Clinical Nurse Leader
EVOLUTION OF A REVOLUTION

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The Partnership Care Delivery Model

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The membership of the American Association of Colleges of Nursing, in partnership with its practice partners, has initiated a national effort to create a new nursing role that is more responsive to the realities of a complex, technologically advanced, ever-changing healthcare system. This new role is the clinical nurse leader. Nurses in this new role will be prepared at the master's level and will act as the lateral integrators of care, patient advocates over the many components of the care continuum, and information manager to the multiple disciplines involved in care delivery. Practice and education partners are working together to define the curriculum for this role and create a new care delivery model needed to maximize the skills of the clinical nurse leader and other team members to achieve better patient outcomes. In this article, the third of 6, the author presents a summary of system drivers that are mandating the need for change and an overview of the Partnership Care Delivery Model. This model, which is being implemented at Maine Medical Center in Portland, Me, has been developed to provide the necessary support and practice environment for the clinical nurse leader to function as envisioned by the American Association of Colleges of Nursing and its practice partners.

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Healthcare has changed dramatically in the last 20 years, and nursing has adapted its work to meet those demands. The time has come to make significant change to support safe patient- and family-centered care in a complex environment. It is within this context that the role of the clinical nurse leader has been conceptualized. Academic-practice partnerships have been established to provide education and the necessary clinical environment to support the role. At Maine Medical Center in Portland, Me, the Partnership Care Delivery Model has been developed in response to the pressing need for patient care delivery systems that are appropriate for healthcare delivery in the 21st century.

"Dramatic changes in healthcare—an aging population, growing diversity, biomedical advances—all require nurses with more knowledge, more education, and more skills."[1(p221)] However, the environment in which nurses practice is conspiring against them to deliver the level and quality of care they desire. The present healthcare system is an aged delivery model functioning in a problematic infrastructure. As new solutions are crafted, it is important to assure that mistakes that have been made in the past are not repeated. In particular, we need to understand the sources of dissatisfaction for nurses; the staccato pace and high demand of their work, which is increasingly task focused; and the changing role of the clinical nurse manager and how all of these factors contribute to fragmentation in patient care.

The Work of Nurses

Aiken and colleagues[2] clearly demonstrated the extent to which nurses are "burned out" and dissatisfied with their jobs. In a cross-sectional analysis of data from 10,184 staff nurses, they found that 43% were experiencing "high emotional exhaustion"[2(p1990)] and 41% were dissatisfied with their current job. Of the nurses with high burnout and dissatisfaction, 43% stated that they

intended to leave their job within the next 12 months.

What is it about the work that nurses find dissatisfying? A study by Tucker[3] provides some answers to that question. Tucker observed 26 nurses in 9 different hospitals for a total of 239 hours.[4] Observations were made on all 3 shifts and all days of the week to ensure an accurate representation of their work.[5] The observations included multiple nursing units and ranged from 75 (at a time) to 814 minutes. In a typical 8-hour shift, Tucker found that nurses cared for an average of 6 patients. They completed 160 tasks with an average task time of 168 seconds (2 minutes 48 seconds). On average, a nurse spent 35% of her time in direct patient care, which is equivalent to 25 min/patient during an 8-hour shift.

Tucker also observed 194 failures, which included problems (n = 166) and errors (n = 28), occurring approximately every 1.6 hours of observation. A problem was defined as "a disruption in a worker's ability to execute a prescribed task"[4(p57)]; examples of problems included missing supplies, information, or medications. An error is when a task is executed, either incorrectly or unnecessarily, and is seen as being avoidable. Thirty-three minutes per shift—approximately 8% of the total shift time available—were lost coping with problems and errors.[4]

Most of the time (92%), nurses coped with these problems and errors by first-order problem solving. This means that they used a short-term remedy that allowed the work to continue but did not address the underlying organizational routine that contributed to the problem in the first place. Although this often had the effect of immediate gratification by overcoming the problem, the root cause was not addressed, thus making it likely that the problem would recur. This tension acted as a stressor and contributed to nurse burnout. Tucker and Edmondson made the point quite eloquently when they stated, "[Nurses] experience an increasing sense of frustration, exhaustion, and, in some cases, leave the organization—worn out by the task of swimming upstream against an incessant tide of small, annoying problems."[4(p66)] It is exactly this phenomenon that drives turnover and dissatisfaction as documented by Aiken et al.[2]

The other finding from Tucker[3] is the pace of work performed by nurses, such as the 160 tasks during an 8-hour shift. Furthermore, when nurses were observed for an entire 8-hour shift, 9 of 10 stayed an average of 45 minutes after their shift ended to complete patient care duties. Meals were eaten in less than the time allotted and breaks were postponed or not taken at all.[4] This staccato pace was found to be unrelenting and exhausting.

