Using the Quality-Caring Model to Organize Patient Care Delivery

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The organization of patient care in many acute care institutions lacks a foundation in nursing theory, yet preliminary evidence of the value of professional nursing care is increasing. The process and preliminary benefits of organizing patient care according to a professional practice model are presented using a collaborative partnership between an acute care organization and a school of nursing. A pilot implementation plan with formative and summative evaluation provided preliminary evidence used in project expansion.

Organizing how patient care is delivered is a managerial function that includes how responsibilities for patient care are assigned, work is coordinated, clinical decisions are made, communication occurs, resources are allocated, and goals are accomplished. Traditionally, these components were combined to form “patient care delivery systems” such as total patient care, functional nursing, team nursing, and primary nursing.1 During the 1990s, acute care institutions and the nursing workforce entered a powerful period of transition. The organization of patient care in hospitals took on new forms and included multiple workers who shared responsibility for patient care with registered nurses (RNs). Although some of these approaches helped decrease costs and offset the burdens of the nursing shortage,2-5 the result is that fewer professional nurses are providing care to sicker patients in shorter periods of time.

Consistent with many US hospitals, Holy Cross Hospital in Silver Spring, Maryland, organized patient care on medical-surgical units using support from patient care technicians in a 50- to 60-RN to 40- to 50-patient care technician staffing scheme. Registered nurses delegated specific tasks (such as vital signs and hygiene needs) to patient care technicians while assuming higher level tasks, such as medication administration and overall accountability for patient care. In 2005, concerns related to RN–patient care technician interactions, “willingness” to accept assignments, skill levels, and RN delegation and follow-up abilities, were verbalized. Registered nurses expressed frustration with the work environment and reported finding themselves driven further away from the bedside. This is consistent with the literature in which RN–unlicensed assistive personnel relationships were found to be stress provoking to nurses.6 Furthermore, some objective measures such as patient reported pain, patient and nurse satisfaction, and nurse vacancy rates needed improvement.

Interestingly, most such patient care delivery systems were implemented for financial reasons or to ease the nursing shortage and were implemented without sound reliance on nursing theory or empirical evidence that they were beneficial. Only recently, the Magnet Recognition Program7 has the emphasis on professional models of care that provided the impetus for theoretically based nursing practice. However, evidence that increased numbers and better educated professional nurses positively influence patient outcomes is beginning to...
Nursing and, in particular, the caring behaviors of nursing are consistently tied to hospitalized patients' satisfaction levels as well as other outcomes variables. Nurses themselves report that contact with patients is a job satisfier. Responding to this evidence, some nursing administrators have adopted caring-based or relationship-centered theories to guide their practice, yet little could be found in the literature about associated care delivery systems and less still regarding their impact on patient outcomes.

**Process**

Holy Cross Hospital Division of Patient Care Services in collaboration with The Catholic University School of Nursing designed a professional infrastructure that honors the vital role of nursing while responding to the unique needs of patients and families. The Quality-Caring Model laid the groundwork for professional nursing practice and provided the basis for organizing patient care in this 352-bed acute care hospital. The major proposition of the model that "relationships characterized by caring contribute to positive patient, nurse, and system outcomes" was consistent with the organization's mission and the philosophy of nursing.

In Spring 2006, groups of staff nurses, nursing leadership, and others supportive to nursing in the organization entered into unprecedented discussions about quality patient care, nursing, and the future. The active participatory relationship with The Catholic University School of Nursing facilitated by a Health Resources and Services Administration Nurse Education Practice and Retention award guided understanding of the theory, development of a pilot implementation plan, and evaluation of the results. The project principal investigator and the chief nurse executive jointly shared responsibility for the project and used a facilitator to guide the process.

First, a series of lunchtime leadership workshops were held to stimulate discussion and improve knowledge of the model. Simultaneously, a 32-hour educational program (see course objectives in Figure 1) was implemented to expose staff to the principles of the Quality-Caring Model. The importance of guided leadership development and staff education concerning an adopted practice model cannot be overestimated. It was during these sessions that the true nature of nursing was examined, whereas the risks and benefits of practicing in this manner were exposed and agreed upon.

During the second design phase, a strategic design team (composed of staff, clinical specialists, and leadership) used a set of Guiding Principles (Figure 2) developed by the theorist to create specific aspects of the care delivery system. A unique feature of this developmental activity was that the group determined the elements of the delivery system in contrast to other models where "off the shelf" replication of elements have been used. The theoretical constructs of whole system change and large group intervention shifted the leaders' control over outcomes. This transfer in leadership roles from identifying and solving problems to allowing the collective wisdom of the group to emerge was used successfully to facilitate openness, flow of ideas, and ultimately specific revisions in practice.

