EP5: Describe and demonstrate how nurses use the Care Delivery System(s) to make patient care assignments that ensure continuity, quality, and effectiveness of care within and across services and settings.

Riverside nurses use the concepts of the Vigilance Care Delivery System to make patient care assignments that support the continuity, quality, and effectiveness of care within and across services and settings. Structures and processes will be described and several examples of patient care assignments will be provided to demonstrate how patient care assignments are made across the continuum within and across services and settings.

**Structures**

The concepts of our care delivery systems serve as foundations for assuring that patients are assigned to the appropriate service, unit, room, and nursing staff. These concepts and their application to making patient assignments are summarized in the tables below.

<table>
<thead>
<tr>
<th>CONCEPT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Family Care Vigilance</td>
<td>In the care environment, the nurse’s watchful, continual oversight of the patient’s/family’s changing needs and responses resulting in effective clinical judgments, nursing actions, and intended outcomes.</td>
</tr>
</tbody>
</table>

**EXPLANATION:**
Assignments of patients to a nurse depends upon a number of factors, such as the patient’s diagnosis(es), condition, severity of presenting symptoms, physician preference, and appropriate knowledge and skill levels of nurses. The degree of care needed – the watchful, continual oversight of the patient’s/family’s changing needs and responses - is a key factor in making a patient assignment that will result in optimal outcomes for the patient.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Primary Care Vigilance</td>
<td>In the patient care department or unit, a team of RNs who assume responsibility and accountability for 24-hour/7-days per week, direct care of patients and families. (All RNs work with interdisciplinary team members to support optimal outcomes.)</td>
</tr>
</tbody>
</table>

**EXPLANATION:**
Placement of the patient in a unit where primary care is the staffing model signifies the level of patient need is highly acute, and the watchful, continual oversight requires nurses who have a smaller patient assignment. The ICUs, Special Procedures Lab, and PACU are examples of hospital units that employ only RNs. Occasionally, unlicensed assistive personnel (UAP) might assist with patient care, but almost all patient care is delivered by RNs.
<table>
<thead>
<tr>
<th>CONCEPT</th>
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<tbody>
<tr>
<td>Team Care Vigilance</td>
<td>In the patient care department or unit, a team of RNs and other caregivers who provide 24-hour/7-days per week, direct nursing care for patients and families. RNs lead the direct care team, delegating tasks and assignments that are appropriate to the skill and knowledge level of all nursing team members. (All RNs and nursing team members work with interdisciplinary team members to support optimal outcomes.)</td>
</tr>
<tr>
<td>EXPLANATION:</td>
<td>Placement of the patient in a unit where team care is the staffing model signifies the level of patient need is less acute, and UAPs can assist the RN in patient care delivery. The degree of watchful, continual oversight needed is less than in a primary care setting. Examples of units where team nursing is practiced are the medical-surgical units, rehabilitation unit, post partum/gyne area in obstetrics, telemetry units, and some parts of the ED. The ICUs, Delegation is also a related concept. According to the Illinois State Practice Act, RNs may delegate some patient care responsibilities to other RNs, LPNs, or UAPs.</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>Consistently and appropriately coordinates care delivery through the utilization of department, organization, and community models and resources; critical thinking; interdisciplinary teamwork; patient advocacy; and the unique nurse-patient connection.</td>
</tr>
<tr>
<td>EXPLANATION:</td>
<td>This concept is key in making patient assignments that match the needs of the patient and/or family. The RN must have the knowledge and skills to synthesize all aspects of the patient’s needs and all available resources into a care delivery plan for each care occurrence, shift, day, and hospital stay.</td>
</tr>
<tr>
<td>Health Teaching and</td>
<td>Consistently and appropriately employs strategies, including the art of translation, to promote healthy behaviors for patients and families.</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>EXPLANATION: The patient’s need for learning new behaviors or having current behaviors reinforced can affect the patient assignment. Addressing learning needs is just as important as any other aspect of nursing care and the RN must have the time and resources available to devote to activities aimed at health promotion and injury/illness prevention.</td>
</tr>
</tbody>
</table>
Quality

Consistently, appropriately and systematically enhances the quality and effectiveness of nursing practice through communication, documentation, initiation of change, creativity, innovation, participation in quality improvement (QI), evidence based practice (EBP), and research processes.

