

March 1, 1968

Dr. Elmer W. Learn
Assistant to the President
202 Morrill Hall
University of Minnesota

Dear Dr. Learn:

Attached is the committee report relating to requirements for a hospital patient care unit.

In addition to listing the elements required on a patient floor, the uses of these elements, and special relationships among them, we have attempted to define specific space requirements. Space needs listed in the report are often approximations which can be altered through more exacting calculations and the design of areas for functions which are closely related.

Although space requirements in this report are considerably higher than those originally projected for patient care units, there are several elements not included in original projections which the committee feels are essential to a patient care unit, e.g. satellite pharmacy, unit manager's office, nurse clinician's office, etc. We also assume that space which we have allocated to a large class-conference room on each patient floor is a duplication of some class-conference room space already included in hospital and clinical services space projections.

We hope that this report will be of value to the more detailed planning now in progress.

Sincerely yours,



David R. Preston, Chairman
Hospital Patient Care Unit Committee

DRP/ch

REPORT OF THE HOSPITAL PATIENT CARE UNIT COMMITTEE

March 1, 1968

Members of the committee include Mr. Martin Grady, Mrs. Marie Manthey, Dr. Michael Paparella, Dr. Henry Sauls, Dr. George Flora, Mrs. Margaret McHugh, Miss Mary Lou Freeberg, Miss Marie Perreault, Mr. Wally Petrykowski, Mr. Leland Schultz, Mr. David Preston, Chairman.

Four categories of space and activities are used by the committee in defining elements of the patient care unit, their uses, special relationships and sizes.

These categories include: 1) The Station Area represents a grouping of rooms or areas centrally located in relation to the patient rooms. It is used as the primary work area, outside of the patient room, by physicians, nurses, unit management personnel and other health team staff and students who are directly concerned with patient care. Patient records are maintained in this area and it serves as the communications center for the patient care unit. 2) Patient Facilities, including beds, patient bathrooms and a solarium. 3) Supporting Service Areas Located Outside of the Station, but Within the Patient Care Unit. Facilities and services in this category need not be located within the station, but their relationships to patient care and/or station activities dictate location within the patient care unit. 4) Supporting Service Areas which Can Serve More Than One Patient Care Unit, e.g. one for two patient care units, one for each 100 beds, etc.

As depicted in the diagram on page 23, the first three of these categories represent

the patient care unit, while the fourth category represents supporting services which can serve two or more patient care units. Special relationships with patients, their families, and unit staff dictate, however, that these services be located on patient unit floors.

The consensus of the committee, particularly with reference to design of the unit station, is that present layouts of unit work areas are not satisfactory as they exist in University Hospitals. While the "classic" design of station areas is not felt to be adequate, the committee has no specific design to recommend; rather, it is hoped that new design possibilities will be created with the guidance of the committee's description of the elements, their uses and special relationships.

Estimated space requirements are summarized on pages 20 to 22 of this report.

I. Station Area

A. Nurses' Work Area

1. Nurses' Charting Area

This area is used by nurses for recording in patient records. The area must have counter space for writing and immediate access to patient records. The area should be located adjacent to the unit management work area to facilitate communications with the clerical staff. It should also be located with or adjacent to the physicians' charting area because of the need for access to charts by both physicians and nurses.

Ten nurses may be working in the area during peak periods of activity. The combined size of the nurses' and physicians' charting area should be approximately 300 square feet.

2. Head Nurse's Office

The head nurse's office will be used for nursing administration duties, e.g. personnel interviewing. This office should be located in the station area (preferred location) or adjacent to the station, to facilitate its availability for nursing and physician staff.

The office must be large enough to contain space for a desk, file cabinets, bookcases, and seating for up to three people - approximately 100 square feet.

B. Physician's Work Area

1. Physicians' Charting Area

This area must be located adjacent to or with the nurses' charting area and have immediate access to patient records. It should also be located adjacent to the unit management work area to facilitate communications with the clerical staff. The area will be used by physicians for recording on patient records, dictation, and "chart rounds." The primary need, as with the nurses' charting area, is for counter space.

The area, during peak periods, may contain 10 to 15 people and combined with the nurses' charting area should contain approximately 300 square feet.

2. Offices for Residents, Interns and Medical Students.

These offices will be used for such duties as interviewing patients, dictation, and writing case histories. The offices will serve approximately one to two residents, two interns, and four medical students on each patient care unit. Offices should be located adjacent to and with access from the physicians' charting area.

Three offices are required, each approximately 100 square feet.

C. Unit Management Work Area

Station Receptionist and Clerical Work Area

The receptionist-clerks will receive visitors and others with business at the patient care unit. This area will also be the unit information center (station telephones and patient room intercoms.) Patient appointments, charting, patient service requests, transcription of orders and other clerical tasks will be performed at this location. Computer terminals will be located here.

The area must be adjacent to the physicians' and nurses' charting area, with immediate access to patient records and convenient for communications with nursing and medical staff.

A. One Bed Rooms

Assuming a 36 bed unit, 20 beds should be located in one bed rooms (including isolation rooms.)

The minimum room size should be 12 X 14 feet (unencumbered floor space.)

B. One Bed Isolation Rooms

Four rooms should be specially designed for isolation purposes. An ante-room between the hallway and the patient room will be used for hand washing, gowning, storage of isolation linen and will contain a receptacle to receive soiled linens.

The ventilation system in isolation rooms will require special consideration, including bacterial control filters and a no return, positive pressure air system.

The minimum patient room size should be 12 feet by 14 feet (unencumbered floor space.)

Size of the ante-room - 7 X 8 feet.

C. Two Bed Rooms

Assuming a 36 bed unit, 16 beds should be located in two bed rooms.

Space requirements include seating and counter work area for two clerical staff plus space for station forms, a computer terminal, telephones and patient intercom equipment. Size - approximately 100 square feet.

D. Medication Area

1. We anticipate minimum floor stock requirements as a result of improved distribution systems; however, a medication area or two areas with access to a common stock will be required in the station.

Total size of medication area(s) - 50 square feet.

E. Conference Room

A station conference room will be used for nurse reporting, medical staff and student conferences, team conferences, "health rounds" and other meetings relating to the care of patients on the unit. It should be located with proximity to patient records, preferably adjacent to the nurses' and physicians' charting areas.

The conference room should be large enough to seat up to 15 people - 250 square feet.

II. Patient Facilities

The patient care unit should contain 30-36 beds.

The minimum room size should be 12 feet by 23 feet (unencumbered floor space.)

D. Bathing and Toilet Facilities

1. Patient Room Facilities

Each patient room should have private bathing and toilet facilities. All bathrooms should contain a shower and, as a minimum, isolation rooms should contain a combination tub and shower. Consideration should be given to tub-shower accommodations in more patient rooms, perhaps all one bed rooms; the actual number should be dependent on space implications and requirements of clinical services, e.g. special needs of dermatology patients.

2. Separate Bath Facilities

Separate central bath tub rooms designed for access by stretcher will be required, the number dependent upon the number of bathtubs in patient rooms. GYN and OB services will also require sitz bath facilities.

Size of bathtub room - approximately 100 square feet. Size of sitz bath room - approximately 60 square feet.

E. Solarium

The solarium, reserved for patients, can also be used as a

dining room for ambulatory patients. It should be located at the extremity of each unit, furthest from the center of patient care activity.

Size - approximately 450 square feet.

III. Supporting Service Areas Located Outside of the Station but Within the Patient Care Unit

A. Related to Patient Care

1. Treatment Room

The use of a treatment room will vary with different clinical services. It may be used by physicians and other health team staff for the performance of procedures which because of special equipment, need for privacy or sterile precautions cannot always be performed in the patient's room, e.g. venapunctures, thoracentesis, cut downs, spinal taps, minor surgery, etc. The room might also be used for storage of sterile supplies, setting up trays, IV's, etc.

The treatment room should be located adjacent to the examining room and central to patient rooms. It should be convenient to the station area and accessible by wheelchair and stretcher.

The room must be large enough to accommodate four to eight people surrounding a treatment table. It will also require substantial storage space. Size - approximately 170 to 225

square feet, depending upon its use by a particular service and its design in relation to the clean utility room.

2. Examining Room

This room is used for the examination of patients, and may serve as an auxiliary or primary treatment room. The room should be adjacent to the treatment room.

Size - approximately 140 square feet.

B. Other Service Areas

1. Clean Utility Room

This room will be used for the storage of clean and sterilized equipment and supplies required for patient care. It should be located near the treatment and examining rooms and may include the conveyor area.

The size of this room will vary substantially depending upon the distribution systems, i.e. the need for storage on the patient unit - approximately 100 to 150 square feet.

2. Soiled Utility Room

The soiled utility room will be used for preliminary cleaning of soiled equipment prior to its return to central cleaning facilities, and the storage of discarded patient care supplies.

and equipment prior to their removal from the station.

The size of this area will depend upon distribution systems and the centralization of cleaning facilities. Approximate size - 100 square feet.

3. Conveyor Area

This area will be used for the reception and sending, by conveyor, of patient care supplies and equipment. The conveyor should be centrally located in the patient care unit and as near as possible to, or a part of the utility rooms.

The size of this area is dependent upon the type of conveyor system used, the size of items which can be conveyed and its location in relation to, or as a part of the utility rooms. Approximate size - 80 square feet.

4. Medical and Emergency Equipment Room

This room will be used for the storage of an emergency cart and other portable medical equipment, e.g. defibrillator, ECG machine, pulmonary function equipment, etc. The room should be located adjacent to the treatment room and near the work areas of physicians and nurses.

Size - approximately 100 square feet.

5. Linen Storage Rooms (2)

Linen storage rooms will be used for the storage of clean linen supplies required on the unit. The rooms should be located to minimize distance from any patient room to a linen room. The rooms should have center opening double doors.

Each linen room must accommodate a linen stock truck and have space for shelving of pillows and other bulk items. Size (each room) - minimum of 9 feet by 5 feet. Total space requirement per patient care unit - 90 square feet.

6. Soiled Linen Storage

This area will be used for the storage of soiled linen pending its removal from the Unit.

Size of the room and its need will depend upon the system used for the moving of soiled linen from the unit. Estimated size - 25 square feet, assuming a system enabling a very brief period of time for storage on the patient care unit.

7. Custodial Work Room

The room will accommodate heavy duty electrical and battery equipment used on the unit. There will also be storage of work carts, hand tools and cleaning supplies. The room will require facilities for waste water and will contain double sinks, cupboards and counter space. It may be located anywhere

in the patient unit, preferably away from the station.

Size - 100 square feet.

8. Waste Storage

Used for the storage of waste pending its removal from the unit.

Size of the area required and its need will depend upon the system used for moving waste from the unit. Estimated size - 25 square feet, assuming a system enabling a very brief period of time for storage on the patient care unit.

