From the Editor-in-Chief

Nursing Practice Models: Time for Change

The organization of nursing care in acute care hospitals is increasingly challenging. The traditional models of primary, team and functional nursing, or even total patient care and combinations thereof, are insufficient in today's complex healthcare environments. Patient units in acute care are now characterized by extremely ill patients who require high levels of technical and assessment skills on the part of nurses; significant numbers of novice nurses who do not have these skills but must be integrated into these units; student nurses who require mentoring from experienced nurses; lack of continuity in patient assignments; short lengths of stay on any given unit, hindering nurses' ability to develop relationships and to negotiate patient participation in care decisions; 12-hour shifts that test nurses' energy and enthusiasm; lack of technology to support nurse-to-nurse wand interprofessional communication within and across shifts; and increased pressure for evidence-based and outcomes-oriented practice so that individuals and cohorts of patients achieve the highest possible outcomes of care. And these are just a few of the pressures confronting the average unit.

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Leadership is an obvious need if these pressures are to be managed. But research demonstrates that many nurse managers have extraordinary numbers of nurses reporting to them, more than any individual could reasonably expect to assess, mentor, develop or even know (McCutcheon 2004), in addition to the challenges of organizing and monitoring patient care. In many hospitals nurse managers are not highly visible on patient care units, as they attend to the many other demands on their time and expertise.

In a previous editorial, I noted that the requirement of a baccalaureate degree for initial licensure as a nurse in most Canadian provinces will result, over the next decade, in a much higher proportion of degree-prepared nurses in the workforce. These nurses expect and need greater autonomy and more leadership opportunities than have been typical up till now in most environments. Furthermore, the system needs to capitalize on this better prepared workforce by changing many aspects of the nursing role. Unless we use these nurses wisely, we will lose them.

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It is difficult to find research on, or even descriptions of, new approaches to the organization of patient care units in response to these challenges. I tried a number of words and phrases on the OVID search engine, but did not find very much. I discovered that if you enter "nurse deployment," you get articles about nurses being assigned to Iraq. "Nursing assignments" gets you a lot of material on float assignments, patient abandonment and travel nurses; "nursing organization" yields a mish-mash of articles. While "nursing practice models" seems the most productive combination, it does lead to the conclusion that the word "model" can be applied to anything, absolutely anything.

The work by Patricia Brennan and her colleagues (1998) at the University of Wisconsin and Case Western Reserve University is helpful in explicating the components of nursing practice models. These authors describe three main components: nursing care delivery, interaction among healthcare team members and unit environment. These components comprise 11 factors: "continuity of care, participation in management, collaboration, leadership, learning environment, nurse's role, staffing, communication, specialization, orientation of temporary staff and group commitment" (Brennan et al. 1998: 26). The challenge of changing a practice model is obvious, given the number and complexity of the factors involved.

The American Association of Colleges of Nursing proposed a new role to meet the challenges of today's clinical environments, the clinical nurse leader (CNL) (AACN 2003). The association notes that this type of role has already begun to emerge, and the proposal simply codifies what is already occurring. This is a generalist role, in contrast to that of a clinical nurse specialist or a nurse practitioner. The expectations of the CNL role are extensive: leadership in caring for sick people across all environments, provision of evidence-based practice, design of plans of care, identification and collection of care outcomes, delegation and oversight of care delivery, team management and collaboration with the interprofessional team, development of resources and management and use of client-care and information technology, among others (AACN 2003: 9). Although not explicitly stated, education is presumed at the baccalaureate level and would become the preparation for BScN nurses. It seems that a nurse in this role would function between the nurse manager (in acute care) and other registered nurses who do not have baccalaureate preparation.

One hospital in Florida (Smith et al. 2006) has reported on piloting a role that is similar in many ways to the CPL, although the authors refer to it as patient care coordinator (PCC). All the hospital's PCCs are master's prepared in a range of disciplines. Each is responsible for the "administrative and personnel management issues related to their assigned staff" (Smith et al. 2006: 29). The authors do an excellent job of describing the staffing patterns and the data that were collected to assess whether the new PCC role and the new practice model achieved the desired objectives: after 12 months, they seem to have done so. The PCCs were highly influenced by the work of Laschinger and her colleagues on nurse empowerment (Laschinger et al. 2000, 2001), and built self-governance and self-scheduling into their operation. On all the indicators for which they had data – nurses' job satisfaction, patient and physician satisfaction with nursing care, nurse–physician collegiality, length of stay, use of restraints and patient falls – the outcomes improved. Tellingly, the unit went from having to cover more than half its RN positions with agency staff to eliminating their use entirely, because all positions were filled. A puzzling aspect of this report, however, is the lack of any reference to a nurse manager, either before or after the pilot.

Perhaps the CPL role is part of the answer to the challenges of 21st century acute care nursing, although it may entail more than is possible or even necessary. Preparing this type of graduate would require modifying baccalaureate programs as they currently exist to include much more emphasis on leadership and accountability. On the other hand, the creation of CPL roles for these graduates would respond to the need for greater autonomy and more leadership positions. Clearly, however, it must be accompanied by other structural and organizational changes, essentially taking into account all 11 factors described by Brennan et al. (1998). To address the issues most often raised by nurses and patients would require multiple strategies, for example, organizing patients into smaller clusters cared for by consistent teams of nurses; assigning experienced nurses to mentor students and new staff and take responsibility for ensuring optimal patient outcomes; and providing consistent and competent nursing leadership. Such an approach would also offer the opportunity to integrate other disciplines within these teams, thereby enhancing interdisciplinary practice and students' education. The role of the nurse manager as we currently understand it needs to be examined to determine if and how it fits into this picture.

The article by Smith et al. (2006) provides an excellent description of how one hospital tackled a problem. I wish it had been published in *CJNL*. But I am sure there are other innovations out there, perhaps not as comprehensive as the one I've just described, but nevertheless demonstrating how new ideas and new approaches are being tried in the real world of patient care. Please write about

them – as case studies, as descriptive articles or as research projects. We look forward to receiving them.

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