

DEPARTMENT OF THE ARMY
 HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
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MEDCOM Regulation
 No. 40-62

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THE WORKLOAD MANAGEMENT SYSTEM FOR NURSING-internet
 Medical Services

Supplementation of this regulation and establishment of forms other than U.S. Army Medical Command (MEDCOM) forms are prohibited without prior approval from Headquarters, MEDCOM, ATTN: MCHO-CL.

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- 1. History.** This issue publishes a new regulation.
- 2. Purpose.** The purpose of this regulation is to provide guidance relevant to the application, concepts, and utilization of the Workload Management System for Nursing-internet (WMSNi) for the MEDCOM and assign responsibilities for implementation.
- 3. References.** References are listed in appendix A.
- 4. Explanation of abbreviations and terms.** Abbreviations are explained in the glossary.

5. Applicability. This policy applies to all personnel who input or extract data from WMSNi in support of nursing care, inpatient staffing, and workload decision making. WMSNi is the umbrella system that includes the main WMSNi, the Labor and Delivery System (LADS), the Post-Anesthesia Care System (PACS), and additional WMSNi modules.

6. Background. Data generated by the WMSNi are used for decision making at Department of Defense (DOD), MEDCOM/Office of The Surgeon General (OTSG), military treatment facilities (MTFs), and unit levels. WMSNi data are used at the enterprise level for strategic and operational decision making and are instrumental in determining manpower requirements for professional and paraprofessional nursing personnel throughout MEDCOM. The foundation of the WMSNi is patient classification and the determination of nursing care hour (NCH) requirements in inpatient care. The task of ensuring accuracy of the WMSNi data and the patient's classification is a part of the professional nursing role.

7. Responsibilities

a. The registered nurse (RN) will, at a minimum of once every 24 hours, classify each patient according to critical indicators based on the anticipated nursing care needs of that patient for the next day. For WMSNi recording purposes, each day begins at 0700 and ends at 0659 hours. Newly admitted patients or transferred-in patients should be classified during the nursing shift that receives the patient. The RN is responsible for the completion of the classification on each patient every 24 hours or more often in response to changes in the patient's condition and subsequent changes in nursing care requirements.

b. The clinical nurse officer in charge (CNOIC) will—

(1) Control the accuracy of WMSNi data (including personnel management, patient management, and patient classification) for his/her respective nursing unit/ward by checking data for correctness and ensuring that clinical staff nurses are technically competent in the classification of patients.

(2) Monitor the nursing unit's inter-rater reliability (IRR) testing results and implement actions to correct identified problems. (Refer to para 9 g.)

(3) Utilize the WMSNi "scheduling" application to input staff schedules in order to generate accurate reports from the WMSNi system and update the schedule as applicable. The CNOIC may delegate the scheduling input function to the appropriate staff on the unit.

(4) Utilize WMSNi data for daily staffing decisions. The current goal is to achieve daily staffing on each unit of between 90-120 percent of required staffing.

(5) Ensure that the clinical staff nurse understands the WMSN_i “classification” definitions and application. The clinical staff nurse monitors compliance through direct observation and review of WMSN_i tactical reports.

(6) Ensure staff compliance with educational requirements including initial training with WMSN_i computer based training (CBT) modules (see para 7*i*, below).

c. The section chief/supervisor will—

(1) Review unit WMSN_i data to identify patterns and trends in NCHs and utilize this information for daily decision making. This may be done by reviewing reports within the WMSN_i and communicating with unit leadership.

(2) Monitor NCHs, required versus scheduled full-time equivalents, and unit occupancy rate. Evaluate the “nursing unit daily WMSN_i report” and the “24-hour report” utilizing the WMSN_i tactical reports for each unit.

(3) Consider the accuracy and appropriate uses of WMSN_i information in the evaluation of the CNOIC.