EXPLANATION:
The ultimate goal in making patient assignments is to provide the highest quality of care to achieve the optimal outcome for all patients. Quality and effectiveness go hand-in-hand: quality is the type of care delivered and effectiveness is the result of that care.

**CONCEPT** | **DESCRIPTION**
---|---
Consultation | Consistently and appropriately identifies and uses available resources to define and implement the plan of care.

EXPLANATION:
Occasionally the RN making patient assignments needs to consult with other nurses in making patient assignments. For example, the RN might need to seek clarification of regulatory requirements for staffing in some areas, such as in obstetrics. Department or service-level directors have the knowledge needed to make assignments that are beneficial to the patient and realistic and practical for the nurse. Consultation with the patient placement coordinator (Monday through Friday during the day shift) or house supervisor (nights and weekends) may be needed to determine potential admissions, discharges, and transfers of patients from one area to the other, such as from the PACU to the medical-surgical unit. Having appropriate an staffing plan for upcoming shifts requires knowledge beyond the unit environment.

**Policy**

The hospital plan for provision of care is another structure that supports patient care assignment guidelines. Riverside’s Hospital Plan for the Provision of Patient is a policy that defines all areas where care is delivered. This policy includes staffing guidelines for each patient care area. Following are excerpts from this policy, which address patient care assignments.

We believe patient care should be planned and goal directed, with continuous evaluation of the effectiveness and appropriateness in conjunction with the patient and his/her care providers.

The Riverside Medical Center staff will follow established procedures, treatments, interventions and care. Efficient, safe, and appropriate treatment, interventions, and care will be provided based on patient assessments, state-of-the-art practice, and desired outcomes with respect for patient rights and confidentiality.

The Hospital Plan defines the types of staff who render care to our patients across the continuum. Staffing plans and patient care assignments for hospital services are developed according to the level and scope of care that needs to be provided, the
frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently, comfortably, and confidently) provide the type of care needed. The hospital bases its staffing levels and assignments on a variety of factors including staff qualifications, physical design of the environment, diagnoses treated, co-occurring conditions and age and developmental functioning of patients.

In the Plan, every patient care department has defined populations served, hours of operation, services provided, staffing information, and the competencies RNs and other staff need to care for the specific population in the specific unit or department.

**Flex Meeting**

In addition to the conceptual bases of our Care Delivery model and the Hospital Plan, another structure to support patient assignments is a regular meeting of nurse leaders that occurs two to three times a week, or more often as the hospital patient census increases. The meetings are approximately 30 minutes long. The meeting, called Flex, is designed as a forum for nurse executives (the CNO, Vice President of Nursing Services, and/or Vice President of Perioperative and Procedural Services), nursing directors, the patient placement coordinator, managers, and ancillary representatives to share information about patient census. Regular ancillary staff who attend the meetings are a dietitian; a environmental services director or manager; Brenda Menard, RN, the Director of Case Management; Martha Bouk, RN, BSN, CIC, the Infection Preventionist; and the Director Patient Safety/Employee Health.

The dietitian attends to share any issues related to nutritional care and nurse leaders also share any issues from their perspective. Issues might involve warmth of food, timing of meal tray delivery, or isolation trays. A leader form environmental services and nurse leaders discuss any issues related to cleanliness of rooms and timeliness of getting rooms cleaned between patient discharges and admissions. For example, the laundry department had a problem of tape being stuck on sheets that went to the laundry services. This ruined the sheets and incurred unnecessary costs. The leader of environmental services brought several examples and managers took the examples of ruined sheets back to their units to show direct care staff what happened when tape was inadvertently left on sheets.

The Director of Case Management, Brenda Menard, RN, shares information on appropriate designation of patient admission status. The implementation of pay for performance processes from the Centers for Medicare and Medicaid Services and RAC (recovery audit contractor program) has made appropriate coding of admission status and patient placement a science (American Hospital Association, 2010). Brenda’s nursing staff is trained to help physicians and nurses determine the proper admission status for patients, which affects where the patient will be placed in the hospital and the level of nursing care needed.

Martha Bouk attends the meetings to share information related to proper placement of patients with specific isolation needs. The Director of Patient Safety/Employee Health
shares information on risk management issues. Other hospital staff may also on an ad hoc basis. For example, Jean Koehler, HR manager, shares information on employment of nursing staff, such as nursing position openings and recruitment practices, which can affect nurse staffing. Representatives from Educational Services might attend a Flex meeting to discuss educational needs or competencies of nurses. Other hospital representatives, such as social workers, come to the meetings to share updates.