IV. Supporting Service Areas Which Can Serve More Than One Patient Care Unit

Unless otherwise indicated each room or facility can serve two patient care units (60 - 72 beds)

A. Teaching Facilities

1. Classroom - Large Conference Room

Requirements include both classroom facilities (to be used by the nursing school, medical school, for inservice education, etc.) and a large conference room. These two areas may be combined into a large room with one or two soundproof curtains used to create separate rooms. In addition to classroom seating and conference tables, the area will contain television monitors and other audio-visual equipment. The room should be located equidistance from the two patient care units.

The total area should seat up to 60 people - approximately 1200 square feet.

B. Consultation Room

This room will be used by physicians and other staff for discussions with patients' families and as a family waiting area during a patient crisis or immediately after demise of a patient.

The room should be located away from heavy traffic areas but central to the two patient care units.

Size - approximately 120 square feet.

C. Offices

1. Medical Social Worker

This office will be used by medical social workers for both administrative duties and consultations with patients or families of patients.

Size - Adequate for seating 4 to 5 people-approximately 100 square feet.

2. Dietician

The office will be used by a dietician, dietary aide, and a

dietetic intern. They will use the office for administrative duties, consultation with medical and nursing staffs and for providing instruction to patients and patients' families. It should be located adjacent to and have direct access to the food distribution and nourishment area.

Size - approximately 100 square feet.

3. Nurse Clinician's Office

The nurse clinician's office will be used for administrative tasks and for discussions with staff members.

Size - approximately 100 square feet.

4. Clinical Instructor's Office (Nursing)

This office will be used for administrative tasks and individual consultation with students. It should be located adjacent to the classroom-conference room.

Size - Approximately 100 square feet.

5. Unit Manager's Office

This office will be used for administrative tasks and for discussions with individuals and groups of two or three people.

Approximate size - 100 square feet.

6. Secretarial Office

This office will be used by secretaries serving the two units and should be located adjacent to the unit manager's office.

This office must be large enough to seat two secretaries and the required secretarial equipment and files - approximately 150 square feet.

7. Housekeeping Office

The housekeeping office will be used by a supervisor for administrative tasks and discussions with housekeeping staff. One office will be required to serve three patient care units.

Size - 100 square feet (for three patient care units)

D. Satellite Pharmacy

Satellite pharmacies will be used for the storage of drugs on an "as needed" basis or "immediate need" basis. The area will also be used for the preparation and storage of IV solutions. It will contain an abbreviated drug information library and desk space for a clinical instructor of pharmacy students. The satellite pharmacy should be centrally located to the patient care units which it will serve.

A satellite pharmacy will not be required on every patient

floor. Space requirements include an area of approximately 450 square feet for the service of 120 medical and surgical beds and, for other clinical services, an area of 300 square feet to serve 120 beds.

E. Food Distribution and Nourishment Area

The food distribution area will be used for the receiving of patient food trays and for the return of soiled dishes and trays to the central kitchen area. This area must also accommodate a refrigerator, hot plate, counter space and cupboard to be used for patients who wish to take nourishment at other than meal times.

Size - approximately 70 square feet.

F. Battery Equipment Charging Room

The housekeeping department will require one room for each three patient care units. There are special ventilation requirements for this room.

Size - 100 square feet (for three patient care units)

G. Stretcher and Wheel Chair Storage

This storage area will be used for stretchers and wheel-chairs serving two patient care units.

Assuming a central transportation system, the area must be

large enough to accommodate six stretchers and 12 wheel-chairs. Size - approximately 250 square feet.

II. Clerical Supplies Storage Room

This room will be used for the storage of forms and office supplies required by unit management staff. Its use will be under the control of the unit manager and it should be located near the secretarial office.

Size - Approximately 4 feet by 6 feet.

I. Staff Facilities

1. Staff Lounge

This lounge area will be shared by all staff and hospital personnel who work on the floor.

The area should provide seating for 15 people approximately 250 square feet.

2. Female Change Area, Lockers, and Toilets

Full height lockers for coats and personal articles will be required. It should be located centrally to the two patient care units.

The area must be large enough to include space for 70 lockers.

a change area, toilet facilities, a shower and room for a cot. Up to 30 people may be using the area at one time.

Size - Approximately 625 square feet.

3. Male Locker Area and Toilets

Requirements include full length lockers for 30 males, a change area, toilet facilities and a shower.

Size - Approximately 325 square feet.

4. Sleeping Quarters

Three to five single sleeping rooms will be required for on-call staff. Requirements for sleeping rooms will vary by service.

The rooms should have shared bathroom and toilet facilities.

Size - Approximately 200 square feet.

J. Public Facilities

1. Waiting Room

The waiting room will be used by those waiting to visit with patients or to see staff members in offices which are located in the area.

Seating is required for 20 to 25 people - approximately 350 square feet.

SUMMARY OF SPACE REQUIREMENTS FOR INPATIENT CARE UNIT
(One Unit Equals 36 Beds)

	<u>Square Feet</u>
I. Station Area	
Nurses' Charting and Physicians' Charting	300
Head Nurse's Office	100
Residents', Interns' and Medical Students' Office 3 @ 100 square feet	300
Unit Management Work Area	100
Medication Area	50
Conference Room	250
	<hr/> 1,100
II. Patient Facilities	
Sixteen One Bed Patient Rooms @ 168 square feet	2,688
Four One Bed Isolation Rooms @ 168 square feet plus 50 square feet	890
Eight Two Bed Patient Rooms @ 278 square feet	2,208
Patient Room Bath and Toilet Facilities with Tub/Shower 20 @ 30 square feet (assumes tub/shower in all private rooms)	600
Patient Room Bath and Toilet Facilities with Shower Only 8 @ 23 square feet (assumes shower only in two bed rooms)	184
Two Bath rooms or Sitz Baths	200
Solarium	450
	<hr/> 7,220

Square Feet

III. Supporting Service Areas Located Outside of the Station but
Within the Patient Care Unit

Treatment Room	170
Examining Room	140
Clean Utility Room	100
Soiled Utility Room	100
Conveyor Area	80
Medical and Emergency Equipment Room	100
Two Linen Storage Rooms	90
Soiled Linen Storage	25
Custodial Work Room	100
Waste Storage	25
	<hr/>
	930

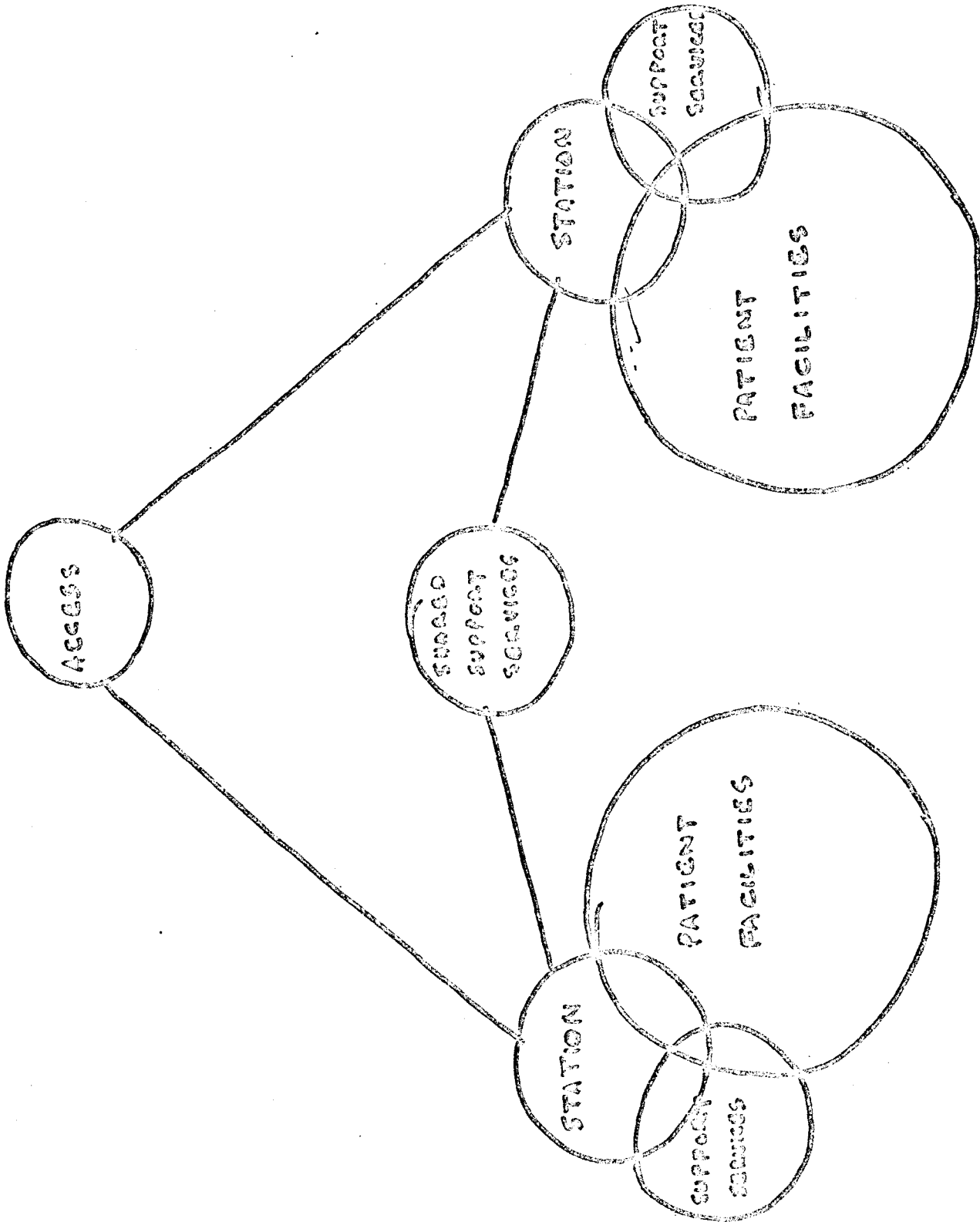
IV. Supporting Service Areas which Can Serve More Than One Patient Care Unit

Classroom - Large Conference Room	1,200
Consultation Room	120
Medical Social Worker Office	100
Dietician's Office	180
Nurse Clinician's Office	100
Clinical Instructor's Office	100
Unit Manager's Office	100
Secretarial Office	150
Housekeeping Office (one for three patient care units)	67

	<u>Square Feet</u>
Satellite Pharmacy (450 square feet for 120 Med-Surg Beds) (300 square feet for 120 beds on other clinical services)	225
Food Distribution and Nourishment Area	70
Battery Equipment Charging Room (one for three patient care units)	67
Stretcher and Wheel Chair Storage	250
Clerical Supplies Storage	24
Staff Lounge	250
Female Locker Room, Change Area, Toilets and Shower	625
Male Locker Room, Toilets and Shower	325
Sleeping Rooms with Shared Toilet and Shower	200
Public Waiting Room	350
Public Lavatories 2 @ 35	70
Public Telephones	<u>60</u>
TOTAL FOR TWO UNITS	4,613
TOTAL FOR ONE UNIT	2,306

I	1,100	
II	7,226	
III	930	
IV	<u>2,306</u>	
	11,562	TOTAL AREA PER PATIENT CARE UNIT

PATIENT FLOOR
DIAGRAM SHOWING RELATIONSHIPS



April 24, 1968

TO: Peter H. Sammond
FROM: David R. Preston
SUBJECT: Space Requirements for Patient Care Unit

As indicated in the summary prepared by TAC, the 11,562 sq. ft. required for each patient care unit is substantially in excess of the space originally projected for this purpose. Eight 36 bed units would contain 92,496 sq. ft. as envisioned by the Patient Unit Committee, an average of 56, 485 sq. ft. when compared with the 36,011 sq. ft. projected for expanded patient units in the hospital report. The space allocated in the hospital report is based on the consultant's projection of 56,023 additional sq. ft. less 20,192 ft. edited by the Hospital Planning Committee. Since the space edited by the Hospital Planning Group was based on total allocation rather than on increased space, approximately 35 per cent of the consultant's recommendation for additional space was deleted.