(4) Be involved in problem resolution if a unit fails to achieve a minimum of 80 percent agreement on the monthly IRR. In-depth discussion, unit meetings, teaching, remedial training, and retesting are appropriate actions. IRR testing is conducted every 2 weeks until an IRR of greater than 80 percent agreement by category is achieved and maintained.

d. The deputy commander for nursing (DCN)/nurse executive/assistant DCN will—

(1) Be responsible for the accuracy and appropriate use of WMSN_i information.

(2) Be responsible for distributing or redistributing nursing personnel in accordance with WMSN_i workload.

(3) Monitor monthly comparisons of the WMSN_i full-time requirements to the requirements, authorization, and assigned numbers documented in the table of distribution and allowances (TDA), unit IRR scores, and unit NCHs for major changes and trends within the facility.

(4) Share the managerial and manpower implications of the WMSN_i with the command team.

(5) Facilitate compliance with MEDCOM regulations, policies, and procedures. Facilitate the development of local policies and procedures in collaboration with individuals affected by the system to promote use of the data to balance workload and manpower.

e. The healthcare systems analyst (HSA) will serve as staff officer for the nurse executive. Three categories of HSAs (facility, regional, MEDCOM) are addressed below.

(1) The facility HSA will—

(a) Be responsible to the DCN for workload, staffing, and personnel requirements analysis.

(b) Monitor changes in workload and staffing.

(c) Monitor changes in the staffing needs of units/wards in the MTF, compare manpower requirements from WMSNi and the most current TDA, and recommend to the DCN adjustment to manpower requirements based on workload trends.

(d) Provide trend analyses and identify factors contributing to fluctuations in workload and the impact on the organizational structure to include possible consolidation or expansion of nursing services for the DCN.

(e) Work closely with other departments.

(2) The regional HSA will—

(a) Function as the region-wide WMSNi point of contact for WMSNi workload and manpower issues.

(b) Analyze MTF data, within the region assigned, for consistency and comparability to like-size units with similar missions and beneficiary populations.

(c) Monitor regional level changes in NCHs of like-size units and IRR scores and provide information and findings to the regional nurse executive (RNE).

(d) Serve as a regional consultant for nursing in areas such as manpower analysis and staffing needs assessments based on WMSNi data.

(e) Assist regional medical command (RMC) and MTF manpower departments with application of the approved manpower models and standards.

(f) Review and analyze manpower applications to provide MEDCOM and OTSG with regional short- and long-term effects and requirements.

(3) The MEDCOM HSA will—

(a) Function as the Army Medical Department (AMEDD) WMSNi point of contact for questions or issues related to the WMSNi.

(b) Be actively involved in working with the U.S. Army Medical Information Technology Center (USAMITC) Program Office on WMSN_i sustainment, performance, and development; and provide clinical, AMEDD, and user input into the program priorities and efforts.

(c) Assist RMC and MTF nursing and manpower departments with application of the approved manpower models and standards. Communicate WMSN_i updates, changes, or problems to the MEDCOM Chief Nurse Executive (CNE), RNEs, and MTF DCNs and HSAs.

(d) Review, analyze, and track worldwide trends in WMSN_i workload and manpower data to provide AMEDD leadership with information on short- and long-term effects and potential requirement implications.

(e) Educate the MEDCOM/OTSG and MTF staff members about the clinical, managerial, and manpower implications of the WMSN_i and communicate appropriate information.

(f) Routinely present at courses such as CNOIC/Non-Commissioned Officer in Charge (NCOIC) Course, Advanced Nurse Leadership Course, U.S. Army Baylor Graduate Program in Healthcare Administration Course, and the Basic Officer Leadership Development Course.

f. The USAMITC program manager team will—

(1) Provide program management oversight of the WMSN_i system as a whole.

(2) Monitor the automated systems and interface with automated data processing personnel to troubleshoot and correct problems.

(3) Recommend improvements in system automation based on input from users at all levels.

(4) Coordinate system enhancement and new system components.