During Flex meetings, regular reports on staffing, budget, length of stay, and call light results are shared between nursing managers and leaders, and nurse executives. This regular sharing of information has helped Riverside Medical Center to stay financially stable in an unpredictable environment. The term, Flex, actually refers to this part of the meeting in which discussion of flexibility in staffing needs and patient care assignments take place. Flex meetings and the activities and processes which occur in the meetings are enculturated into all areas of the hospital. Direct care nurses know the purpose of these meetings and the reason these meetings are held. Prior to the meetings, nurse managers touch base with their team leaders/charge nurses and direct care staff to assess the care delivery environment, the patient assignments and placements made.

*Process*: During times of high census, this same group of nurses and ancillary leaders/staff might meet several times a day to facilitate patient placement and patient throughput along the hospital continuum. Specific patient needs are discussed. Case managers and/or nurses work with physicians to ensure that discharges are being expedited if the patient’s condition warrants it.

*Outcome*: One example was several years ago during the influenza season: a patient was being discharged following a mastectomy but was waiting for a ride home. The surgical bed was needed for another patient who would be coming from PACU before the patient planned to go home (this was before RACs!). The Director of Women’s and Children’s Services had a bed in the OB/Gyne department. Leaders of the two areas knew the patient was a non-infectious case and the OB director offered an open room in the Gyne section of OB to hold the patient until discharge. The surgical unit nurse leader explained to the patient the reason for the transfer and provided the patient with any amenities needed to minimize disruption to the patient’s recovery. This discussion – and many others like it – demonstrates the collegial team atmosphere that is evident throughout the hospital when patient assignments and unit/room placements are made.

*Processes*

The nursing process built into the Vigilance Nursing Care Delivery model is assessment, problem identification, planning and outcomes identification, implementation, and evaluation. This process is applied to the process of making patient assignments.

*Assessment/Problem Identification*
One of the first considerations in making appropriate patient assignments is to place the patient in the appropriate unit/department, where the staffing ratios and knowledge and skill level of the nurses match the level of patient needs. Riverside’s acuity system and nurse-patient ratios affect unit-specific patient care assignments for individual units and will be discussed in more detail in EP11 and EP12.

The bed placement coordinator (Monday – Friday, days) or house supervisor (nights, weekends, and holidays) keeps a worksheet on a clipboard with all patients in the hospital. This nurse knows the location of empty rooms/beds; bed placement rules such as knowing patients undergoing detoxification are always assigned to 3rd Ortho/Neuro; the number and diagnoses of patients who are in short-term care areas such as the ED, PACU, or Cardiac Cath Lab and are waiting for or will be waiting for beds; special considerations such as type of isolation, gender, or requests for certain units; and expected admissions and discharges. This RN uses knowledge gained from many years of experience and collegial relationships with unit leaders and direct care nurses to make appropriate unit and room assignments.

Once the patient is assigned to a unit, the charge nurse or team leader on that unit assigns the patient to a nurse. This RN also makes patient assignments for each nurse starting a shift. Factors to consider/assess are proximity to other patients already assigned, types of isolation, and patient acuity. Each unit has acuity ratings that are assigned to each patient. The shift leader takes into account these acuity ratings so one RN is not assigned to care for all of the most complex patients. The nurse making assignments must also identify potential problems that could arise, such as a shortage of housekeeping staff that could slow down room cleaning between patients.

**Planning and Outcomes Identification**

The next step in making patient assignments at the unit level is to plan whenever possible for any unexpected events – a code 33 (Riverside’s cardiopulmonary arrest code), code CVA, code STEMI, code RRT, etc. This effects patient assignments in those areas. For example, a nurse from 5ICU (coronary care unit) carries a Code 33 pager. The unit leader making assignments needs to provide a patient load that would allow the RN to leave the unit quickly if necessary.

At the hospital or unit level, the nurse making patient assignments relies on Patent Placement Guidelines (see table below). These guidelines show where the protected patient populations – those with specific diagnoses – are placed. Placement guidelines are based on the knowledge and skill level or competence of the nurses in that unit to care for patients with those diagnoses. The following table shows how the dissemination of patient placement guidelines in medical, surgical, and critical care areas have affected each unit’s patient population throughout the hospital. These placement guidelines have been in place for many years and are updated as needed.