In the sequence of hospital planning both the consultant's projections and the allocation of hospital space were accomplished before the review of patient care needs was made by the Patient Care Unit Committee. This review identifies substantial amounts of space needs which, while normally not considered part of a patient care unit, were felt to be related to patient unit activities to the extent that they should be located on patient care floors. Most of this space including classroom-conference room space; offices for nurse clinician, unit manager and housekeeping supervisor; linen and waste storage areas; satellite pharmacy; Mayo locker facilities; and a staff lounge on each floor were not included in original space projections.

This space as well as other elements included in what the Committee defined as "supporting service areas which can serve more than one patient care unit" could more appropriately be allocated to the department or school concerned. In the case of the large classroom-conference room, the size and location should be further reviewed by the special committee appointed to consider overall teaching needs. A total of 4,800 sq. ft. was allocated for large classroom-conference rooms

and most of this space would be for other than hospital use.

Space which might be reallocated or which may duplicate space already planned in other reports includes:

<u>Space in Pt. Unit Recommendation</u>	<u>Sq. Ft.</u>	<u>Reallocate to or duplicated by</u>
Classroom - Large Conference room	4800	Clinical Services, School of Nursing, Hospital Calss and Conference Rooms
Medical Social Worker Office	4800	Medical Social Service Dept.
Dietitian's Office	640	Nutrition Department
Clinical Instructors Office (School of Nursing)	400	School of Nursing
Housekeeping Office	268	Housekeeping Department
Satellite Pharmacy	900	Pharmacy Dept., College of Pharmacy
Staff Lounge	1000	Employee and Visitor Facilities
Female Locker Room Change Area, Toilets and Shower	2500	Employee and Visitor Facilities
Male Locker Room, Toilets and Shower	1300	Employee and Visitor Facilities
Public Waiting Room	1400	Employee and Visitor Facilities
Public Lavatories	280	Employee and Visitor Facilities
Public Telephones	240	Employee and Visitor Facilities
	<hr/>	
TOTAL	14,128 18,528	

Space recommended by the Committee are approximations which can be altered through more exacting calculations and the design of various function which are closely related. Any substantial reductions in space other than those mentioned above would have to be taken from areas allocated to

patient facilities. These reductions could be achieved by:

- 1) decreasing the total number of beds or units built in the new building or
- 2) decreasing the size of patient rooms from the recommended 12 x 14 for one bed rooms and 12 x 23 for two bed rooms.

DRP/ph

8.19

JOB MEETING NOTES

JOB: U. OF MINN H.S.E

DATE: OCT 21, 1968

PRESENT: DAVID PRESTON

SUBJECT: P.C.U.

1. Medical Social Services will require 2 Offices @ 100SF ea.
One office available for Peds & one for Med. Space allocation from Soc. Ser. Dept. area.
2. Nurse Clinicians require
1-150^{sq ft} each for Peds, Med (2 person office)
1-150^{sq ft} Nurse Admin.
Two Offices part of PCU space allocation. One office from Nursing Service Dept area.
3. Unit Managers can be located on alternate floors but must have Sec'y. Sec'y required every floor for clinical work for doctors, ordering supplies etc.
Space allocation from Hospital Admin. area.
4. Housekeeping needs one office @ 120^{sq ft}. Space allocation from Housekeeping.

9/21/68

5. Pharmacy requires a satellite for office & distribution point of 200 ft². Space allocation from dept area. Can be located on base or center floor.
6. Classrooms / Conference are academic spaces. Provide 3 areas. Hospital C.R./Comb will assume 1/3 of area. (± 1200 ft²)
7. On call suite part of PCU allocation
8. Staff lounge should be new.
9. Male lockers for med. students, doctors.
10. Purse lockers @ D.S.
11. Battery charging needs 2 @ 100 ft². Space allocation from Housekeeping area.
12. Pediatrics beds
 - Infants \rightarrow up to 1 year old
 - Toddlers \rightarrow up to 6 years old
 - Adolescents \rightarrow up to 16 years old
13. Exam and Treatment may be combined on some units.
14. Dietary requires office & food distribution areas. Office area from nutrition allocation & food dist. from PCU.
15. Siled holding & J.C. from PCU allocation
16. X-ray room area from radiology area allocation.
17. Medicine I.C.U. similar to Station 3A Mayo

18. Peds Surgery patients will go to central I.C.U. in Mayo.

19. Pediatrics beds = total 104

Infants = 30

Toddlers = 31

Adolescents = 31

} 2 of 2nd. & Tod. areas
@ Childrens, Boston

Adolescent rooms same size as adult rooms with $\frac{1}{3}$ singles and isolation beds. Adolescent

20. Day room same as adult station.

20. Pediatrics facilities have different demand than adult stations. Ratio of staff to patient is higher, also food demand, linen use & quantity of waste is higher than adults. EPT rooms must be separate.

21. Infant & Toddlers Stations

Tubs 1-2/10 beds

10-15 beds/unit = 20-25/station

Private cubicles of 80-100 ft² in each room.

Charting @ N.S.

Play space

School room required

22. One call @ each floor of 1-2 bedrooms

23. All peds I.C.U. cases to be sent to Mayo.

8.19

JOB MEETING NOTES

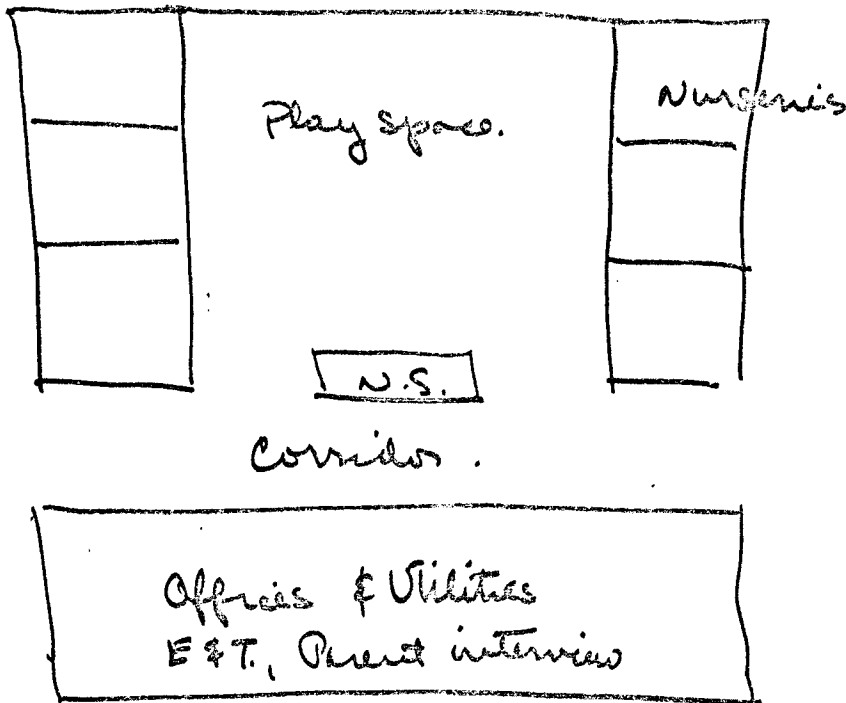
JOB: U OF MINN HSE

DATE: OCT 24, 1968

PRESENT: David Preston, Dr. Sauls, Mrs. Somers

SUBJECT: P.C.U.

1. Admitting may move to new building for in & out patients.
2. Pediatrics module
10-12 patients per team of 1 intern & 2 students.
3. Heart peds separate in J. C.H. H.
4. I.C.U. to new bldg?
5. Parents are not to room in.
6. Dining room / play room for toddlers
7. Class room required for peds staying over 3 weeks. Some schooling @ bedside
8. Crib rooms min size for 2 = 12x15
9. Provide clothing storage.
10. Bole coats for drs, residents on floor duty.
Storage for brief cases etc & should be supervised.

DR. SAULS SUGGESTIONS

11. Provide O.V for all ped beds. Provide 2 ea O.V for each I.C.U. bed.
12. Dietician required for feeds & special food ^{prep.} area for toddlers
13. On call suite

Intern	1/36 beds	= 3
Res.	1/60 beds	= 2
Med & Stu	1/36 beds	= 3

Should be separate, small quarters & sound proof.
Perhaps adjacent to staff lounge.

HOSPITAL PATIENT CARE UNIT PLANNING MEETING

January 28, 1969

Present: David Preston, Chairman; Charles Drage, Benjamin Fuller, Ramon Fusaro, Florence Julian, Arnold Leonard, Marie Manthey, Margaret McHugh, Robert Mulhausen, Walter Petrykowski, Peter Sammond, Henry Sauls, Lee Schultz, Thomas Smith, John Verby, Roland Kluver, Fred Larsen, Olga Petters

Experimental Patient Care Unit

The architects require more detailed information on the space for experimental nursing unit in the School of Nursing program. School of Nursing planning for the unit will have to be coordinated with Hospitals planning and serious consideration given to the operational implications of the unit.

Pediatrics Intensive Care

Since the Clinical Medicine Task Force Report stipulating centralized intensive care beds, Pediatrics, in addition to Medicine, desires decentralized IC beds located in proximity to the rest of Pediatric beds. Whether allocated Pediatrics beds will be designated for ICU or additional beds added from the centralized ICU will have to be determined.