(5) Communicate, as appropriate, WMSN_i automation updates, changes, or problems to the MEDCOM CNE and MEDCOM HSA; RNEs; and MTF DCNs, HSAs, and informatics officers.

(6) Manage configuration control of the WMSN_i and be responsible for total system management, to include system maintenance, development, and coordination of system refinements and new system components.

(7) Maintain WMSN_i data in the system for the AMEDD.

g. The MEDCOM CNE will—

(1) Ensure the effective use of WMSN_i information in decision-making processes at the MEDCOM level. Advise the MEDCOM staff (for example, the program budget advisory committee) on the most efficient and effective distribution of nursing authorizations and the utilization of data extracted from the WMSN_i. Provide objective input for prioritizing MEDCOM manpower issues.

(2) Educate the MEDCOM/OTSG senior staff members about the managerial and manpower implications of the WMSN_i and routinely communicate appropriate information.

(3) Monitor utilization of nursing resources among facilities and initiate inquiries when data trends suggest inefficient utilization.

h. The Chief, Manpower Division, MEDCOM HQ (or his/her representative) is the functional proponent of the WMSN_i system. The functional proponent, in concert with the MEDCOM HSA and the USAMITC program manager team, is primarily responsible for the sustainment of the system. Other responsibilities include recommending structural changes to the system, requesting funding for upgrades and sustainment, and ensuring the system outputs and performance support the needs of the nursing and manpower missions.

i. WMSN_i training requirements are the responsibility of nursing leadership and HSAs as delineated below.

(1) Nursing leadership is responsible for ensuring inpatient nursing staff and managers are trained in the use of WMSN_i by having a plan that outlines how nursing staff will be trained in their facilities.

(2) HSAs in conjunction with nursing leadership (para (1), above) are responsible for the training of nursing personnel in the correct use of WMSN_i. Inpatient nursing personnel may be trained using one of two methods: by CBT or by an experienced user either in face-to-face delivery or in an interactive mode which includes both visual and audio capabilities.

(a) Computer-based training. CBT is available for each of the eight WMSN_i modules; each module addresses roles and/or levels of responsibility. The CBT training matrix is provided in appendix B.

- Individuals will use the Army Training Requirements and Resources System (ATRRS) to enroll in WMSN_i CBT.

- The courses are then accessed and completed in the Army Learning Management System (ALMS).

- Both ATRRS and ALMS are accessed through Army Knowledge Online (AKO).
- CBT certificates can be used as validation of WMSNi competency for inpatient staff (excluding the CNOIC).

(b) Face-to-face or interactive (combination of visual and audio in real time) training by an HSA.

- All new DCNs should receive face-to-face or interactive training by an HSA if they have not previously received face-to-face training.
- All primary unit/ward/section leaders should receive face-to-face or interactive training from an HSA if they have not previously received face-to-face training.
- All IRR testers should have a minimum of 6 months experience using the WMSNi in the inpatient environment prior to being assigned as an IRR tester and receive training in the face-to-face or interactive mode by either a trained CNOIC or an HSA.
- The face-to-face training requirement for leadership may be fulfilled by attending the appropriate level course (for example, the CNOIC course, Nursing Executive Skills and Leadership Development Courses). Courses should be completed within 1 year of assuming the leadership position.
- Senior HSAs will ensure that new and junior HSAs are trained in the use of WMSNi in the following areas: classification of patients, personnel rosters, patient management, WMSNi scheduling, LADS, PACS, IRR, administration (authentication and authorization), reports (including reportable enterprise metrics), and online analytical processing report development and use.