Based on the powerful work of the strategic design team, patient care was organized using 5 components (Figure 3). Central to the patient care

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**Figure 1. Relationship-centered caring course objectives.**

- Describe the multiple dimensions of relationship-centered caring including interdependence, community, and cultural competence.
- Interpret the human experience of health and illness and its various meanings among diverse populations.
- Identify the nature of caring relationships.
- Examine the philosophical/theoretical foundations including the multiple dimensions of relationship-centered caring including interdependence, community, and cultural competence.
- Identify barriers to the integration of psychosocial and biomedical issues in health care, and strategies for overcoming these barriers.
- Analyze the threats to the integrity of caring relationships, including social and cultural differences, and characteristics of the caregiver, the patient, and the health care system.
- Synthesize information from theory, practice, and research findings in the relevant literature.
- Practice human interaction skills such as effective communication, active listening, collaboration, acceptance, and other techniques for developing and maintaining caring relationships.
- Develop a plan for professional development including strategies to enhance self-awareness, the capacity for regular reflection, and continuous learning.
delivery system is the patient experience that honors the holistic nature of humans and the patient/family as the authority for care received. This component recognizes cultural and intergenerational aspects and assumes that healthcare decisions are made in partnership. Placing the patients’ experience at the center of the system reminds clinicians of the vulnerability of the hospital experience and the responsibility to meet patient needs and preferences. To that end, beginning with the admission assessment, 3 specific questions were created to help all providers come to understand the patient as person. They are the following: What do you want to be called while you are in the hospital? What is most important to you? And, how do you learn best? Answers to these questions are written on a white board hung in the patient’s room. They are made public with permission of the patient and are used by members of the healthcare team to facilitate interaction and promote recovery.

**Roles and Responsibilities of Professional Nurses**

Founded on the Quality-Caring Model,\(^2\) the work of professional nurses is focused on initiating,
cultivating, and sustaining caring relationships with patients and families, as well as other health professionals. In the context of caring relationships, professional nurses are individually responsible for intent, competence, and autonomous practice decisions within the scope of professional nursing practice. Along with an organization-wide shared leadership decision-making system, nurses are empowered to exercise their expertise at all levels of the organization.

Because professional nurse work is considered relationship-centered, nonrelational tasks are delegated to assistive personnel. Supporting the professional nurse are the health unit coordinator and the nursing assistant. The major function of the Health Unit Coordinator is greeting patients, family members and visitors, physicians, and others in a timely, courteous, and confident manner. Clerical functions such as transcribing orders, answering call lights, and medical record maintenance remain significant tasks. However, the emphasis in this patient care delivery system is warmly welcoming and honoring the needs of all individuals on the unit. Nursing assistants help the RN in the provision of direct patient care in accordance with state nurse practice acts. Nursing assistants are important contributors in this patient care delivery system and are encouraged to develop their careers through on-site RN education programs.

To facilitate the professional role, the strategic design team revised the RN job description and associated Professional Development Program. The role and responsibilities of the RN reflect the primacy of relationships and are aligned with an incentive system designed to enrich the practice of professional nursing. Professional nurses maintain competence in the Quality-Caring Model through annual competency fairs, self-learning activities, and ongoing reflection about practice.

Caring Practices
Specific caring practices that help RNs stay focused on relationships and engage in frequent interactions with patients and families differ from other care delivery systems in that they add a depth of practice that is expected, acknowledged, and rewarded. One example of caring practices used in this system is purposeful interaction. Purposeful interaction is dedicated uninterrupted time spent with patients and/or families. Providing this devoted time fosters authentic caring relationships and allows nurses and patients to mutually get “to know” the other. Purposeful interaction can occur at any time but must occur at least 5 minutes every 8 hours. Looking at the patient directly, the nurse sits down, chooses a subject personally meaningful to the patient/family, and initiates a conversation. The interaction continues for at least 5 minutes, and the RN is required to document the interaction and any pertinent information received. For patients too young or unable to converse, the nurse can use purposeful interaction with a family member or sit in silence with the patient.

Environment
Professional nursing care is accomplished within a caring-healing-protective environment. Nursing units in this care delivery system are distinguished as places of engagement, openness, and inclusion. Therefore, therapeutic lighting, peaceful places for reflection, inspirational artwork, and phrases and noise control procedures (such as no overhead pages during certain hours) help create a caring milieu within which to work and heal. To facilitate the caring milieu, the strategic design team justified the hiring of a “resource coordinator” who ensures that the environment is aesthetically appealing and that necessary equipment and supplies are available 24/7 allowing the professional nurse more time for direct patient interaction.

