mr. Robert E. Frank, Director, Barnes Hospital, St. Louis, Missouri, April 9, 1970.

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ABSTRACT

A STUDY OF GUIDELINES FOR A SELF-CARE FACILITY AT PRESBYTERIAN HOSPITAL OF DALLAS, TEXAS

A Problem Solving Thesis Submitted to the Faculty of Baylor University in Partial Fulfillment of the Requirements for the Degree of Master of Hospital Administration

by
Major John F. Davis, MSC

August, 1971 77 Pages

A copy of this document may be obtained on interlibrary loan from Stimson Library, United States Army Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

The purpose of this study was to determine guidelines for the optimal utilization of a self-care facility at Presbyterian Hospital of Dallas, Texas.

A review of the literature revealed some of the distinguishing features of the self-care concept and also experiences which some hospitals have reported pertaining to the operation of such facilities. Research methods included research of the literature, patient surveys utilizing questionnaires prepared by nursing team leaders and physicians, and interviews.

The conclusions of the study provided the required guidelines for a self-care facility at Presbyterian Hospital which were: (1) realistic and obtainable objectives; (2) valid admission criteria; (3) procedures for estimating the percentage of patients eligible for admission; (4) services which the hospital can adequately provide to meet the medical and nursing needs of self-care patients; (5) nurse staff patterns that would permit a considerable reduction in nursing personnel and consequently, of hospitalization costs; and (6) procedures which the hospital can employ to insure the required evaluation and control of a self-care facility.

Recommendations were made that the hospital, prior to making plans for a self-care facility, conduct: (1) an extended survey of patients to determine more accurately the services and number of beds required; (2) studies to determine the optimal location, design, and equipping of a facility; and (3) a thorough staff orientation and inservice education program before implementing the concept of self-care.