8. WMSNi concepts

a. The WMSNi is a prospective system. The WMSNi system was intentionally designed to be prospective to ensure that future staffing requirements would be based on actual patient care needs rather than on the care that was provided by available staff in the past. By designing the WMSNi to provide an estimate of staff requirements for the next day, it becomes a valuable management tool for making staffing decisions. Retrospective workload can only reflect what was done, not what will be required. Nevertheless, some critical indicators counted retrospectively do apply (for example, patient admission, new orders placed by physicians, each hour requiring continuous staff attendance (for events such as cardiac arrest and rapid response team requirements)).

b. The WMSNi is linked to direct patient care. Calculated manpower requirements generated by WMSNi for inpatient care are based on the time nursing personnel spend providing direct care to each patient. Nurses perform a variety of bedside care activities, from simple, concrete tasks such as taking vital signs to complex tasks like

providing emotional comfort to a dying patient. These direct care activities are then translated into critical indicators which the nurse inputs based on the patient’s needs. The WMSNi is designed to quantify nursing workload and develop a patient acuity category based upon the amount of direct bedside nursing care the patient will require within the next day. The critical indicators of the WMSNi are direct nursing care activities that have been documented in time studies. An indirect care time factor is included as described, below, in table 1.

Unit Type	Indirect Care Multiplier
Medical/Surgical	65.8%
Intensive Care	69.4%
Neonatal Intensive Care	59.6%
Pediatric	67.5%
Psychiatric	73.1%
Labor and Delivery	57.4%
Postpartum	58.6%
Combined Labor and Delivery/Postpartum	63.9%

NCHs are calculated using the following formula:

$$\text{Total NCHs} = (\text{direct care hours}) (1 + \% \text{ of indirect care multiplier})$$

Table 1. Indirect care multipliers

c. The WMSNi allows time for indirect care. Staff time necessary for indirect nursing care is included in the WMSNi staffing formulas. The percentage of staff time spent in indirect care activities was determined through research. The work sampling technique used in the research addressed the variety of indirect care activities that occur daily on a nursing unit. These include time for activities in support of a direct care task such as communicating critical lab values and discharge planning, as well as administrative activities like time to answer the phone, give a change-of-shift report, and document in the patient record. Each patient type has an indirect care multiplier that is specific to that type.

d. The WMSNi quantifies the number of nursing personnel that are recommended to be available for patient care. Based on the input from the nursing staff, the WMSNi determines how many staff members are needed on a particular nursing unit to provide care during a 24-hour period. Monthly WMSNi data are used to calculate the total number of personnel recommended to staff a unit, allowing time for personal leave, sick time, in/out processing, mandatory military training, organizational duties, and other miscellaneous job requirements. This time, called non-available time, is a constant that has been determined by the DoD for use by all the Services.

e. The WMSNi does not include the staff time for administration and management of a nursing unit. The CNOIC, NCOIC, and medical support assistants (clerks) are positions on each nursing unit that are recognized as fixed requirements for administration and management, in addition to personnel requirements for direct patient

care. It is recognized that the CNOIC and NCOIC participate in direct patient care in times of unexpected workload. In such instances, patient care provided by the CNOIC and NCOIC will be reflected as patient care time in the appropriate human resources system.

f. The WMSNi is the basis for determining inpatient nursing manpower requirements in the U.S. Army. Workload data from WMSNi are used in the Automated Staffing Assessment Model (ASAM) manpower models as the basis for generating manpower requirements to document on future TDAs. The ASAM models also utilize the staffing skill mix (table 2) to generate the skill mix of unit staff. The manpower models utilize 36 months of NCH (workload data) and then average the annual workload. The total annual NCHs are divided by 1740 hours (Army available factor) to generate the variable workload requirements. Fixed requirements are added to the variable workload requirements. Fixed requirements are allocated based on two criteria: (1) If total earned (variable only) requirements are less than 23 = 4 fixed requirements (1 CNOIC, 1 NCOIC, 2 admin clerks); or (2) If total earned (variable only) requirements are 24 or greater = 5 fixed requirements (1 CNOIC, 1 acting clinical nurse officer in charge, 1 NCOIC, 2 admin clerks). Once the requirements are identified, the skill mix ratios (table 2) are applied to the total requirements and recommended for documentation on the TDA. Staffing levels are based on the average workload and do not provide requirements for staffing peak periods which is managed at the facility leadership level using professional nursing knowledge and expertise.

