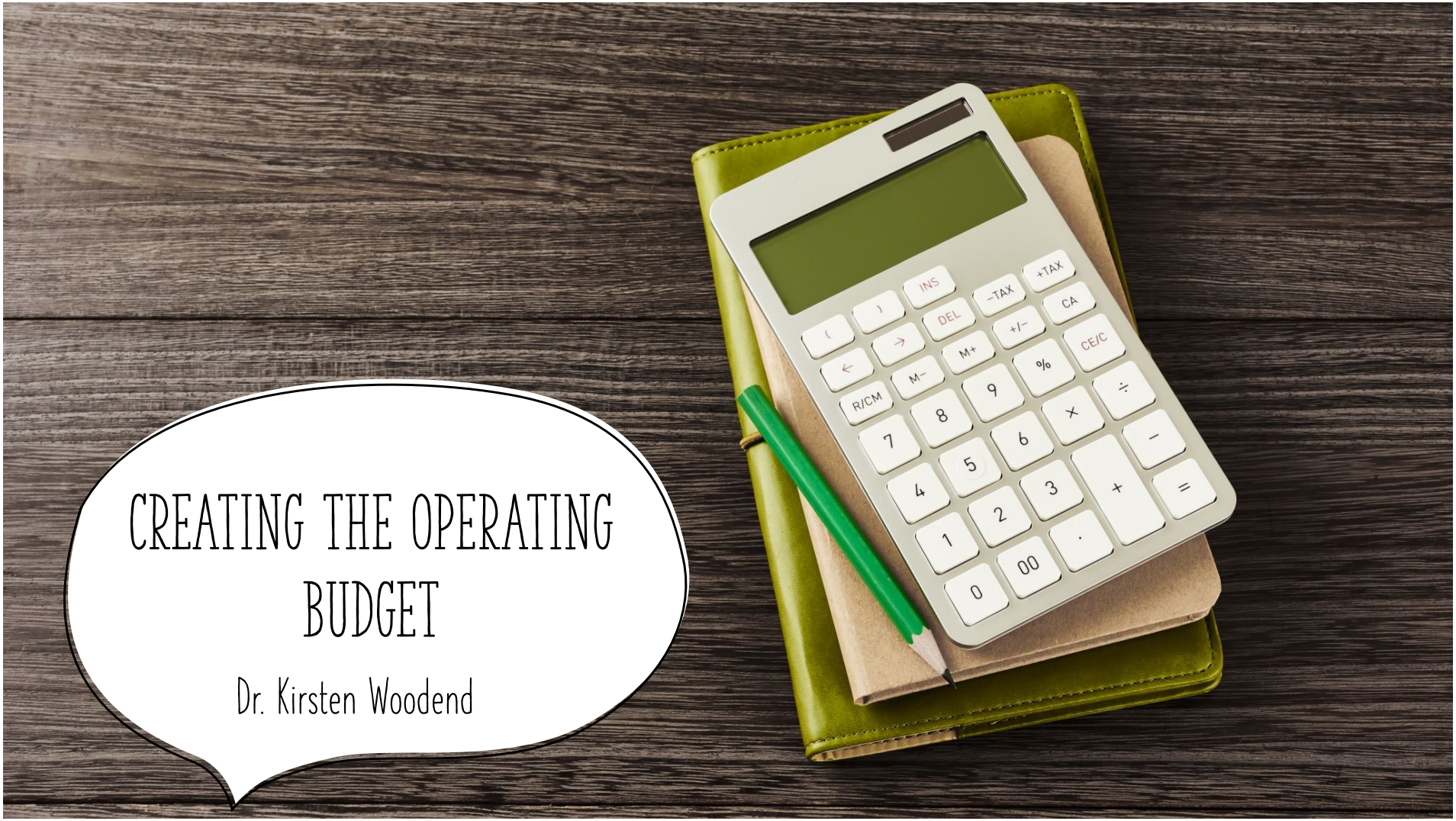
CREATING THE OPERATING BUDGET
Dr. Kirsten Woodend