<table>
<thead>
<tr>
<th>PATIENT CARE SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT PLACEMENT GUIDELINES</td>
</tr>
</tbody>
</table>
**AS OF JULY 7, 2009**

<table>
<thead>
<tr>
<th>UNIT</th>
<th>TARGET CENSUS</th>
<th>CAPACITY</th>
<th>PROTECTED DIAGNOSIS</th>
<th>DO NOT PLACE THESE DIAGNOSES ON THIS UNIT</th>
</tr>
</thead>
</table>
| 4th Med/Peds | Winter = 20  
   Summer = 20 | 40       | Pediatrics           | Shapiro/Fox Actively Receiving Chemo |
| 2nd Med/Surg | Winter = 28  
   Summer = 28 | 40       | Surgical Oncology  
   Bariatrics  
   Radium Implants | T/A ^18  
   Medical Patients  
   Bedridden Shapiro/Fox |
| 3rd Orth/Neuro | Winter = 18  
   Summer = 18 | 36       | Orthopedics  
   Neurology  
   Detox  
   Stroke/CVA/TIA With DNR or Palliative Seizures | Pediatrics over 12 years  
   Medical patients |
| 3rd Med/Tele | Winter = 11  
   Summer = 11 | 12       | Telemetry  
   Cath Recoveries  
   Plasties  
   ACID  
   PPM  
   Stroke/CVA/TIA | |
| 2ICU | | 12       | Stroke/CVA/TIA  
   Trauma | |
| 5th Tele | Winter = 28  
   Summer = 28 | 33       | Telemetry | |
| 5ICU | Winter = 15  
   Summer - 15 | 15       | Post surgical CVOR patients | |

1. Please know the units census, when placing patients
2. If the first unit is at target number, look to the next unit in which the patient can be placed. Please use the above grid.
   Example: If the patient is a 54 year old pneumonia patient, the patient can go to 4th Med/Peds, 2M/S, or 3rd. Look to see what the actual census is, if the unit is at its target, and then go to the next that is not at their target.
3. The protected diagnosis still remains the same for the units.
4. Stroke patients to go to 3O/N or 3M/T or 2ICU

**Implementation**

Once the other steps are complete, the unit nurse leader posts the assignments on write-boards in units so everyone can see the patient assignment. In some units, patient assignments are made mutually among the direct care nurses.
Evaluation.

The unit patient assignments are evaluated throughout the day, and changes are made as needed. Effort is made to minimize changes to nurses’ assignments during the shift and to minimize patient transfers during hospitalization. Patient care assignments across hospital and service continuums are made to promote quality, effectiveness, and continuity of care.

The nursing process has been fully enculturated in all areas and at all levels of nursing at Riverside Medical Center. This process is our scientific foundation of care.

Example

One example of using the Care Delivery Model in making patient assignments to assure continuity and effectiveness of care can be seen in the Obstetrics (OB) department. This department is actually comprised of three areas: Labor and Delivery Unit (L&D), a Level II Nursery, and a Post Partum-Gynecology Unit.

When a laboring patient presents to Riverside, she goes directly to L&D for the admission process, bypassing the ED. The staff in the ED does not have the knowledge or skill level required to care for a laboring patient. In many cases, the RN who is working in L&D is familiar with the patient. Obstetricians send their patients to L&D for routine fetal monitoring such as non-stress tests during the course of their pregnancy. Some may visit the department on a weekly basis. These visits help to build a level of trust and comfort for the patient and her family during the pregnancy continuum.

Once admitted to L&D in active labor, the patient is monitored closely by the L&D staff, which consists of RNs and OB Techs. The L&D areas use the team care vigilance system, meaning caregivers other than the RN do have patient care responsibilities. OB techs can assist with the delivery. Care is delegated by the RN according to our state practice act.

The patient and family are orientated to the room and the equipment such as monitors and call lights. Comprehensive patient teaching is initiated on admission. This teaching includes what the patient should expect before, during, and after delivery. The L&D staff is vigilant with the patient during labor. They will quickly become aware of any maternal or fetal distress. If this does occur, the physician as well as the Operating Room (OR) staff is notified of a possible or pending emergency Cesarean Section. The L&D and Nursery RN accompany the patient to the OR and assist the physician with the procedure and delivery. Additional staff such as an Anesthesiologist and a Pediatrician may also be present at the delivery. The OR is directly adjacent to the OB department which aids in the seamless delivery of quality care.