g. WMSNi 2.0 captures outpatient workload performed in the inpatient environment. Currently, outpatient workload performed in the inpatient environment is not captured within WMSNi; the new WMSNi 2.0 will provide this capability. WMSNi 2.0 will document outpatient workload performed in the inpatient environment only. Adequately capturing the outpatient workload in the inpatient environment using critical indicators will fully inform staffing decision making processes. WMSNi and WMSNi 2.0 will provide actual NCH requirements for both outpatients and inpatients in the inpatient environment. This system provides precise and effective staffing forecasting; potentially reduces labor expenses for nursing staff; avoids needless admissions; potentially improves patient outcomes by enhanced analysis of patient care requirements; and centralizes and standardizes reports for data capture, accuracy, and meaningful display. The WMSNi 2.0 development is underway and anticipated to be ready for use in FY14.

Ward/Unit	RN	Paraprofessional	Paraprofessional - LPN Breakout	Paraprofessional-Medic/NA Breakout
ICU	80%	20%	75%	25%
Medical/Surgical	60%	40%	40%	60%
Progressive Care	60%	40%	50%	50%
Labor and Delivery	90%	10%	100%	0%
LDRP	90%	10%	100%	0%
NICU	90%	10%	100%	0%
Postpartum/MBU/NBN	80%	20%	100%	0%
Pediatrics	60%	40%	100%	0%
Psychiatric	38%	62%	30%	70%

Table 2. MEDCOM suggested unit staff skill mix

9. Utilization of WMSN_i

a. WMSN_i applicability. The WMSN_i is applicable to labor and delivery and post-anesthesia care units (PACUs) as well as all inpatient units.

b. Patient management.

(1) An active Composite Health Care System interface provides unidirectional population of patient admissions and transfers into the WMSN_i application, based on activation into prescribed inpatient nursing locations by physicians and patient administration division admission and discharge staff.

(2) If a patient is not automatically admitted through the active interface, the nursing staff should manually manage the patient in the patient manager module following the steps outlined in the WMSN_i User Manual.

c. Classification.

(1) Patients are classified at a minimum of once every 24 hours by an RN (para 7a). The RN classifying a patient enters the quantity of critical indicators projecting the needs of the patient for the next 24 hours.

(2) Refer to the WMSN_i User Manual for guidance on how to perform a classification.

(3) Classifications should be updated multiple times a day based on changes in the patient's status. Updates can be accomplished retrospectively to capture care that cannot be predicted such as care provided to a patient during cardiac arrest.

(4) Critical indicator worksheets are available to assist in the classification process, including each of the critical indicators by patient type, and are located in the WMSNi User Manual.

(5) For definitions of each critical indicator, refer to the WMSNi User Manual or the critical indicator definition on the classification screen.

(6) For those times that the system is down due to extended maintenance, repair, power failure, or lack of Internet connectivity/service, the following apply: Notify the Enterprise Service Desk of the situation as soon as possible and input classifications as soon as you are able following return of service. If the downtime exceeds 8 hours, the WMSNi application manager can apply a minimum of nursing care hours (nursing care hours approximating a level 2 classification) to each patient in the system for that time period. Future plans include applying a unit-specific average of nursing care hours per patient to these situations.

d. PACS.

(1) Although S-3 is the system that manpower utilizes currently to validate requirements within the current peri-operative manpower model, nursing personnel will still use PACS. PACUs will continue to utilize S-3 for manpower validation.

(2) PACS provides NCH requirements to determine nurse staffing needs and a method of evaluating the work process in the PACU.

(3) Nursing workload is measured in NCHs and includes both direct and indirect care time. In PACS, indirect care time also includes patient transportation, restocking, and delay time such as time spent waiting for patients.