LEARNING OUTCOME

1. Apply the budget development process for a nursing or clinical department

ANNUAL BUDGET PROCESS

Budgeting is done annually based on the cycle of the organization's fiscal year

Major steps in the budgeting process include

- gathering information and planning,
- developing unit budgets,
- developing the cash budget,
- negotiating and revising, and
- using feedback to control budget results and improve future plans (Finkler and McHugh 2007)

Organisations generally develop a list of specific dates for implementing the budget process at each level

DEVELOPING A NURSING DEPARTMENT BUDGET STEP BY STEP

1

Determine:

- Volume
- Nurse-Patient Ratio
- Skill Mix
- Non-productive time

2

Determine the key components of the unit that will influence staffing and budgeting

3

Build a staffing model

QUESTIONS TO CONSIDER AS YOU START YOUR NEXT YEAR'S BUDGET

- Has the type of admitted patient changed over the previous year or is likely to change in the next year?
- Has been a change in the medical staff or other healthcare staff practices during the current year?
- Is average length of stay for patients is decreasing or increasing or for a clinic is the number of patients being served is increasing or decreasing?
- What does the workload index/patient acuity increasing or decreasing?
- What has staff turnover has been? What might you expect?
- How much sick leave has been taken by staff? Was this anticipated?
- Have overtime hours increased?

ESTABLISHING VOLUME

Depends on the service(s) offered

- Average patient days
- Number of outpatient visits
- Units of service provision

Average patient days = sum of the daily unit patient census for 365 days

Total bed days available = total # of beds available times 365

DETERMINE NURSE-PATIENT RATIO

Ratio dictated by:

- Hospital policy
- Accreditation standards
- Community standards
- Desired clinical outcomes

Specific clinical settings will have different nurse patient ratios (i.e. MedSurg versus ICU)

Nurse-to-patient ratio can be computed from productive direct patient care nursing hours:

$$\frac{\text{Nurses}}{\text{Patients}} = \frac{\text{Productive Nursing Hours}}{\text{Patient Days} \times 24}$$

SKILL MIX

Proportion of staff in each "job class"

"The combination of different categories of health-care personnel employed for the provision of direct client care in the context of a nursing care delivery model" (McGillis Hall, 2004)

May be affected by:

- Organization policy
- Type of patients on unit
- Community standards

FACTORS TO CONSIDER

Including but not limited to the following:

CLIENT

- Health-care needs
- Acuity, complexity, predictability, stability, variability, dependency
- Type:
  - Individual
  - Family
  - Group
  - Community/population
- Cohort:
  - Numbers
  - Range of conditions
  - Fluctuations in mix
- Continuity of care provider

STAFF

- RNs, LPNs, RPNs, UCPs:
  - Numbers
  - Availability
  - Education
  - Competencies
  - Experience
- Teamwork and collaboration
- Clinical support and consultation
- Continuity of assignment
- Continuity of care

ORGANIZATIONAL

- Nursing care delivery model
- Physical environment
- Resources and support services
- Practice setting
- Legislation and regulations
- Workplace health and safety
- Policies
- Collective agreements
- Vision, mission and nursing philosophy
- Culture
- Leadership support

From: CNA, Staff Mix Decision-making Framework for Quality Nursing Care

FACILITY OVERVIEW

Name of facility
Time period = fiscal year for which the budget is being planned
Cost Centre
Unit type
Average daily census (or average # of patient visits expected)
Total patient days
Paid time off
Incidental overtime

provided
- Contextual issues, such as the architecture/geography of the environment and technology

Patient-specific physical and psychosocial variances
- Age and functional ability
- Communication skills
- Cultural and linguistic diversities
- Severity and urgency of admitting condition
- Scheduled procedures
- Availability of social support

Unit function variances (hours worked away from the bedside; these may be considered nonproductive hours in your organization)
- Unit governance
- Involvement in quality measurement activities
- Development of critical pathways or protocols
- Evaluation of practice outcomes

Unit role variances (whose hours are
- Education and training
- PTO

Staff-related variances
- Experience with the population served
- Level of experience (novice to expert)
- Education, preparation, and certification
- Tenure on the unit
- Level of control of practice environment
- The number of competencies and necessary learning assessment