Many hospitals, including Maine Medical Center, have attempted to address these issues by creating more flexible scheduling and reducing the work week to three 12-hour days. For most nurses, 12-hour shifts are rarely scheduled more than 2 days in a row. The number of part-time staff has also increased. Unfortunately, this combination of part-time staff and 12-hour shifts has diminished the continuity of care and compromised the monitoring of the ongoing progress of the patient.

Further exacerbating the continuity problem is the changing role of the nurse manager. There was a time when the manager had a strong clinical presence and involvement, but not now. Today many managers are responsible for multiple units and function as department heads. They represent the staff at budget and administrative meetings. All of these activities have enhanced their administrative influence and impact but have taken them away from the clinical units, resulting in less involvement in clinical care.

In summary, nurses are working at a staccato pace, increasingly task and shift driven, managing problems and error due to system failures, working 12-hour shifts, causing fragmentation of care and reduced continuity of care, and dissatisfied with their roles. The questions that must be asked are the following: Who knows the patient story from beginning to end? Who is managing patient care to identified outcomes?

Looking to the Past to Understand the Future

The healthcare system that exists today is a product of the industrial age, an era that is rapidly ending as we move into the information age. The industrial age gave us many benefits, including processes to feed the world, dramatic advances in science and technology, and a safer, healthier world for its citizens.[6] Industrial age models of work were built on linear processes. Industrial age organizations were

hierarchical with structure and authority in place. This is evident in healthcare institutions, with functional divisions of labor, departments, and control mechanisms firmly established. Nursing, which matured in the industrial age, is not exempt. Today, hospitals maintain this model, with organizational structures, chains of command, defined policies, and roles that promote separate and distinct departments. The modern hospital is a building of silos—small entities—each unique to themselves. This model, a product of the industrial age, is neither workable nor feasible in the modern information age.

Another key driver of our healthcare system are costs and changes in payment systems. The US healthcare system, fueled by the Medicare Act, is the most expensive in the world. For 25 years, US healthcare expenditures have experienced double-digit growth, reaching $1.4 trillion in 2001.[7] There has been a relentless drive to reduce costs, which has dramatically changed how healthcare is delivered. Key is that patient care or stays have become shortened and fragmented. Patients are sicker and leave the hospital sooner, which has resulted in the staccato pace documented by Tucker.[3,5] Care has shifted from hospitals to ambulatory centers. Hospital capacity has tightened, as hospitals have reduced the number of beds or even closed completely.

Care coordinators and case managers have emerged as a way of dealing with the fragmentation. Although the role was originally designed to coordinate care over the continuum, it has evolved as a way to be efficient and use scarce resources. Although we have worked to adapt to this changed environment, it has become apparent that the solutions have been incremental, not fundamental. What is needed is a transformational change, one that recognizes the complexity of the healthcare environment.

The Partnership Care Delivery Model as Transformational Change

The Partnership Care Delivery Model is proposed as a transformational change. The clinical nurse leader's role will be key, but all disciplines are critical and must be at the table and actively engaged for the partnership to work. Nurses are in the ideal leadership role to bring about this transformational change. Throughout history, nurses have been the single group of professionals who have consistently known the patient and have always been willing to do what it takes to provide the care that the patient needs. It is clear that over the years, nursing has tried to adapt to changes that affect our profession. However, our focus has been on the workforce, not on the work itself. We have also tended to remain within our discipline, adhering to the industrial age, departmental model. In this era, this is no longer feasible. To quote from Albert Einstein, "We cannot solve our problems with the same thinking that created them." It is in this environment that change is proposed.

Complexity science offers a way to view these challenges in a different light. Within the realm of complexity science, the world is not viewed as a simple place and simple linear solutions are not effective. It is clear that the lack of progress to change our healthcare delivery model is because of our failure to recognize our interdependencies. We have tried to change in isolation while practicing in a dynamic, interrelated, and constantly changing environment. Wheatley has described it, thus, "Each of us lives and works in organizations designed for Newtonian images of the universe. We manage by separating things. We believe influence occurs as a direct result of force exerted from one person to another. We engage in complex planning for a world we keep expecting to be predictable, and we search continually for better methods of objectively measuring and perceiving the world."[8(p7)] However, the world we are in is not predictable; we cannot predict the census or changes in disease management, even with rapid advances in pharmacology and technology.