Patient Care Unit Circulation

It is not feasible to have the nursery situated with two corridors running through it. Similarly Pediatrics intensive care areas must be isolated with limited access. Even toddler areas must be confined to restrict the movement of children.

Offices

It is imperative that station offices be adjacent to the charting area.

Conference Space

Dr. Mulhausen inquired what space was for medical student teaching on the patient care unit. Each floor has a 250-sq. ft. conference room and one 400 sq. ft. classroom that will be operated on a scheduled basis. The larger classroom originally began as a large enough to accommodate sixty students but due to lack of clinical support it was reduced to its present dimensions. Dr. Mulhausen was concerned about additional smaller classroom areas which the architects will be pleased to provide if space is made available.

Medicine Intensive Care

The architects inquired what advantages are to providing the eight medicine intensive care beds in one cluster. Consideration will be given to the possibility of dividing the 8 bed unit into 2 smaller units despite the staff and supply advantages of the larger unit.

Dermatology Staffing Problems

It is not in the best interest of dermatology patients to share staffing with a more acute service since (1) dermatology patients are frequently neglected and (2) derm patients are carriers of infection.

On-Call Rooms

Sleeping rooms must be single-bed rooms located near patient areas.

X-Ray Facilities

A plug and storage facilities will have to be provided for intensive care x-ray requirements. The family practice inpatient unit, however, does not require x-ray equipment.

Family Practice Pediatric Patients

Dr. Fuller will discuss the Family Practice program position on pediatric patients with the Pediatrics Education Committee 30 January 1969. The Family Practice program seeks to develop a working relationship with the Pediatrics Department in sharing pediatric facilities.

Implication of Emergency Program

If an active emergency program develops, acute inpatient facilities will be required for the observation of emergency patients.

Private Funds

The Design Coordinating Committee has indicated that gifts are considered part of 50 per cent matching funds required to finance the development program.

Relation of Unit C to Other Buildings

In addition to the major circulation corridors already proposed a tie from the fifth floor of Unit C to Diehl is requested.

Planning Schedule

Finished drawings reflecting a fairly fixed plan are required by 1 March 1969 to go before the legislature. Comments submitted within the week will be incorporated into this phase of the drawings, while comments taking longer to develop will have to be worked in later. Please submit comments to Mr. David Preston, Chairman, Hospital Care Unit Planning Committee.

8.19

TELECON:

FROM: Dr. Sauls (Tel. 612-373-8114)

TO: Olga Petters

DATE: January 30, 1969

SUBJECT: Patient Care Units, Building C.

Dr. Saul raised the following points:

1. The total area of the Pediatrics floor, with 104 patients, is not very much greater than a Medicine patient floor for 50 patients. The area allocated for each crib in the 4-crib rooms is too small (the original request was for 80-100 SF per crib). Pediatrics assigns fewer patients to staff members than Medicine in a ratio of 1 interne & 1 resident per 13 Peds. patients as opposed to 1 interne & 1 resident per 16 Med. patients, thus providing more patient/staff than Medicine does. Dr. Sauls feels that this greater staff concentration will lead to exceedingly crowded conditions if Pediatrics are on one floor.
2. Dr. Sauls wants TAC to consider placing Patient Care Units on four levels to relieve the problems of placing Pediatrics on a single level.
3. Dr. Sauls requested a return call giving the total areas involved on the 14, 15, 16 levels. The following figures were given to his secretary:
 - a. Level 14 (Pediatrics) = 37,728 (Infants = 6300)
 - b. Level 15 (Medicine) = 37,728 (Exp. Unit = 6300)
 - c. Level 16 (Medicine) = 31,428
4. Dr. Sauls met with Nursing Service Administration and David Preston on January 30 previous to contacting TAC. He did not state whether these criticisms were exclusively his from the Pediatric viewpoint or a general conclusion of the group. He is preparing a critique to be discussed with Bob Turner next week.

MEDICINE DEPARTMENT MEETING ON PATIENT CARE UNIT

3 February 1969

Present: Dr. Charles Drage, Mrs. Marie Manthey, Mr. David Preston,
Miss Kathy Nixa, Mrs. Pat Robertson and Dr. Paul Winchell

NURSING SCHOOL EXPERIMENTAL UNIT

The School of Nursing should get in contact with the Hospitals to see whether the proposed unit is operationally feasible.

PATIENT UNIT CIRCULATION

Hallways by patient rooms should not be major circulation routes. Patient rooms should be clustered around the nursing station rather than strung out along corridors. Is it possible to have a configuration that will minimize the distance from station offices to patient rooms? The rectangular shape of the patient floors seems to inhibit development of a more functional layout for bed units.

SINGLE ROOMS

Consideration should be given to providing all single rooms.

NUMBER OF BEDS/STATION

Thirty to thirty six beds is ideal patient care unit size, dividing into 15 to 18 beds per service. A service with less than 14 beds is too small while 18 beds is the maximum acceptable.

FACILITIES REQUIRED FOR EACH STATION

Offices will have to be provided on each station contiguous with the charting area. Conference, examination, and treatment rooms will also have to be provided for each unit.

NURSE OFFICES

Only one nurse administration office is required for every two 72 bed units. One nurse clinician office is required for each 72 bed unit.

INTENSIVE CARE

Eight intensive care beds are required but two units of four beds may be preferable although some duplication is involved. An eight-bed unit may be too large to be manageable. The four-bed room should be designed with some privacy for patients.

ON-CALL QUARTERS

Two single sleeping rooms are required on each floor.

NURSE FACILITIES

What is the basis for the size of nurse toilet and locker facilities? The areas appear to be unnecessarily large.

EMERGENCY EQUIPMENT

The room labled EQ is about 10' X 24'. Is this much space necessary for emergency equipment storage?

LINEN ROOM

Location of the linen room behind the charting area is not sufficiently accessible.

ISOLATION ROOMS

For every 36 beds the Hospital Patient Care Unit Committee recommended that four have ante-rooms and liminar flow for isolation. Two should be on each station.

8.19

February 3, 1969

Mr. David Preston, Chairman
Patient Care Units
School of Medicine
University of Minnesota
Minneapolis, Minnesota

Subject: University of Minnesota Health Sciences Expansion

Dear Dave:

Enclosed is a copy of our meeting notes relative to the meeting held on January 23, 1969 at the University of Minnesota Hospitals concerning the Patient Care Units to be provided in Building C of the proposed new structures.

Some of the comments, with which you may not be familiar, were made after the general meeting adjourned, but are included as pertinent information.

We are anticipating a decision on the Experimental Unit for the School of Nursing in the near future.

Very truly yours,

THE ARCHITECTS COLLABORATIVE Inc.

Olga E. Betters

OEP/cg

cc: Hugh Peacock
Dr. Robert Mulhausen

Enclosure

bcc: Chip, Roland, Bob Turner

DEPARTMENT OF FAMILY PRACTICE AND COMMUNITY HEALTH
MEDICAL SCHOOL • MINNEAPOLIS, MINNESOTA 55455

February 14, 1969

Mr. David Preston
Associate Director
Box No. 606
University of Minnesota Hospitals
Minneapolis, Minnesota 55455

Dear Dave:

Reference is made to our conversation last week regarding the location of the adult beds for the Department of Family Practice and Community Health in the new construction. As you recall, the beds originally were placed adjacent to Department of Medicine beds. You inquired of me whether it would be preferable to have these beds associated adjacent to Department of Pediatric beds. I am writing this letter to confirm that I would look unfavorably on such a move. There are many cogent reasons why the adult beds of the Department of Family Practice should be adjacent to Department of Medicine beds. Among these are the following.

1. A large portion of our adult patients who are hospitalized would fall into an elderly age group. The problems of caring for hospitalized patients in this age group are different from the problems associated with caring for patients in the pediatric age group. Consequently, it would be easier for the personnel on both nursing stations if their function were similar. In addition to this, those patients who were semi-ambulatory and who occasionally left their rooms would be in association with others who would have common problems and would share common interests.
2. It is almost certain that from time to time there would be opportunity for an overlapping use of beds in that there may be certain occasions when we would



need to use some of the empty Medicine beds and there may be other occasions when the Department of Medicine would be crowded and would want to use some of our beds. Having the nursing stations in apposition to each other would make for a more efficient utilization of beds under these circumstances.

As we also discussed, we will have certain need to utilize Pediatric beds for our patients in this age group. It is my understanding that it is satisfactory to the Pediatrics Department for us to use beds on their service for infants and young children. This would seem to be a better arrangement than having a separate Pediatric unit associated with the Department of Family Practice.

If there are any questions regarding this, please call me and we can discuss it further.

Sincerely,

B. F. Fuller, M.D.
Professor and Chairman
Department of Family Practice
and Community Health

BFF:jw

cc: Mrs. Karen Levin ✓

OFFICE MEMORANDUM

TO : Robert Turner

FROM : Olga Petters

DATE : 21 MARCH 1969

SUBJECT: UNIVERSITY OF MINNESOTA - PATIENT CARE UNITS

1. The typical BR as indicated is planned for an anteroom with Nurservers, a work counter w/lav. and a patients toilet and shower. This is similiar to Tufts and the new St. Lukes in Chicago which has been visited by many of the staff of the U. of Minn. Hospitals. Discuss mockup.
2. The dispostion of the Experimental Unit for the School of Nursing is still in doubt since no service indicates a desire to supply either patients or physicians for the Unit.
3. On levels 15, 16, & 17 some BR's on the E & W walls of the South station do not have visual control from the Nurses station area. Is this acceptable?
4. The location of Family Practice on level 15 with the Peds Adolescent station has been questioned. Family Practice could be interchanged with the Experimental Unit on level 17 which would place F.P. with a Medicine Station. However an objection might arise relative to associating the Exp. Unit with a Peds Station.
5. If convience foods are used and the system requires storage and reconstitution of food trays on the stations, the nourishment area will increase appreciably in size beyond the programmed area. In addition the utility area would have to be replanned. This should probably be coordinated with overall Food Service consulting in The Health Sciences.

JOB MEETING NOTES

UNIVERSITY OF MINNESOTA HEALTH SCIENCES EXPANSION
TAC JOB NO. 68013

DATE: May 14, 1969

PLACE: U. Minn. Hospitals

PRESENT: Drs. Sauls, Ebert, Fuller, Winchell, Fusaro, Vergey, Mrs. McHugh,
Mrs. Manthey, Peter Sammond, David Preston, Karen Levin -- U. Minn.