When the patient is close to delivery, the physician is notified by the RN. An RN from the Nursery is introduced and is present for the delivery. If the patient is going for a
scheduled C-section, a nursery RN is also assigned as the FID nurse (father in
delivery). The RN’s responsibility is to care for the father in the OR, which can be
intimidating to family members. Having an RN with the father also protects the OR
environment in terms of patient and father safety. Patient teaching is continued by the
Nursery RN who instructs the patient regarding care of the infant during and directly
after delivery. For a normal vaginal delivery, the physician, an L&D RN and the RN from
the Nursery are present.

After delivery, the patient is monitored in L&D and the infant, who now becomes a
patient, is taken to the Nursery about an hour after delivery for routine care including
vital signs, cleaning, and foot printing. The infant is closely monitored by the Nursery
staff, where care can be team or primary care vigilance. The father is allowed in the
nursery to watch the assessment. Other family members may watch the staff attend to
their new addition through a series of picture windows. A new mother or father will not
have to walk far to see their newborn as the Nursery is only a short walk from L&D and
is located within the same department.

Following delivery, the patient recovers in the same L&D room where she delivered he
baby, and then is transferred to the Post Partum unit which remains in the same
department. (In the case of a C-section, the new mother recovers in the PACU). In the
Post Partum area, the new parents receive teaching from the Nursery RN with whom
they are already familiar. The Post Partum staff – RNs and UAPs – also provide
教学 for the mother. This continuity of care promotes a sense of comfort with the
staff. This comfort facilitates trust between caregiver and patient. This trust, so
important in any nurse-patient relationship, is vital when teaching care of the newborn.
The L&D, Post Partum, and Nursery nurses and UAPs work together to treat both
mother and baby and prepare them for discharge. It is not uncommon for the L&D staff
to visit the mother and her newborn on the Post Partum unit. Although considered one
department, OB is in fact three separate units which work together to provide quality
patient care for the new mother and the neonate across this service continuum.

The outcome is seen in our market share: approximately 70 – 75% of all deliveries in
the community occur at Riverside Medical Center. Our patient satisfaction scores for the
OB area have outperformed the national mean of the Press-Ganey database for the last
8 quarters in four main areas: pain control, nurses kept patients informed, friendliness
and courtesy of staff, and responsiveness to needs. These graphs are shown below.
How Well Your Pain Was Controlled

Data Source: Press Ganey
Exceeded the mean 7 of the 8 quarters (88% of the time)

Nurses Kept You Informed

Data Source: Press Ganey
Exceeded the mean 6 of the 8 quarters (75% of the time)
Data Source: Press Ganey
Exceeded the mean 8 of the 8 quarters (100% of the time)
Quality outcomes are also indicators of the success of the continuum of care across the OB service continuum, as seen in one graph below. For the 9 quarters preceding 4th quarter 2009, we were below the national Joint Commission mean for inpatient infant mortality. (Data for 4th quarter 2009 was not yet available at the time this narrative was written.)

![Inpatient Neonatal Mortality Graph](image)

**Data Source:** The Joint Commission Core Measures
Below National 6 of the 8 quarters

**Summary**

The structures which support continuity, quality, and effectiveness of care when making patient care assignments include our Care Delivery concepts of Patient/Family Care Vigilance, Primary Care Vigilance, Team Care Vigilance, Coordination of Care, Health Teaching and Health Promotion, Quality, and Consultation. The Flex meeting structure also supports the overall vigilance in making appropriate patient assignments to units and levels of care that are congruent with nurses’ knowledge, skill, and competence levels. The Hospital Plan for Provision of Care is another structure that supports appropriate patient care assignments. Our patient acuity scales assist with making patient assignments that are reasonable and practical while still meeting our established nurse:patient ratios. These ratios serve as guidelines only; many factors affect the patient care assignment and include the patient’s diagnosis, current condition, severity of presenting symptoms, physician preference, and appropriate knowledge and skill levels of nurses. The degree of care needed – the watchful, continual oversight of the
patient's/family’s changing needs and responses - is a key factor in making a patient assignment that will result in optimal outcomes for the patient.

Reference