Resource Allocation
The Quality-Caring Model emphasizes the significance of nursing to quality health outcomes and minimizes non-value-added work. Nursing time spent “in relationship” is valued, and caring relationships are best cultivated when continuity is maintained. To that end, the design team created new rules for RN scheduling. Overall, an 80/20 professional/nonprofessional staff mix was agreed upon. Increasing the numbers of professional nurses with respect to unlicensed personnel was a decision made based on best evidence and was intended to directly reflect the relationship aspect of the Quality-Caring Model. Taking into consideration the average length of stay (4 days) and the personal needs of the staff, RNs choose to work either 8- or 12-hour shifts. However, those nurses working 12-hour shifts must work 2 consecutive days, and those nurses working 8-hour shifts must work at least 3 days in a row. The result of this scheduling pattern is that on any given day (24-hour period), a patient is assigned no more that 3 RNs; during a patient’s hospital stay, a patient is assigned no more than 8 nurses. While on duty, RNs are assigned consistently to the same patients and float nurses are consistently assigned to specific units. By decreasing
the number of nurses a patient encounters during hospitalization, patients develop meaningful relationships with a core group of nurses who are more aware of their needs and preferences.

Communication

Readily accessible and accurate information is integral to practicing within the Quality-Caring framework. The use of technology supports the RN and reduces time spent away from patients. An electronic documentation system with built-in caring language supports RN workflow. Wireless telephones decrease the amount of overhead paging and central telephone calls and allow patients and various health team members immediate access to RNs. Personalized clipboards with preprinted reminders assist the RN in organizing thoughts for discussions with physicians and provide a list of caring factors. Individual e-mail accounts facilitate communication among RNs and hospital administration. Access to the nursing literature directly from the nursing unit allows for evidence-based clinical decision making, a major component of the Quality-Caring Model.

Implementation and Evaluation

In phase 3, a pretest-posttest pilot study approach was executed, and selected patient and nurse outcomes indicators were chosen for evaluation. For 3 months, the redesigned patient care delivery system was gradually integrated on 3 units (1 medical, 1 surgical, and 1 intermediate), randomly chosen from a list of medical-surgical units. Units not participating in the pilot study continued to deliver usual nursing care. The evaluation plan included both formative and summative aspects. Before implementation, staff RNs were invited to 2 all-day meetings to provide feedback and offer suggestions for improvement. The meetings were carefully designed to elicit responses to the organizing elements via the following questions: (1) What did you hear? (2) What are the connections to the Quality-Caring Model? and (3) What are the challenges?

In keeping with the principles of engagement and whole system change, boundaries and primary stakeholders were identified and also used in formative evaluation. Key hospital stakeholders including the chief executive officer, the medical staff, pharmacy, case management, evening/night nursing coordinators, and human resources were sought out for discussion. The director of human resources was an especially important stakeholder since roles and responsibilities of professional nurses and unlicensed personnel were revised. Finally, presentations were made to the medical staff and hospital board of directors to gain their support for the revised design.

To summatively evaluate the influence of the revised care delivery system, indicators were chosen that represented patient (satisfaction, pain, functional status) and nurse (vacancy rates, nurse satisfaction) outcomes indicators of interest. After 3 months, findings include patient satisfaction rose 2.71%, patient reported pain decreased 33% from a high of 3.5 to 1.1, and patient functional status remained unchanged. Nurse vacancy rates decreased 18.55% from 22.1% to 18%. Overall nurse satisfaction rose 20% from 64% to 77%. In addition to these measures, focus groups were held with staff nurses from implementation units to elicit feedback about the revised patient care delivery system. Responses from the focus groups indicated that purposeful interaction “makes patients feel special”; the resource coordinator “allowed nurses more time to spend with patients and families”; and the RN staffing changes, although difficult, ensured that caring relationships were primary. One surgeon commented that a surgical unit “was a delight to practice on.” Issues needing refinement included the revised roles and responsibilities of RNs and nursing assistants and open visitation.

Although only preliminary, these results were used to justify expansion to other hospital units. Ongoing modifications to adapt the model to specialty units such as intensive care, operating room, labor and delivery, and emergency departments are necessary. Finally, further evaluation including financial indicators is warranted.

Conclusion

Recognizing that healthcare organizations have differing missions and patient populations, the organization of patient care described here is not prescriptive, rather using guiding principles, it allows for flexibility in design. It is consistent with state nurse practice acts, professional standards of practice, and the American Nurses Association Code of Ethics. Nursing work is maximized in this care delivery system because it recognizes and honors the full capabilities, expertise, and values of nursing. In addition, it establishes a clear value for the many nonfunctional clinical activities related to nursing performance. Most important, the theoretically based patient care delivery system preserves the professional aspects of nursing that current evidence suggests are crucial to quality patient care.
References