John Harkness, Roland Kluver, Robert Turner, Ken Taylor, Olga Petters --
TAC

SUBJECT: Patient Care Unit

1. Dr. Fusaro stated that one central tub room for dermatology patients is not acceptable. Patients are immersed for long periods of time in an extra large tub and additional facilities will be required. Either a tub/shower combination should be provided for each bedroom or a tub & separate shower could be provided for each two bedrooms. Toilets and Nurservers would still be provided for each bedroom. Each tub must have an adjustable shampoo tray. The central tub room may be omitted if tubs are provided for medicine bedrooms as well as dermatology bedrooms.
2. Dr. Winchell feels that the staff does not have visual control of all patient room doors from the nurses' station and that the view from the corridor into the room is blocked by the service elements. Alternate toilet locations on the exterior walls or between patients' rooms were discussed. TAC explained some of the architectural implications of these locations. Dr. Fuller stated that location of the lavatory on the bed side of the partition would be acceptable.
3. Installation of a working mock-up of the patient's room is considered essential. Location of a mock-up in the shell space of the Student Health Bldg. may not be desirable since this is scheduled for completion in the near future. Various locations in Mayo will be studied. Station 32 is considered particularly appropriate since it is already in use as an experimental area for testing new nursing and management techniques. TAC examined the patient rooms on this station and also room #598. Evaluation will be made of the possibility of remodeling one of these rooms into a mock-up of a proposed patient room in Unit 'C'. TAC explained that the mock-up could be constructed with wood partitions and flexible plumbing locations to allow for modifications of the unit during the evaluation period.
4. Dr. Sauls stated that 28 beds per adult nursing station does not allow an efficient ratio of house staff to patient. Units of 18 or 36 are more suitable. On pediatrics stations (infants and toddlers) 10-12 patients per intern is the usual assignment, but 18 would be acceptable.

5. Concern was expressed that the plans do not reflect the original program requirements of 36 bed stations with 2 stations per floor which will use common support facilities.
6. The Patient Care Committee will visit installations recommended by TAC & D. Prest in order to evaluate patient bed rooms and nurses stations.
7. Subsequent to the meeting, Dr. Sauls requested TAC to consider modification of the support areas at the nurses' station by moving the house staff offices to an exterior wall and opening up the center for better visual control and a more open environment.
8. TAC will restudy the Patient Care Unit with these various suggestions in mind.
9. TAC will transmit 6 prints of reductions of the 4 levels of Patient Care Units.

OP

8.19

UNIVERSITY OF *Minnesota*

DIVISION OF DERMATOLOGY
MAYO MEMORIAL BUILDING • MINNEAPOLIS, MINNESOTA 55455

June 16, 1969

Mr. Ken Taylor
TAC
c/o Mrs. Karen Levin
3100 Powell Hall

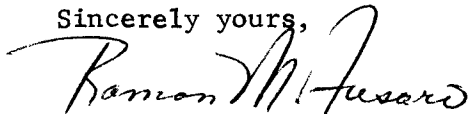
Re: Dermatology In-Patient Hospital Unit

Dear Mr. Taylor:

Doctor Lynch and I have reviewed the plans, and we again want to emphasize the need for the six-foot tubs to be shared by two rooms. We also feel that there can be a shower in each room for the patient, along with the other bathroom facilities. In addition to the tub, there should be a fold-up head tray for shampooing the scalp over the tub. The patient can then have his scalp shampoo in his room. If there are tubs in all the rooms on the Dermatology floor, I see no need for a central tub facility. This would mean that that room that has been designated as a central tub facility can be used for a conference room, and the wall between the conference room and the tub room can be eliminated; thus, making a rather large conference area with a folding wall. This would be of immense teaching value to the Dermatology and Medical Services. Teaching facilities are going to be at a minimum.

If there are any questions, please let me know.

Sincerely yours,



Ramon M. Fusaro, M.D., Ph.D.
Associate Professor

RMF:lw

CC: Mr. Preston
Dr. Lynch
Dr. Winchell
Dr. Drage



HEALTH SCIENCES CENTER
MEDICAL SCHOOL

UNIVERSITY OF *Minnesota*

12.3
8.19

DIVISION OF DERMATOLOGY
MAYO MEMORIAL BUILDING • MINNEAPOLIS, MINNESOTA 55455

May 9, 1969

Mr. David Preston
Associate Director
University of Minnesota Hospitals

Dear Mr. Preston:

With respect to the size of the tubs that are needed in the new In-Patient Dermatology Service, it is difficult for me to agree on the use of the standard-size tub. These tubs are approximately five feet in inner length and not more than a foot-and-a-half in height. The dermatological tub on Station 31 is an old-fashioned stand-up tub and is much larger than the present-day household tub. I would think that the tub we would need should be at least six feet in length and should be capable of handling at least two feet of water in depth.

Let me know what luck you have with the architects.

Sincerely,




Ramon M. Fusaro, M.D., Ph.D.
Associate Professor

RMF:lw

RECEIVED

MAY 27 1969

THE ARCHITECTS COLLABORATIVE INC.



HEALTH SCIENCES CENTER
MEDICAL SCHOOL

Dr. Gene Coon
My Proctor
Seals

PROGRAM OF EVALUATION -- DOCTORS'

Typical Patient Room (Mock-up)

1. OBJECTIVES:

This program of evaluation is intended to obtain an assessment of dimensions and spatial relationships of the typical patient room as presented in mock-up form. It should be borne in mind that this room represents the basic patient service module which has contributed to establishing the dimensions of the proposed new Unit C. Since this mock-up is intended to ascertain general relative merits of the room many elements, such as closets, have been defined only by boxed-in units. Evaluation of these elements in detail will be possible at a later date after the construction of a completed working model. Your comments and criticisms of this room towards providing a better area in which to accommodate and treat patients will contribute much to the success of the overall project. Where practical your suggested changes to the mock-up will be incorporated for further evaluation.

2. THE PROGRAM OF EVALUATION:

a. On entering the room you will note that the patient's records (charts) can be placed on the shelf to your left. This shelf is on top of a box representing a two-compartment cupboard. These compartments are to house sterile packs, clean linen, soiled trays and soiled linen.

1. Is the shelf height correct for your convenient review of records (charts)? *Yes*
2. Is the level of illumination at the shelf acceptable? *NO*

b. The lavatory basin has been placed primarily for the convenience of the patients.

1. Is there sufficient space for you to conveniently wash your hands? *Yes*
2. Are the soap and paper towel dispensers provided readily accessible? *Yes but 8" too high*

c. The patient beds (two-bed arrangement) have been positioned with 8-foot center to center spacing, leaving 5 feet between beds.

1. Does this bed position allow proper space for the examination of patients? *Yes*

2. Is there sufficient space for yourself, residents and student doctors to review a case of special clinical interest? *Yes*

d. A privacy curtain has been provided. When pulled around the patient:

1. Has your working space become restricted in any way?

2. Will this curtain always be used during patient examination or only on occasions such as at night to limit the disturbance of the other patients?

e. The patient examination light is incorporated in the over-bed light. It is an extremely high intensity indirect source that should provide between 60-100 footcandles at the patient.

1. Is the distribution of this light along the length of the patient adequate for all normal examinations that will be conducted at the bed? *Yes, except perineal exams*

2. Is the quality of the light source adequate as to proper rendition of skin pallor, etc. and the limiting of shadows?

Yes - excellent but a direct down light would help for procedures.

f. Two dummy panels have been placed on the wall at the right of each bed. These represent bed-head service units. Each of these units will contain coded, quick connect oxygen, vacuum and air outlets, one duplex electrical outlet (on emergency power), and outlets for telephone and patient communications with the nurses' station.

1. Are these bed-head units properly positioned with respect to the beds and to give the proper diversity of outlets? *I think they should be to the left of the bed head.*

2. Is the height of this unit correct? (Standard = 5'-0" above finished floor.) Does the bed head interfere with any of the outlets or apparatus which will be connected thereto? *No Height is correct*

3. Does the suction bottle fit easily into the recessed cabinet?

4. Does it appear that the erection of an oxygen tent or a bed with a traction frame seriously limit the use of any of the outlets provided?

5. Are there other services that you would consider mandatory to be included on this panel? (Provisions for physiological and closed circuit TV monitoring are now being studied.)

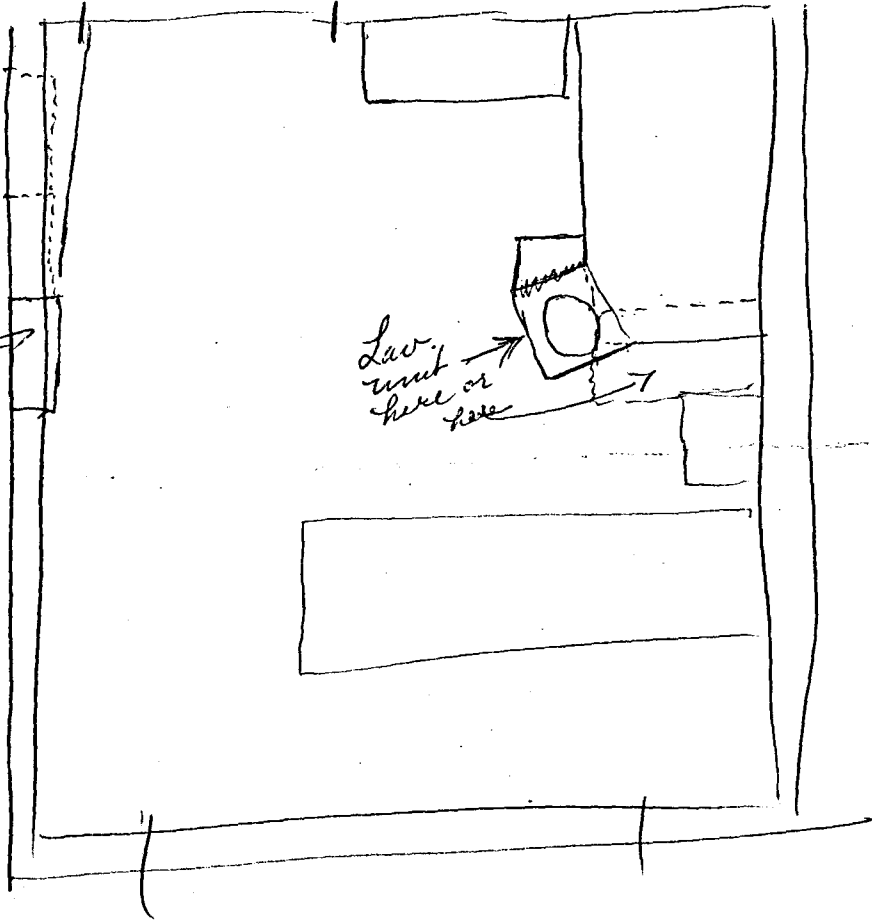
No
As standard items physiologic monitoring is not necessary. Some rooms should have this.

- g. On completion of the patient examinations you may want to make notes in the room before leaving.
 1. Does the shelf inside the door where the patient's records (charts) can be placed lend itself to that use?
3. The above outlined investigations are not intended to be conclusive in themselves, but are to serve as a suggested mode of evaluation to follow. The doctor who is cooperating in this evaluation is requested to project himself into as many situations as time will permit and record his findings.