(4) Because of the high correlation between the volume of post-anesthesia patients and workload, the only reporting requirement of the PACS is the volume of patients and the categories of anesthesia. The volume is separated into two primary categories: (1) the number of patients recovered who received general and/or spinal/regional anesthesia, and (2) the number of patients recovered who received only local or sedation anesthesia. The first category is reported in the PACS module under the general anesthesia column while the second category is reported under the local anesthesia column.

(5) For recording purposes, each day begins at 0001 and ends at 2400 hours. Record each patient visit in the PACU only once even if the visit extends past midnight. A patient visit is defined as an episode of care that includes admission to the PACU, an initial assessment, routine post-anesthesia care, and discharge to another unit.

(6) It is not uncommon for patients to be recovered in a variety of areas beyond the recovery room and by a variety of different types of staff. (This most often occurs for patients who receive surgery after PACU normal duty hours.) Regardless of recovery

location or the staff who recovers them, the entire volume of post-anesthesia-recovered patients must be entered into the PACS. The staff involved in performing the recovery, rather than the location of the recovery, determines where the data are to be recorded in the system. All patients who are recovered by PACU staff, regardless of location, must have their volume entered into the columns marked for PACU staff. Conversely, all other "consolidated" patient recovery data are recorded and columns marked for non-PACU staff.

e. Labor and Delivery System.

- (1) The LADS is a retrospective data capture component within the WMSNi system.
- (2) LADS data are collected for the period 0001 to 2400 hours.
- (3) Patients will be classified daily and as patients are transferred in or transferred out.
- (4) All patients will be classified including mothers and newborns.
- (5) Twins are not counted as two deliveries unless one delivers vaginally and one by cesarean section. However, once born, each child will have their own LADS classification.
- (6) The staff will report each outpatient visit within the LADS outpatient module. The same patient may "visit" repeatedly during the same-day period as per the outpatient plan of care.

f. Staffing requirements and skill mix.

(1) The objective and prospective classification of patients is the most important aspect of the WMSNi. Inflating or underestimating classifications carries serious implications, since these data determine the manpower requirements for each nursing unit. Inflation of the system by selecting critical indicators that are not required or ordered becomes falsification of official documents and holds the same consequence as falsification of information on any other official document. Staff RNs are responsible for the accurate classification of each patient at a minimum of once every 24 hours.

(2) Once the staffing requirements are determined, a suggested daily skill mix is established based on the MEDCOM standard and as indicated in table 2. These skill mix ratios were determined by reviewing the current literature and consulting with experts in each of the clinical areas.

(3) OTSG nursing consultants determined the distribution of staff across shifts. The distribution varied by clinical area as listed below.

(a) Medical/surgical, mother/baby (obstetrical), psychiatric, pediatric.

- Days = 40%
- Evenings = 35%
- Nights = 25%

(b) Intensive care, neonatal intensive care, newborn nursery.

- Days = 33%
- Evenings = 33%
- Nights = 33%

g. Inter-rater reliability:

(1) It is important that any system be consistent. Research shows that the WMSNi is reliable; that is, it can be used by two independent nurse classifiers on the same patient with a high degree of agreement. IRR is the method used to determine this degree of agreement. Maintaining the integrity of WMSNi through IRR is very important to the continued accuracy of the workload data.

(2) An IRR monitoring system must be a component of the WMSNi in order to ensure that the system generates accurate and usable information. Reliability refers to the consistency or stability of the WMSNi patient classification measurement from user to user. Reliability is evaluated by having two individuals classify the same patient independently. A comparison of their classifications is then used to compute an index of equivalence or agreement between the classifiers.

(3) The patient classification is completed by *two* independent raters— a unit nurse and an experienced and trained classifier. The experienced classifier must be assigned from another unit; both classifiers should never be from the same unit. The classifier should be familiar with the unit standards of care. Each nurse must classify independently; that is, neither should know the critical indicators the other has selected until both have completed the classification process.

