Modes of organising patient care

Choosing the most appropriate organisational mode to deliver patient care for each unit or organisation depends on the

> skill and expertise of the staff
> the availability of registered professional nurses
> the economic resources of an organisation
> the acuity of the patients
> and the complexity of the tasks to be completed.

Patient Allocation (Total patient care nursing)

Oldest mode of organising patient care.

At the turn of the 19th Century total patient care was generally provided in the patient's home and the nurse was responsible for cooking, house cleaning, and other activities in addition to nursing care.

Care for the wealthy and middle class took place at home, hospitals were for the poor. During the depression of the 1930s, people could no longer afford home care and began using hospitals. Nurses and students then shifted their care to hospital and so did patient allocation.

In patient allocation holistic care delivered by one nurse therefore patient seen as a whole, 'a person'.

Develops a nurse / patient relationship.

Caring   Trusting
Teaching   Counseling
Helping

Responsibility also ends when ending duty.

Greatest disadvantage occurs when nurse is inadequately trained or prepared to provide total care to the patient.

Task allocation (Functional Nursing)

Evolved primarily as a result of World War II. This was due to the rapid construction of hospitals leading to the great demand for nurses.

Ancillary personnel employed to do simple tasks – assigned to complete specific tasks rather than care for specific patients.

Task allocation was appropriate in times of trained nurse shortage, especially since the training of healthcare assistants was essentially task-centered.

This form of organising patient care was thought to be temporary as it was assumed that when the war ended, hospital would not need ancillary workers.

In task allocation every nurse does a little bit of care on each patient. Nurses become like machines - industrialisation of patients.

Assigning tasks to workers, rather than assigning workers to the professional nurse, resembles, at least in part, functional nursing.

Some workers feel unchallenged and under stimulated in their roles thus leading to low job satisfaction.

Task allocation:
   aimed at physical care only e.g. washing, cleaning, feeding medications etc.
   hierarchy of tasks basic vs. technical.
   basic - done by unqualified junior staff.
   technical - done by senior or experienced staff.

Who is to decide what is important patient, doctor or nurse?

Nursing care fragmented - medical / paramedical dominated care.

Stress is reduced problems referred to higher up the hierarchy (Menzies 1960).

Henderson - task allocation is not satisfying for the patient neither for the nurse. Both are dehumanised in the process.

Team nursing (Modular Nursing)
Developed in the 1950s in an effort to decrease the problems associated with task allocation.

Many believed that despite the continuous shortage of nursing staff, there should be a system which reduces the fragmented care given by task allocation.

A team should consist of not more than five people or it will revert to more functional lines of organisation. Nowadays teams consist of two or three personnel and are called modular nursing.

Team nursing associated with democratic leadership. Group members are given as much autonomy as possible although the team shares responsibility and accountability collectively

Team nursing allows members to contribute their own special expertise or skills.

The role of the team leader is to co-ordinate the activities of the team, including the giving of care.

Team leaders should use their knowledge about each member's abilities when making patient's assignments. The team leader is also responsible for knowing the condition and needs of all the patients assigned to the team and for planning individual care.

E.g. 2 nurses (SN + EN) taking care of a group of patients (such as the big ward). Working together but SN takes responsibility, therefore senior nurse acts as team leader - plans care, supervises, implement.

Responsibility ends when ending duty.

Must be careful otherwise task allocation creeps in.

Primary Nursing (Professional Practice Model)
Developed in the 1970s, uses some of the concepts of total patient care and brings the nurse to the bedside to provide clinical care.

The nursing care of a patient is under the continuous guidance of one nurse from admission to discharge. Round the clock care is co-ordinated for each patient by the designated or primary nurse for that patient.

One registered nurse is designated as the primary nurse for a small group of patients upon their admission and for their duration of their hospital stay. The primary nurse takes responsibility for the planning and evaluating all aspects of their nursing care.

Primary nursing facilitates autonomous practice and is therefore viewed as a professional model of work.

Nursing process and nursing models helped in the development of Primary Nursing.

Four key principles underpin primary nursing and distinguish it from other modes of care delivery.
1. Accountability
2. Autonomy
3. Coordination
4. Comprehensiveness

In primary nursing consider the following:
Continuity of care may be a significant factor in developing good patient / nurse relationship.
The effects of staff sickness, holidays etc should be examined in the light of their effect on the continuity of care.
Targets should be set about the amount of time nurses spend with patients.
Effective communication should be encouraged so that nurses are helped to work in primary groups.

Primary nurse - registered first level (Senior SN) primary nurse must offer.

a. accountability - must be answerable for nursing care 24 hrs a day.

b. autonomy - self-governance.

c. co-ordination - ensures smooth flow of nursing care from shift to shift with direct

communication from care givers.

d. comprehensiveness - each care giver gives all the nursing care required during the course of a shift.

Primary nurse have the responsibility of assessing, planning care, implementing it and evaluating care.

Added responsibility of teaching, researching and managing others in the team.

Associate nurse - EN or junior SN.
Associate nurse whose function involves the continuation of care according to the primary nurse's plan either under her / his supervision or in her / his absence.

Cares for the patient in the absence of the primary nurse and may adjust care as necessary.
Works very closely with primary nurse to co-ordinate patient's care and contribute to a rich information exchange.

Care Assistant – Nursing Aide
Help primary nurse and associate nurse by carrying out the non-nursing duties.

Although not a qualified nurse, must be included with others as part of the team.

Contributes to decisions about the unit as well as offers observations on patients' care.

Helps in evaluating care.

Ward Sister / Ward Manager
Radical transformation from traditional role.

From total control of nursing team to individual autonomy and accountability of each primary nurse.

Acts as a support for colleagues.

Monitors and supervises care to ensure safe practice some primary nurses may initially need greater help than others.

Acts as co-ordinator, must avoid fragmentation of ward environment.

Named Nurse

Wright (1992) said that primary nursing is probably the most highly developed form of named nursing.

Wright (1992) and Hancock (1992) agreed that primary nursing, team nursing and patient allocation were the most stable vehicles for named nursing. They rejected task allocation as inappropriate, as the named nurse looks after the whole patient.

Continuity of care is a key issue in named nursing, and a shortage of trained nurses is cited as the major detriment to maintaining the named nurse.

Case Management

Latest work design proposed to meet patient needs.

Can be defined as a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Gletter & Leen 1996).

Focus is on individual clients and not whole populations. Handles each case individually, identifying the most cost-effective providers, treatments and care settings for insured individuals.

Case Management is composed of three basic models:
1. Brokerage case management model: Case Managers identifies needed services and makes referrals to various sources but does not directly provide the service.
2. Service management model: The case manager manages both the client's service budget and directly provides most if not all services.
3. Managed care model: Providers are paid for the services prospectively.

Some healthcare organisations use the term case management to define a client-centered model of care that uses critical pathways and multidisciplinary action plans to help plan patient care.