I like the feeling of privacy created by the cabinet & sink partition — i. e. it cuts off the hallway without restricting the view of a nurse from the door. This unit does consume space, however and is an obstacle to the patient reaching the shower or toilet.

In my opinion the width of the room is adequate. It definitely should not be decreased even one inch. The length of the room also is correct — adequate for rounds, visitors, transfer of patients onto carts. A foot ~~might~~ be sacrificed but should be from the shower room & not the patient area. By the time heating & air conditioning equipment is installed under the window the floorspace will be just about right. ~~By the way~~ It is hoped that the final size of a single room will be adequate but not large enough to crowd two beds into.

⊗ A wide windowsill is useful for flowers.



wall recessed in
wall wardrobe →

Lav. unit →
here or here →

W

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2. THE PROGRAM OF EVALUATION:

a. On entering the room you will note that the patient's records (charts) can be placed on the shelf to your left. This shelf is on top of a box representing a two-compartment cupboard. These compartments are to house sterile packs, clean linen, soiled trays and soiled linen.

1. Is the shelf height correct for your convenient review of records (charts)?
No - Too HIGH

2. Is the level of illumination at the shelf acceptable?

No - the record would be in my shadow

b. The lavatory basin has been placed primarily for the convenience of the patients.

1. Is there sufficient space for you to conveniently wash your hands?

Yes

2. Are the soap and paper towel dispensers provided readily accessible?

Yes - How ABOUT A FOOT FAUCET CONTROL?

c. The patient beds (two-bed arrangement) have been positioned with 8-foot center to center spacing, leaving 5 feet between beds.

1. Does this bed position allow proper space for the examination of patients?

IT IS A LITTLE CLOSE IF MANY PEOPLE ARE PRESENT - 76, perhaps

RIGHT.
Communication outlets should be on PATIENT'S

2. Is there sufficient space for yourself, residents and student doctors to review a case of special clinical interest?

It depends on the NUMBER - VIDE SUPRA

- d. A privacy curtain has been provided. When pulled around the patient:

1. Has your working space become restricted in any way?
2. Will this curtain always be used during patient examination or only on occasions such as at night to limit the disturbance of the other patients?

Yes
During PATIENT EXAMINATION

- e. The patient examination light is incorporated in the over-bed light. It is an extremely high intensity indirect source that should provide between 60-100 footcandles at the patient.

1. Is the distribution of this light along the length of the patient adequate for all normal examinations that will be conducted at the bed?
2. Is the quality of the light source adequate as to proper rendition of skin pallor, etc. and the limiting of shadows?

No
IT will depend on what color the room is PAINTED

- f. Two dummy panels have been placed on the wall at the right of each bed. These represent bed-head service units. Each of these units will contain coded, quick connect oxygen, vacuum and air outlets, one duplex electrical outlet (on emergency power), and outlets for telephone and patient communications with the nurses' station.

1. Are these bed-head units properly positioned with respect to the beds and to give the proper diversity of outlets?

← HAVING them ALL ON ONE SIDE MAY MAKE IT CLUTTERED

2. Is the height of this unit correct? (Standard = 5'-0" above finished floor.) Does the bed head interfere with any of the outlets or apparatus which will be connected thereto?

No

3. Does the suction bottle fit easily into the recessed cabinet?

IT should

4. Does it appear that the erection of an oxygen tent or a bed with a traction frame seriously limit the use of any of the outlets provided?

No

5. Are there other services that you would consider mandatory to be included on this panel? (Provisions for physiological and closed circuit TV monitoring are now being studied.)

No, in view of further provisions being STUDIED

g. On completion of the patient examinations you may want to make notes in the room before leaving.

1. Does the shelf inside the door where the patient's records (charts) can be placed lend itself to that use?

No - for REASONS NOTED EARLIER

3. The above outlined investigations are not intended to be conclusive in themselves, but are to serve as a suggested mode of evaluation to follow. The doctor who is cooperating in this evaluation is requested to project himself into as many situations as time will permit and record his findings.

1. LOCATION of SINK & LUGGAGE UNIT IS BAD

2. Why not switch HEAD of BED TO OPPOSITE WALL? SINK & ~~WARD~~ LUGGAGE COMPARTMENT could be ALONG WALL AT FOOT of BED & not projecting out INTO ROOM

3. ? WINDOW IN DOOR

4. Shouldn't the LAVATORY be in the bathroom?

5. Overhead frame for I.V.'s (AS IN CORONARY CARE UNIT) is highly desirable

6. Adequate wiring for X-RAY equipment?

*Mr. Proctor
Fauls*

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1. Is there sufficient space for you to conveniently wash your hands?

2. Are the soap and paper towel dispensers provided readily accessible? *yes*

yes - but 8" too high

c. The patient beds (two-bed arrangement) have been positioned with 8-foot center to center spacing, leaving 5 feet between beds.

1. Does this bed position allow proper space for the examination of patients?

Yes

2. Is there sufficient space for yourself, residents and student doctors to review a case of special clinical interest? *Yes*

- d. A privacy curtain has been provided. When pulled around the patient:
 1. Has your working space become restricted in any way?
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- e. The patient examination light is incorporated in the over-bed light. It is an extremely high intensity indirect source that should provide between 60-100 footcandles at the patient.
 1. Is the distribution of this light along the length of the patient adequate for all normal examinations that will be conducted at the bed? *Yes, except perineal exams*
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 3. Does the suction bottle fit easily into the recessed cabinet?
 4. Does it appear that the erection of an oxygen tent or a bed with a traction frame seriously limit the use of any of the outlets provided? *No*
 5. Are there other services that you would consider mandatory to be included on this panel? (Provisions for physiological and closed circuit TV monitoring are now being studied.)

As standard items physiologic monitoring is not necessary. Some rooms should have this.

- g. On completion of the patient examinations you may want to make notes in the room before leaving.
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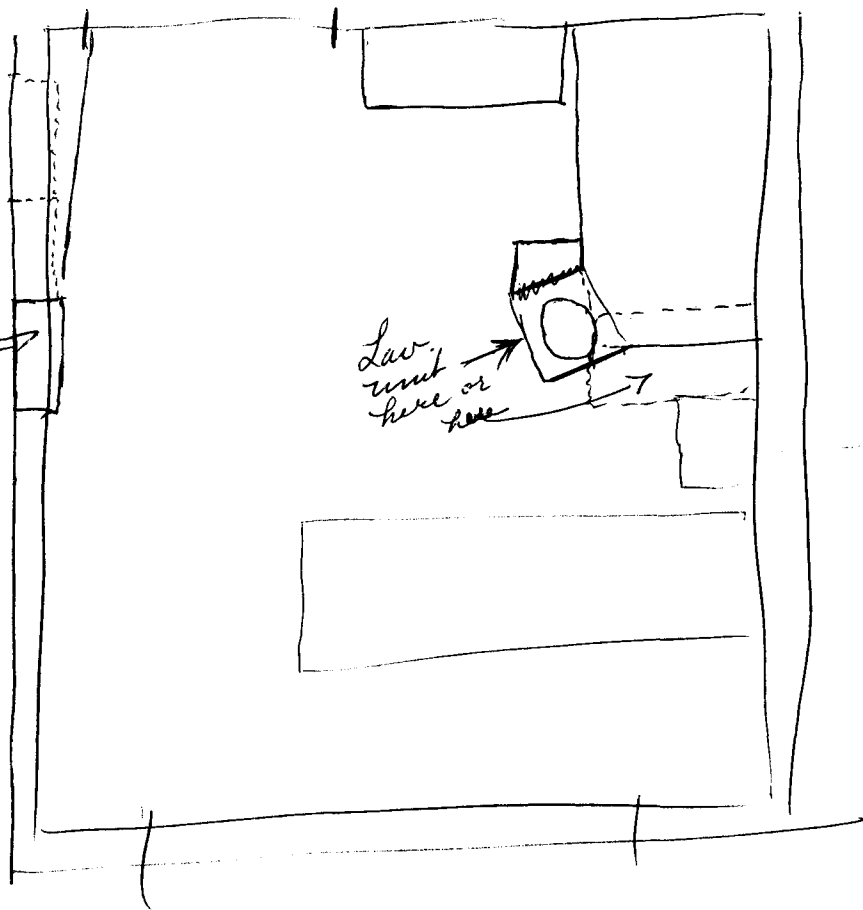
I like the feeling of privacy created by the cabinet v. sink partition — i.e. it cuts off the hallway without restricting the view of a nurse from the door. This unit does consume space, however and is an obstacle to the patient reaching the shower or toilet.

In my opinion the width of the room is adequate. It definitely should not be decreased even one inch. The length of the room also is correct — adequate for rounds, visitors, transfer of patients onto carts. A foot ~~might~~ be sacrificed but should be from the shower room & not the patient area. By the time heating & air conditioning equipment is installed under the window the floorspace will be just about right. ~~It is~~ It is hoped that the final size of a single room will be adequate but not large enough to crowd two beds into.

⊕ All wide windowsill is useful for flowers.

recessed in
wall wardrobe

Law.
unit
here or
here



W

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1. Is the shelf height correct for your convenient review of records (charts)? *OK*

2. Is the level of illumination at the shelf acceptable?
OK

b. The lavatory basin has been placed primarily for the convenience of the patients.

1. Is there sufficient space for you to conveniently wash your hands? *OK*

2. Are the soap and paper towel dispensers provided readily accessible?
OK

c. The patient beds (two-bed arrangement) have been positioned with 8-foot center to center spacing, leaving 5 feet between beds.

1. Does this bed position allow proper space for the examination of patients?
Yes

2. Is there sufficient space for yourself, residents and student doctors to review a case of special clinical interest? *yes*

d. A privacy curtain has been provided. When pulled around the patient:

1. Has your working space become restricted in any way? *NO*

2. Will this curtain always be used during patient examination or only on occasions such as at night to limit the disturbance of the other patients? *Not used all the time*

e. The patient examination light is incorporated in the over-bed light. It is an extremely high intensity indirect source that should provide between 60-100 footcandles at the patient.

1. Is the distribution of this light along the length of the patient adequate for all normal examinations that will be conducted at the bed? *yes NO*

2. Is the quality of the light source adequate as to proper rendition of skin pallor, etc. and the limiting of shadows? *yes NO*

*Lighting
as depicted
is not adequate!!*

f. Two dummy panels have been placed on the wall at the right of each bed. These represent bed-head service units. Each of these units will contain coded, quick connect oxygen, vacuum and air outlets, one duplex electrical outlet (on emergency power), and outlets for telephone and patient communications with the nurses' station.