(4) Random monthly IRR tests must be done on all nursing units, by experienced raters, to ensure that patients are being correctly and consistently categorized. The approach used in assessing IRR in the WMSNi patient classification system is *percent category agreement* (that is, the ratio of the number of patient category agreements to the total number of possible agreements).

(5) IRR tabulation and reporting are done in a timely manner, and the results are shared with the unit, the section or service chief, and the DCN.

(6) If the IRR score drops to 80 percent or below, actions must be taken to identify the cause and correct the problem. After reporting the deficiency to the unit leadership and re-education is completed, the process is then repeated until the IRR score is equal to or above 80.01 percent.

h. For additional information on the use of the system, refer to the WMSNi User Manual.

10. WMSNi data and decision making

a. WMSNi provides nursing leadership with real-time data for decision making and action. Examples of how WMSNi data can be applied are described below.

(1) Personnel management—

(a) Improve the utilization of personnel across all shifts.

(b) Determine the nursing unit from which to allocate staff for temporary activities such as patient transport.

(c) Justify requests for overtime and compensatory time.

(d) Adjust the number and mix of staff between units.

(e) Adjust staffing on all shifts.

(f) Justify hiring actions during a hiring freeze.

(g) Make initial personnel assignments to a unit.

(h) Manage the civilian personnel budget.

(i) Compare nursing staff among facilities.

(j) Realign requirements and authorizations among facilities.

(k) Provide justification for changes in authorizations.

(2) Workload management—

(a) Identify the need to transfer or admit patients to a unit, based on the patient's classification.

(b) Adjust or redirect admissions to units.

(c) Adjust or recommend changes to the operating room schedule for more efficient scheduling with unit staff availability.

(d) Implement a selective admission process on units when maximum staffing levels are attained.

(e) Determine the number of staffed beds.

(f) Assist decision making regarding “divert” status.

(g) Recommend adjustment of workload among facilities.

(h) Analyze and evaluate facilities that have had to assess the bed capacity or implement a selective admissions process.

(i) Recommend combining units (temporarily such as for a holiday period or permanently) when decreased workload does not justify their continued operations through the business case analysis.

(3) Staff development—

(a) Teach staff nurses how to use the WMSNi data for staffing utilization.

(b) Encourage appropriate sharing of staff between units.

(c) Teach staff about management of personnel resources.

(d) Determine areas for cross-training.

(e) Develop the staff’s resource management skills.

(f) Orient administrative staff to the manpower and management implications of the system.

(4) Unit, MTF, region, and MEDCOM management—

(a) Determine staffing requirements.

(b) Document workload and staffing trends.

(c) Justify the need for personnel resources.

(d) Realign assets on the TDA and manpower documents.

(e) Provide objective data for the risk management and quality management programs.

- (f) Plan the department personnel budget.
- (g) Determine nursing manpower requirements and project staff requirements for new missions or changes in workload.
- (h) Support the staffing effectiveness process.
- (i) Assess nursing requirements and allocate nursing authorizations.
- (j) Report nursing manpower and inpatient workload statistics to the command group and OTSG personnel.
- (k) Support and substantiate requests for additional nursing assets through business case analysis.
- (l) Evaluate nursing resource management among facilities and the capabilities to support patient volume.
- (m) Monitor and compare utilization of nursing resources.
- (n) Monitor requirements development and application for recommendations to The Surgeon General regarding redistribution of authorizations.

Appendix A References

Section I Required Publications

This section contains no entries.