Organization-related variances
- Effective and efficient support services
- Access to timely, accurate, relevant information
- Sufficient orientation
- Preparation specific to technology
- Necessary time to collaborate with and supervise other staff

Hunt, 2018

BUILDING THE STAFFING MODEL

Use historical and projected data

What to consider:

- Average daily census
- Annual total patient days
- Patient acuity

BUILDING THE STAFFING MODEL - EXAMPLE

	Monday		Tuesday		Wednesday		Thursday		Friday		All Shifts		Total Hours	FTE
	8 hr	12hr	8 hr	12hr	8 hr	12hr	8 hr	12hr	8 hr	12hr	8 hr	12hr		
Manager	1		1		1		1		1		5		40	1
RN		2		2		2		2		2		10	120	3
NP	1		1		1		1		1		5		40	1
RPN		1		1		1		1		1		5	60	1.5
SW	1				1						2		16	.4
Total	3	3	2	3	3	3	2	3	2	3	12	15	276	6.9

NON-PRODUCTIVE TIME

For each staff category, need to estimate:

- Time away from direct care
- Needed replacement staff

In addition to vacation, non-productive time can include time for:

- Education
- Meetings
- Orientation

TIME OFF, EDUCATION AND ORIENTATION

Role	Personal Time off		Meetings		Education		Orientation		Total Replacement hours	Replacement FTE
	Hours	Replacement hours	Hours	Replacement hours	Hours	Replacement hours	Hours	Replacement hours		
Clinical manager (1)	160	80	600	NA	72	NA	NA	NA	160	.1
Uniit clerk (1)	85	80	4	0	8	8	NA	NA	93	.1
RNs (12 FTE)	1632	1632	144	144	576	576	80	80	2432	1.1
RPNs (10 FTE)	1220	1220	120	120	360	360	24	24	1724	.8
PSWs (10 FTE)	820	820	60	0	120	120	24	24	964	.4

BENEFITS

Direct

- Linked to salaries
- Include vacation, sick leave, statutory holidays, pay shift differential, educational allowances
- Usually negotiated in collective bargaining and vary from province to province
- About 20% of salary

Indirect

- AKA benefit contribution expense
- Includes organization's contribution to employee benefits (CPP, EI, provincial pension, health insurance schemes)
- Can be as much as 20%

STAFFING COSTS

Role	FTE	Replacement FTE	Total FTE	Hours	Hourly rate	Benefits	Hourly cost	Total
Clinical manager	1	0.1	1.1	2,376	$46.00	$16.10	$62.10	$134,136.00
Uniit clerk	1	0.1	1.1	2,376	$25.00	$5.75	$30.75	$66,420.00
RNs	12	1.1	13.1	28,296	$38.00	$8.74	$46.74	$1,211,500.80
RPNs	10	0.8	10.8	23,328	$33.00	$7.59	$40.59	$876,744.00
PSWs	10	0.4	10.4	22,464	$18.00	$4.14	$22.14	$478,224.00

Total staffing costs = $2,767,025

MIS GUIDELINES

Standards for Management Information Systems in Canadian Health Service Organizations (MIS Standards)

- Set of national standards for gathering and processing data and for reporting financial and statistical data

MIS Standards include:

- A chart of accounts
- Accounting principles and procedures
- Workload measurement systems
- Indicators
- Management applications
- A glossary of terms

https://www.cihi.ca/en/submit-data-and-view-standards/data-standards/management-information-system-standards

SUPPLIES

Supplies are divided into categories such as medical and surgical supplies, drugs and medical drugs, medical gases, printing and office supplies, laundry and linen

Can represent about 20% of the operating budget

To determine the budget:

- Review actual costs for present fiscal year
- Make adjustments for inflation and workload changes

Supply Category	Present Fiscal Year	Next Fiscal Year
Medical Surgical Supplies	115,000	142,600
Drugs	189,000	234,360
Medical Gases	32,000	39,680
Total	336,000	416,640

REVENUE

Depends on the type of organization

For a hospital unit the income revenue my only include private and semiprivate rooms

- Daily rates set by the province
- Invoices
- for generally generated by the accounting office and given them to patients upon discharge

Revenue calculations usually done by the finance department and nurse managers not usually involved in revenue recovery


PrACTiCE