Patient care is complex. It is delivered by multiple disciplines. The old model of compartmentalized care limits and inhibits high-quality patient outcomes. New behaviors are required to adapt. What has existed and what is needed can be seen as a push/pull of old and new. Cooperation must now be collaboration. Providers used to act as gatekeepers of information; now we must share information. The expert model must become a partnership model. Lastly, rigid systems must be replaced by those that are flexible.

The complexity of care, coupled with the fragmentation and compartmentalization of that care, has led to errors and omissions in care delivery. Since

the publication of *To Err Is Human,*[9] patient safety has become a national mandate. It can be said that many of the errors made in patient care are the direct result of the lack of partnership and collaboration among the multiple care givers who provide care. Although we have long asked the patients to be partners and consumers in their care, we have not required it of ourselves.

The Partnership Care Delivery Model is a system of care that has safe patient- and family-centered care at its core, with all the disciplines engaged in a partnership to provide patient-centered care. Other components of the model include education and support, collaborative practice, and effective communication. The word partnership, as opposed to cooperation, has been specifically selected. People who cooperate "play nice in the sandbox," whereas those who are partners share an equal load of the risks and benefits and are invested in the outcome. To be successful, a high degree of collaboration will be required. Barriers that have long existed must be broken down. All players need to be at the table and be part of the process. Successful collaboration consists of communication, strong interpersonal relationships, based on trust, and time.[10] This work will not be completed in a meeting or a day-long retreat. As we are discussing transformational change, each person needs to have the time to learn, understand, and embrace it. Therefore, the time that leadership invests in bringing all the disciplines to the table will directly affect the success of the partnership model.

At Maine Medical Center, the process began with a day-long retreat. Before the retreat, we asked each participant to interview a patient or family member regarding their experience during an episode of care. Participants were asked to have the interviews last a minimum of 30 minutes to truly understand the patient/family perspective and give adequate time for their thoughts to be fully expressed. At the retreat, the morning was spent with participants sharing patient/family perspectives on care, the environment, communication, positive and negative experiences, and gaps in care and service—data they had collected during their interviews. This exercise brought the patients and families "into the room." It also eliminated the disciplinary barriers that usually exist, since participants came from all departments throughout the hospital. It put all the participants on a level playing field as we began to accept the responsibility of being partners. From this foundation, each participant and the group as a whole began to think about how to realign their care and service to a model of patient-centered care. For many, it was a morning of "aha" moments.

The Partnership Care Delivery Model values and embraces the interdependencies we all have in providing care and involves all disciplines, not just nursing. Since the initial retreat, work has continued for more than a year. Changes have shifted our culture. Patient Advisory Council members are now included in the work as a way to keep the patient's and family's voice at the table. The hospital strategic plan has been modified so that "Safe Patient and Family Care" is the number one area of focus. Every department in the hospital is expected to provide one performance improvement project each year to support the Safe Patient and Family Centered Concept of the Partnership Care Delivery Model. Every day we see more evidence of being partners with our patients and families and with each other.

The silo walls of the hierarchical structure are softening; the realignment of care and service around the patient is resolving system inefficiencies that were created by departmental priorities. Examples include signage that has been redesigned from the patient and family perspective. Dietary is "reclaiming" non-nursing work that had been picked up by nursing, and by doing this, they are finding that they provide better service through their room service model. Daily interdisciplinary rounds on every unit provide the basis for care priority setting for the patient and family and plans for how the care will be delivered. Patient-centered care is the priority instead of discipline-driven routine. Longer-range plans, such as building projects, have incorporated patient and family input into the design. In all, partnerships with patients and families have shifted the culture, and the positive outcomes of safer, high-quality care have brought the Maine Medical Center family to a new level of achievement.

Conclusion

Maine Medical Center has entered a period of transformational change with the implementation

of the Partnership Care Delivery Model. With our academic partner, we are creating an environment that will optimize patient outcomes and support the emerging role of the clinical nurse leader. The work, to date, has been challenging but rewarding. We constantly remind ourselves that change is difficult but required of us as leaders. We realize that the transformation in healthcare that is occurring is so dramatic and far-reaching in our complex, adaptive environment that it is impossible to comprehend. Embarking on this journey has required courage, risk, and energy. The partners have all committed to this process because we realize that the alternative of inaction presents a much greater risk to our patients and our profession.

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