1. Are these bed-head units properly positioned with respect to the beds and to give the proper diversity of outlets? *yes*

2. Is the height of this unit correct? (Standard = 5'-0" above finished floor.) Does the bed head interfere with any of the outlets or apparatus which will be connected thereto? *NO*

3. Does the suction bottle fit easily into the recessed cabinet?

4. Does it appear that the erection of an oxygen tent or a bed with a traction frame seriously limit the use of any of the outlets provided? *NO*

5. Are there other services that you would consider mandatory to be included on this panel? (Provisions for physiological and closed circuit TV monitoring are now being studied.) *NO*

g. On completion of the patient examinations you may want to make notes in the room before leaving.

1. Does the shelf inside the door where the patient's records (charts) can be placed lend itself to that use?

• yes

3. The above outlined investigations are not intended to be conclusive in themselves, but are to serve as a suggested mode of evaluation to follow. The doctor who is cooperating in this evaluation is requested to project himself into as many situations as time will permit and record his findings.

Bathroom (toilet) too far from bed

Sink could be recessed with mirror above sink

Wardrobe space limits view of patient from hall

Lighting in model room is not sufficient
need light on ceiling over bed for examination

Middle Island seems to be more of a

handicap to viewing the patient than is acceptable.
would think sink, wardrobe space, and luggage
space could be recessed in the wall.

THE ARCHITECTS COLLABORATIVE INC.



*M. G. Mc
with file*

JEAN B. FLETCHER
1945 ----- 1965
NORMAN FLETCHER
WALTER GROPIUS
JOHN C. HARKNESS
SARAH P. HARKNESS
LOUIS A. MCMILLEN

RICHARD BROOKER
ALEX CVIJANOVIĆ
HERBERT GALLAGHER
WILLIAM J. GEDDIS
ROLAND KLUVER
PETER W. MORTON
H. MORSE PAYNE, JR.
ERNEST L. BIRDSALL
TREASURER

4 August 1969

Mr. C. Thomas Smith
Planning Coordinator
University of Minnesota
Minneapolis, Minnesota

Dear Tom;

We are sending you four (4) prints of a revised patient mock-up plan. These reflect some additional information which will assist the evaluation program.

The labelings to be attached to various elements of the room are indicated on one print. We feel that the dummy service panel would be most useful, but at this stage need be no more than a plywood panel with the various outlets labeled. The paper towel dispenser may be either a panel indication or an actual unit. However, if an actual unit is used, recessing is necessary since this would reflect the final installation method. The mirror could be a panel of the indicated size.

On July 30, 1969 we mailed to you a suction bottle cabinet to be installed in the mock-up. We are quite anxious to have this in situ since it is a prototype. An evaluation by the staff will help determine our acceptance of this as a practical item in a patient's room.

We are enclosing evaluation programs for consideration by nurses, doctors, unit managers and maintenance personnel. When the working model is constructed, these programs will be enlarged to include all additional features and aspects incorporated in the unit.

Also enclosed are brochures from Bell Hospital Systems Inc. illustrating a new development in audio/visual systems for patients rooms. Perhaps you would like to post these in the mock-up for staff consideration.

Please let us know if there is any further information required for the mock-up.

Very truly yours,

THE ARCHITECTS COLLABORATIVE Inc.

Olga E. Petters

Olga E. Petters

OEP/bb

cc: Peter Sammond

August 21, 1969

TO: Mrs. Karen Levin
FROM: Peter H. Sammond
SUBJECT: Patient Care Mock-up Evaluation

I have sent memos to David Preston and Marie Manthey asking their cooperation in the formal evaluation of the Patient Care Mock-up. You have copies of those memos. I wonder if you would consult with them to offer what assistance you can in the coordination of this evaluation.

I would also appreciate it if you could organize the sporadic evaluation of the individual people looking at the mock-up down in the room. By this I mean putting up copies of the TAC evaluation questionnaire and providing forms in a convenient place with convenient ways of writing their comments. I will leave my folder on the mock-up for you to use.

Thank You

PHS/lmc

dictated but not read



September 8, 1969

Mrs. Karen Levin
Research Assistant
Health Sciences Planning Office
Box 1 Mayo, University Hospitals
University of Minnesota
Minneapolis, Minnesota 55455

Dear Karen:

Reference is made to your request for an evaluation of the mock-up patient room on the first floor of Powell Hall. My initial impression is that this certainly is a spacious room. There is no question that the attending physician could work very comfortably in it. The only question I would raise is whether he could work with equal comfort in a room somewhat smaller. This is something that I would leave to the judgement of the architects.

Another general comment I would make is that the lighting throughout the room is inadequate. This is true both at the surface of the shelf for reviewing records and it is particularly true over the bed. The overhead light on the wall by the bed certainly provides satisfactory illumination for the patient needs but it does not provide satisfactory illumination for examination of the patient by the physician.

A third comment that I would make relates to the panels on the wall at the right of each bed representing the service units. If it is feasible it would seem more satisfactory to separate the telephone from this and bring it to the other side of the bed so that the telephone wires would not be in a position to get inter-mixed with the wires and tubes of the other service units.

The washbasin seems to be quite low, at least for my comfort. This is something that is of minimal importance providing the lowness of it is a definite asset to the patient's comfort. I am not sure that this is so, but again would leave this judgement to the experience of the architect. One other very important comment relative to the washbasin area



Mrs. Karen Levin
September 8, 1969

Page Two

is that it faces onto the first patient's section of the room and may be a disturbance of the privacy of the first patient when used by bed patient number two. If possible it would be more desirable to provide more privacy in the area of the washbasin so that both patients in the room could be free of disturbance when the basin is in use.

I have reviewed all of the other questions in your evaluation sheet and find no other areas of criticism at this time.

Sincerely,



B. F. Fuller, M.D.
Professor and Head
Department of Family Practice and
Community Health

BFF/111

September 8, 1969

To: Mr. Peter Sammond, Mr. David Preston

From: Karen Levin

Subject: Nursing Committee on Design Evaluation of Patient
Care Room Mock-Up

The following comments are from the Nursing Committee on Design in response to the program of evaluation of the patient care room mock-up prepared by TAC. Although the group agree that the mock-up has served an important function in clarifying their thinking, they have taken the liberty of responding to only the most general questions of the program evaluation since it is difficult to concentrate on design details before the basic concept of the room is resolved. The Nursing Committee on Design has given a good deal of thought to the organization of inpatient care and facilities over the past few months and would like to bring Gordon Freisen's Mercy Hospital in Chicago to the attention of the architects.

Litter: The patient closet prevents the litter from moving easily into position parallel to the bed nearest the hall.

Space Between Beds: The space is adequate for nursing students but it is not adequate for easy movement of the litter into position beside the second bed.

Accessory Panel: Sufficient leeway should be provided between the bed and the panel to prevent the breakage of bottles as the bed is moved up and down. The Committee representative from the cardiac care unit, where this is currently a problem, suggested that a groove on the floor indicating the proper placement of the bed would be helpful. It would be preferable to recess the unit into the wall adjacent to the bed, eliminating breakage problems and providing more unencumbered space. The sphygmomanometer also should not be mounted directly above the bed. The communication segment of the panel should be separate, preferably located on the opposite side of the bed. Extended cords should be kept to a minimum.

Light: The three lights already provided for general illumination, for patient reading, and for assistance to the nurse seem to be adequate. Two low level lights controlled at the door should be located in the patient room and one in the toilet room. The spotlight over the bed for examination has not been provided in the mock-up.

Curtain: Were the curtain runners centered around the bed, the space on either side would be adequate for nursing care but not for patient examination by a large group of students. As now placed the curtain is too close to the bed to be useful on the right side. One definite improvement would be to have the curtain recessed into the wall when it is not in use.

Basin Unit: Placement of the sink in relation to the corridor window and door is not acceptable because it does not provide sufficient privacy. With cabinet space labeled rather than operational it is not possible to determine whether luggage space is adequate. Individual medicine cabinets should be recessed into the wall in addition to the recessed paper towel dispenser.

The basin "island" itself is not acceptable to the Nursing Committee. In addition to the basin being too public, it makes the distance from the patient's bed to the toilet room prohibitive and the distance from the entrance door to the patient unwieldy. The Committee urges that consideration be given to moving the toilet room unit to the back of the patient room, bringing the beds closer to the corridor and eliminating the window to the hall. The Committee indicated that bringing the beds closer to the hall is important to the quality of patient care while the window to the hall is not.

Toilet Room: Aside from the fact that access to the toilet room from the patient bed is poor, the room itself is adequate. The door width is good. However, a sliding door of the same dimension might be more manageable and should be considered. A seat within the shower unit folding down from the wall would also be an improvement. A lock indicating when the toilet room is occupied is a good idea if it can be opened from both sides.

Nurse Server Unit: In addition to the clean and dirty compartment, the nurse server unit requires a small sink built into the work counter, separate from the sink used by the patient.

Mr. Peter Sammond
Mr. David Preston
Page 3
September 8, 1969

The work counter should be average height, a bit lower than indicated by the mock-up. Communications facilities for the physician and nurse should be provided. The nurse server unit should be separated from the patient area of the room by a room divider.

The Nursing Committee on Design is willing to consider the more specific aspects of the TAC Program of Evaluation if the information is required at this time. Otherwise, the Committee looks forward to working with a revised patient care room that more nearly complements anticipated patterns of nursing care and provides architecturally for higher quality of patient care.

KL/cp

September 10, 1969

Mr. David Preston
Associate Director
Box 606 Mayo
University of Minnesota
Minneapolis, Minnesota 55455

Dear Dave:

Regarding the mock-up of the typical patient room, I would like to compliment you on this display and to tell you that I enjoyed the opportunity to look at it.

I was particularly impressed by the entry area. I do think that the shelf could be one or two inches lower and a light could be moved somewhat over the shelf to facilitate this use as a working area for physicians. The patient's bath in this location is somewhat far from the bed but is beautifully located for privacy and use, and I am sure that if I were a patient I would enjoy having this type of bathroom arrangement. I think that this is allowable because the critically ill patients are now being cared for in such areas as coronary care units and intensive care units. However, there are still patients who might be subject to that torture device, the bed pan, in the present room arrangement and I was wondering if it might not be possible to have a hidden water closet adjacent to the bed in the private rooms and adjacent to at least one of the beds in the two bed rooms. For example, the bedside stands could swing out revealing the water closet and the patient could be helped directly from the bed onto the toilet. I think that the saving in work and patient discomfort would justify our considering such an additional expense in construction.

I noticed that the mirror as presently located would be very difficult to use as a dressing mirror. However, in walking about the room and looking at the mirror I realized that it could be used to look down the hallway and I remember being a patient and feeling closed in. Therefore, I was wondering if this mirror could not be hinged so that it could be used as sort of a rear view mirror by the patient at times but also swung out to be used as a dressing mirror as it is an ideal location for this if it were only on a hinge.