Section II Related Publications

AR 570-4

Manpower Management
(Available at <http://www.apd.army.mil/>)

Army Medicine Balanced Scorecard (Tier 1)

(Available at <https://ke2.army.mil/bsc/>)

Army Medicine 2020 Campaign Plan

Available at the Army Medicine Portal:
<https://mitc.amedd.army.mil/sites/AMP/Pages/>

User Management Guide, Version 1

The Workload Management System for Nursing Internet (WMSNi)
(WMSNi User Manual)

Available at USAMITC SharePoint Portal:
<https://mitc.amedd.army.mil/as/Pages/WMSNi.aspx>

Section III Prescribed Forms

This section contains no entries.

Section IV Referenced Forms

This section contains no entries.

**Appendix B
Workload Management System for Nursing-internet Computer-Based Training
Matrix**

Role	#2	#3	#4	#5	#6	#7	#8	#9
Registered Nurse		YES						
MED/SURG/ICU/PSYCH Nursing		YES		YES				
M/S/C/P Clinical Nurse OIC	YES	YES		YES	YES			YES
MATERNAL CHILD Nursing		YES		YES		YES		
M/C Clinical Nurse OIC	YES	YES		YES	YES	YES		YES
POST-ANESTHESIA CARE Nursing				YES			YES	
PACU Clinical Nurse OIC	YES	YES		YES	YES		YES	YES
LPN (68WM6s Only)		YES		YES		YES*	YES*	
NCOIC & E/N Supervisors	YES	YES	YES	YES		YES*	YES	YES
Supervisors	YES	YES	YES	YES	YES	YES*	YES	YES
Super-Users	YES	YES	YES	YES	YES	YES	YES	YES
Inter-Rater Reliability (IRR) Team		YES			YES			
Healthcare Systems Analyst	YES	YES	YES	YES	YES	YES	YES	YES
Ward Clerk		YES	YES					
Scheduling Personnel		YES		YES				
Nursing Senior Leadership								YES
IM/IT personnel if applicable	YES							
Administrative Services (RM/QSD/PAD, etc.)								YES

**#1: Introduction to the Workload Management System for Nursing internet (WMSNi) Course
(incorporated into all of the lessons)**

#2: Access and Roles

#3: User Training

#4: Patient Management

#5: Scheduling

#6: Inter-Rater Reliability Testing and Reporting

#7: Labor and Delivery Workload

#8: Post Anesthesia Care Workload

#9: Leadership Tools and Reporting

* Required for individuals who manage or report on Labor & Delivery Patients

**Individuals who fill-in for other roles regularly should complete training for that role. (That is, Acting CNOICs or Acting NCOICs)

Glossary

Section I Abbreviations

AKO

Army Knowledge Online

ALMS

Army Learning Management System

AMEDD

Army Medical Department

ASAM

Automated Staffing Assessment Model

ATRRS

Army Training Requirements and Resources System

CBT

computer based training

CNE

Chief Nurse Executive

CNOIC

clinical nurse officer in charge

DCN

deputy commander for nursing

DOD

Department of Defense

HSA

healthcare systems analyst

ICU

intensive care unit

IRR

inter-rater reliability

LADS

Labor and Delivery System

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LDRP

labor, delivery, recovery, and postpartum

LPN

licensed practical nurse

MBU

mother-baby unit

MEDCOM

United States Army Medical Command

MTF

military treatment facility

NBN

newborn nursery

NCH

nursing care hour

NCOIC

noncommissioned officer in charge

NICU

neonatal intensive care unit

OTSG

Office of The Surgeon General

PACS

Post-Anesthesia Care System

PACU

post-anesthesia care unit

RMC

regional medical command

RN

registered nurse

RNE

regional nurse executive

TDA

table of distribution and allowances

USAMITC

United States Army Medical Information Technology Center

WMSNi

Workload Management System for Nursing-internet

The proponent of this regulation is the OTSG, MEDCOM G-3/5/7 Directorate of Patient Care Integration. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publication and Blank Forms) to Commander, US Army Medical Command, ATTN: MCHO-CL, 2748 Worth Road, JBSA Fort Sam Houston, TX 78234-6006.

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