Searching for the Holy Grail of Care Delivery Models

EXECUTIVE SUMMARY

- Too often health care executives state the need for more research, knowledge, and information in staffing.
- Perhaps what we really need is education and support for innovation in operations.
- In looking for the holy grail of staffing solutions, focused attention will need to be placed on creating innovative care delivery models.
- Leaders who are tasked with developing innovative care delivery models must have a supportive environment and given time to be successful.

It has been nearly 2 years since the publication of Excellence and Evidence in Staffing: A Data-Driven Model for Excellence in Staffing (Anderson et al., 2014). In the last section entitled “Moving Forward” (p. 30), next steps were identified in which all stakeholders were needed to resolve many of the issues faced today. These included standardizing staffing terminology and metrics, identifying needs for further research and resources to fill the gaps, creating forums for exchange of ideas and experiences, identifying ways to disseminate best practices, creating forums for exchanging ideas and lessons learned, developing a business case for excellence in staffing, and exploring new ways of using technology to support excellence in staffing. In the last 18 months, a PubMed search using the words nurse and staffing resulted in 603 articles, studies, and editorials in areas identified above. Some of the many topics from that search were articles and research on workload, patient outcomes, culture, staffing levels, and staffing committees. Many of those articles reinforced what we know to be true: staffing, patient outcomes, and nursing satisfaction go hand in hand.

All too often health care executives state the need for more research, knowledge, and information in staffing; there is not enough information and evidence yet. Given a 5-year range, in a PubMed search using the words nurse and staffing, 6,565 items were identified. So, here are some questions for those who think we need more research and information:

1. What information do we still need?
2. Are we really only looking for information that supports our current beliefs?
3. Are we paralyzed or too afraid to make the right decisions about nurse staffing based on what we know to be true and what we know we need to do?
4. Are we looking for a Holy Grail?

Supporting Innovation

Perhaps what we really need is education and support for innovation in operations. Education should entail how to best staff for ideal patient outcomes, and support for accomplishing that goal. I have spoken with many nursing directors across the country who were asked by top executives in their organizations to cut staffing and get back on budget. Then, 3 months later, the same executives are concerned about a spike in patient falls after staffing changes and want to know what will be done to fix this new issue. The spike in falls should not have been shocking to anyone. The research is there: reduced staffing increases falls rate. When decisions that go against the current level of evidence are made to get back on track with budgets, why is the outcome a surprise?

Health care delivery and payment methodologies are changing. Understandably, care delivery models of today need to change for tomorrow; a large piece of that is registered nurse (RN) staffing. There needs to be a balance in “innovative” care delivery models today and the future. A patient in the intensive care unit still requires intensive nursing care, and a patient on a medical-surgical unit still requires specialized nursing care. A safe level of care must be provided for these patients by an RN in an ever-shorter admission period.

So, in looking for the Holy Grail of staffing solutions, focused attention will need to be placed on creating innovative care delivery models. The term innovative care delivery model cannot be synonymous with less RN staffing. All too often the pressure to become innovative comes at a critical point, such as after a bad month for the hospital budget, when quick solutions are sought.

It has been said necessity is the mother of inventions, but in relationship to staffing, “Necessity is the mother of futile dodges” (Plato & Sigler, 1996, p. 140). Asking even your best leaders to be innovative at a moment’s notice will probably not result in positive
long-term change or outcomes and will surely result in poor patient outcomes.

**Leadership in Innovation**

So, if we were serious about innovation in care delivery models of today, beyond the necessity within a reactive moment to a bad budget month, what would that look like and how do we achieve it? As Sinek (2009) states, start with the question, *Why?* Beyond the mission and vision statement, why do we care for people in any organization? Profit and money are results, so think beyond why your organization provides health care.

Once a leader understands the why, move into a creative mindset placing the why at the forefront. There are multiple thoughts and perspectives about what innovation is, but consider the definition of innovation as a new and valuable creative idea that is realized (Johansson, 2006). Until it happens successfully, it is just an idea. Most ideas are not a eureka moment, but hunches. Managers should be allowed to pursue these hunches. Keep in mind incremental innovation takes a few years to realize, while breakthrough innovation can take 7-20 years (Baldwin, 2016).

One care delivery model that once was thought to be innovative, and still has the potential to be innovative, is the universal bed unit (it may be called something different based on individual state regulations). In this model, the patient stays in the same room throughout his or her stay and is taken care of by the same RNs who are competent in critical, step down, and medical-surgical care. This is the care delivery model in most critical access hospitals; however, it has been used successfully in larger hospitals as the only inpatient care delivery model.

Unfortunately, there have been a few barriers to this model’s success. First, organizations who have toyed with this model end up using it more as an overflow unit within the traditionally structured hospital. Second, because it has been used as an overflow, nurses are not educated and kept competent in all areas, which defeats the purpose of the model. And third, since this is traditionally an overflow type unit for many, when directors of true universal bed models look for comparison groups in quality outcomes and staffing matrix, the numbers do not reflect the result of a pure universal bed care delivery model. This model can be successful with time, attention, and patience to see the results grow over a few years, not next month. This includes the development of a new set of outcomes for this model instead of expecting it to perform within the same context of the outdated inpatient models.

Leaders who are tasked with developing innovative care delivery models must have a supportive environment and given time to succeed. This is tough, when most of the time, the culture and environment are structured with day-to-day, month-to-month outcomes to be met based on the current care delivery models. It is quite possible the solutions we need for innovative care delivery have outcome measures that do not match the outcomes expected of nurse managers today.

**REFERENCES**