Mr. David Preston
September 10, 1969

Page Two

One thing about hospital rooms, they are frequently difficult to examine patients in because of the light during the day. If the curtains are a bright yellow you cannot tell about the color of a patient's skin -- particularly in cases of jaundice. Also, if there is no opaque shade or curtain, it can be difficult if not impossible to do an adequate eye examination and some endoscopic procedures are more difficult when a room cannot be darkened. Most of our examinations are done during daylight hours and this is a consideration as far as the physician is concerned.

One way to cut expenses is to use only push plates and pull bars on the doors. At night in a hospital the doorlocks can become very noisy and they have no functional use. They are just an additional expense. In fact, I do not think that conventional locks are necessary on either the outer door or the toilet doors in a hospital.

As far as the sink is concerned, I wondered if you had considered the possibility of using only one elbow lever with pre-mixed temperature as they have in the present Rehabilitation Building. I think that they have been pleased with it and it certainly simplifies hand washing for the physicians as you don't have to contaminate anything when you turn on the water. Also, this is a great help with neurologic defects because they do not have to worry about the fact that they are unable to tell water temperature.

I think that it is almost mandatory that the bedside panel include a position for patient monitoring, as I believe by the time hospital construction is finished that this type of instrumentation will be routine in most hospitals.

The room seems to be very adequate as far as size is concerned and I think that this is appropriate in a teaching hospital although I had the first impression that almost too much space had been allowed. After I had walked around the room a bit and thought about its many functions, I think that the present size arrangements are excellent. I also think that the expended size would obviate some of the litter transfer difficulties that might otherwise be important in a room arrangement of this sort.

I realize that all of these comments are about very minor matters and there may be good reasons why none of these changes would be practical but I have appreciated the opportunity to look and comment.

Sincerely yours,



John B. O'Leary, M.D.
Associate Professor
Department of Family Practice and
Community Health

JBO/111

Recommended Design Features of
Adult Medicine Station

Station Design

1. The optimum size of an adult station is 24-32 beds.
2. The Nursing Department recommends locating charts in the patient room work area if adequate security can be provided to prevent uncontrolled patient access. If charts are kept only in a central location, the feasibility of sub-stations should be explored. Perhaps charts for 16 patients could be grouped in an area with a phone. The need for staffing this area with clerical personnel should also be explored.
3. The communications center can be central to all patient care areas, and can conceivably serve more than one patient care center, depending on the capacity and type of equipment.
4. Visitors should be received at a central point near the elevators before they arrive on the nursing station. This might be part of the communication control centers function or be assigned to another individual acting as a receptionist for the stations.
5. Short corridors are preferred. Visual control from the corridor to all patients is not necessary; a few rooms for acutely ill patients with windows on the corridor wall for visibility is considered adequate.
6. Support areas can be located away from the immediate patient bed area if services and supplies are provided in each patient's room.
7. A nurse conference room should be located within or proximal to the communication control center. If services and communications are decentralized to the patient room, this conference room could replace the nursing station per se.

Patient Room Design

1. The room for single patient use should be no smaller than 12 X 14.
2. Bathrooms should not be located on the corridor wall; the outside wall is preferred.
3. There should be one hand-washing sink in the patient's bathroom and one located in the nurse-server area. However, if only one sink can be installed, this committee feels it should be located outside the patient's bathroom.
4. In general, the committee advocates the concept of providing as much built-in equipment as possible with as little protrusion of the equipment into the room as possible.

32

STATION 32, UNIVERSITY HOSPITALS

Volume 1, number 3

February 6, 1970

Carpeting will be installed on Station 32 during the month of February. The corridors, patient rooms, service rooms, and desk area will be carpeted with a blue-green carpet made of an acrylic fiber. Woven into the fibers are copper wires to reduce static electricity.

Several studies of the effects of carpeting a nursing station are planned or in progress. Noise, cost of floor cleaning, and surface and air microbial studies are before-and-after comparison studies that are being done. In addition, the psychological effect of carpeting on patients and staff will be studied.

Some of the areas where further experience is needed are the cleaning process and the effect carpeting has on cart traffic. Carpet manufacturers supply a cleaning kit that is apparently adequate in removing most of the stains that occur in hospitals. The preferred equipment for vacuuming is a centralized built-in unit to which a hose can be attached at various places along the baseboard. This kind of equipment is almost soundless. However, because of problems involved in installing such a unit, portable vacuums will be used on Station 32 and may create a noise problem.

Cart traffic will undoubtedly be effected by carpeting. Experience in other hospitals indicates that heavy

carts will be harder to push on carpeting; the thicker the pile, the more resistance there will be. The carpeting on 32 is relatively flat and hard so it should not be difficult to move carts and equipment on wheels through the station.

Experience with cleaning the carpet and with cart traffic as well as findings of the before-and-after studies will help us determine if corridors, patient rooms, service rooms, etc., should be carpeted in the new hospital.

The Department of Environmental Services, Central Sterile Supply, and the Central Storeroom are embarking effort of these hospital departments to assume new roles and extend departmental responsibility to the station level.

The Environmental Services Department has been planning for some time to assume more responsibility for station cleaning. Medical and station equipment such as IV standards, EKG machines, wheelchairs, litters, and scales are now cleaned by Environmental Services personnel. Maintenance and repair of equipment and station furnishings is also part of their new role. In the patient's room, ENS personnel clean all furniture and fixtures in occupied as well as unoccupied rooms. Discharge units are stripped, cleaned, and restocked; beds of patients who are ambulatory are changed by ENS personnel.

The experience acquired on Station 32 will be used by ENS as they expand these services to other stations.

Central Sterile Supply and the Central Storeroom are involved in a major project on station 32. The goal of this project is to provide station areas with all supplies and equipment on an automatic replacement basis, thus eliminating supply ordering by station personnel. Furthermore, it is hoped that in the future there will be a central distribution center for all supplies, instead of the several distribution areas we now have. To facilitate this program, Mr. Iau of the storeroom staff is in charge of instituting the program on Station 32. He is working with CSS, the Storeroom, and ENS to establish standards on which to base an automatic replacement service. He is the one person the station personnel will relate to in all situations involving supplies or equipment needs.

For additional information call M. Manthey 373-8282.

" A Staff Nurse's View of Primary Nursing."

The main advantage I see is in terms of the benefit to patients. It just seems to make so much more sense for a patient to get to know one nurse who identifies with him, knows what his needs are and helps him develop a way of meeting them. This eliminates a lot of duplication in terms of daily tasks as well as long range planning, such as for discharge. Since it is much less confusing for the patient they seem to have less anxiety about hospitalization. It also means a lot to a patient's family to have one nurse that they can get explanations from, ask questions of, and get reports of the patient from, and I think that's a tremendous advantage to the patient, relatives, and to the nurse. Another advantage is in terms of communication and clarification amongst all members of the health team. The nurse gets a good understanding from the doctor of what he has in mind for the patient and she can coordinate the things in his whole hospitalization that sometimes get fragmented otherwise. It eliminates a lot of middle-man kinds of communications, what nurse is caring for the patient, what kinds of treatments he should

receive, when he is scheduled for various tests, etc.

I like the system, I think its an effective way of delivering care to patients, and its a very rewarding way of caring for patients for the nurses. An important part of this system is that it requires a certain type of nurse who really does in fact want to get involved with patients. Because primary nursing is demanding, each of us needs to be encouraged to do the best we can with each patient, and that encouragement can come from our co-workers, the head nurse, the nurse clinician, the physician, social workers, and others who are involved in the care of the patients.

Colleen Dockter

DRAFT - 12/10/70

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

December 10, 1970

TO: Administrative Staff
FROM: Program Committee
SUBJECT: Draft Proposal for Patient Care Organization

Short Range:

1. Assign an administrator as liason to each nursing station. The assignments will be to stations rather than to clinical services.
2. Ask the clinical departments which have not done so to assign a clinical service liason for each station. Where more than one service shares a station, each service would make such an assignment.
3. The administrator would work with the physician, existing nursing and departmental organization toward the following ends:
 - a) Identify current operational and physical factors which inhibit optional care of patients
 - b) Work with appropriate administrators and department heads toward short range connection of these factors
 - c) Develop by March 1, 1971 a report for each station analyzing problems related to patient service; physical plant; nursing, medical staff, and departmental organization.
4. Establish frequent communications and information exchange mechanisms between department heads, nursing, administration.

Long Range:

Establish an ad hoc committee to analyze patterns for patient care organization here and elsewhere. In addition to other resources, that committee should use the experience gained by the administrative staff in its short range assignments. The committee should report recommendations on administrative and patient care organization by May 1, 1971.

HEALTH SCIENCES CENTER NOTE: See next page for proposed assignments

STATION

ADMINISTRATOR

12	Mr. Bob Baker
22	Mr. Schneider
30	Mr. Stan Williams
31	Mr. Stan Williams
32	Mr. Stan Williams
40	Mr. Dennis Countryman
41	Mr. Dennis Countryman
42	Mr. Kenneth Schneider
44	Mr. Kenneth Schneider
47	Mr. Merle McGrath
48	Mr. Merle McGrath
49	Mr. Gary Peterson
50	Mr. Tom Smith
51	Mr. Tom Smith
52	Mr. Gary Peterson
57	Mr. Bob Baker
58	Mr. Bob Baker
59	Mr. Bob Baker
60	Mr. Jack Malban
61	Mr. Jack Malban
62	Mr. Jack Malban
64	Mr. Jack Malban
35	Mr. Peter Sammond
45	Mr. Peter Sammond
46	Mr. Peter Sammond
55	Mr. Peter Sammond
56	Mr. Peter Sammond
201	Mr. Tom Jones
301	Mr. Tom Jones
Masonic I	Mr. Tom Smith
Masonic II	Mr. Tom Smith
Masonic III	Mr. Tom Smith
Rehab. 4	Mr. Ken Schneider
Rehab. 5	Mr. Ken Schneider

ADMINISTRATIVE STAFF MEETING

Thursday, December 11, 1970

I. Immediate - No organizational change

- A. Assignment of administrator to area (service, mission, geographic) with nursing supervisor and head nurses. (Sammond)
- B. Build a support system, recognizing formal and informal mechanisms, utilizing existing structure. (Countryman)
- C. Formation of specific program solving task force with time limits - adaptation of Baker, Schneider, Williams paper.
- D. Focus on the few identifiable problem areas by thrashing out solutions among department heads, nursing supervisor, head nurse, and administrator. (Nursing Supervisors)
- E. Along with the above, restructure meetings with department heads in Jensen Patient Care Problem Seminar.
- F. Talk the problem to death.

II. Longer Range with organizational modification

- A. Grouping of Health Services staff along fewer functional lines.
- B. Examine experience of immediate solutions.