



Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers
autorisés de l'Ontario



Position Statement

Strengthening Client Centred Care in Hospitals

Adopted by the RNAO Board of Directors on January 30, 2010.

Position

RNAO strongly supports the development of hospitals¹ utilizing a patient/client centred care model, where Ontarians have access to continuity of care and continuity of caregiver from a primary nurse. RNAO also strongly endorses strengthening inter-professional care so all health disciplines work closely to support high quality patient care in all health care settings.

Adhering to the appropriate skill mix and nursing model of care delivery is paramount to optimize patient, staff and organizational outcomes.

Excellence in patient/client centred hospital care is supported by three pillars:

- Models of nursing care delivery that advance continuity of care and continuity of caregiver by assigning each patient one nurse per shift, that nurse being an RN or an RPN working to full scope of practice and accountable for delivering the total nursing care required by that individual patient;
- Assignment of the most appropriate caregiver based on the patient's complexity and care needs and the degree to which the patient's outcomes are predictable, with RNs assigned total nursing care for complex and/or unstable patients with unpredictable outcomes, and RPNs assigned total nursing care for stable patients with predictable outcomes. Patients whose condition is unclear remain under the care of RNs to prevent shifting a patient back and forth between RNs and RPNs. When unregulated staff are utilized, they are assigned to assist RNs or RPNs, where appropriate and under supervision - with attention given to prevent disrupting the continuity of care provided by the assigned nurse; and
- Workforce stability, by achieving 70 per cent full-time employment for all nurses, supports continuity of care and continuity of caregiver, improves intra and inter-professional team work, reduces costs and facilitates staff satisfaction and retention.

Background

In letters to the Ontario Hospital Association² and LHIN CEOs³ dated October 23, 2009, the Ministry reiterates

that “new and expanded health care provider roles have been integrated in the system based on the principle of augmenting, rather than substituting or replacing one provider with another” and

that the Ministry supports nursing models of care delivery “that maintain continuity of caregiver”, including the Ministry’s ongoing commitment to 70 per cent full-time employment for nurses.

Access to Registered Nurses

Access to registered nurses (RNs) in all sectors is essential to achieve optimal health outcomes. There is conclusive evidence that relates care provided by RNs with better health outcomes in hospitals.^{4 5 6 7 8 9} A systematic review of the literature found that greater RN staffing was associated with lower hospital mortality such that an increase by one RN full time equivalent (FTE) per patient day would save five lives per 1,000 hospitalized patients in intensive care units, five lives per 1,000 hospitalized medical patients, and six lives per 1,000 hospitalized surgical patients.¹⁰ Models of nursing care delivery that undermine the importance of RNs’ knowledge and reduce direct care hours provided by RNs result in reduced continuity of care and caregiver, fragmented care, and higher morbidity and mortality. The evidence is that in hospitals RNs are more effective in improving patient outcomes and reducing cost.^{11 12 13 14 15 16 17 18 19 20 21 22 23 24}

RNAO Best Practice Guidelines

RNAO has developed evidence-based clinical and healthy work environment Best Practice Guidelines (BPGs) that, when applied, serve to support the excellence in service that nurses are committed to delivering in their day to day practice. Relevant Guidelines include: *Developing and Sustaining Effective Staffing and Workload Practices*,²⁵ *Client Centred Care*²⁶ and *Collaborative Practice among Nursing Teams*.²⁷ These BPGs should be used as markers in all staffing and scheduling practices and models of nursing care delivery.

Definitions

For the purpose of the *Strengthening Client Centred Care Position Statement*, the following BPG definitions apply:

Client centred care: “an approach in which clients are viewed as whole persons. It is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client’s autonomy, voice, self-determination and participation in decision-making.”²⁸

Skill mix: “the distribution of nursing personnel per skill category (i.e. RN, RPN) and per skill level.”²⁹

Three Pillars Strengthening Patient/ Client Centred Care:

Pillar 1: Continuity of Care & Continuity of Caregiver

Continuity of care and caregiver is fundamental to patient/client centred care. Skill mix applications done in the absence of a stated commitment to continuity of caregiver compromise both nursing practice and patient safety.

As set out in RNAO’s *Client Centred Care Best Practice Guideline*,³⁰ continuity of caregiver enables nurses to provide holistic patient care, facilitate higher coordination, and create clear accountability.

Continuity of caregiver enables all regulated nursing staff, RNs and RPNs, to participate in and be accountable for the entire care process, which is essential for patient safety, quality outcomes and nurse satisfaction.

Pillar 2: Most Appropriate Care Provider

Most appropriate care provider based on the patient’s complexity and care needs and the degree to which the patient’s outcomes

are predictable is central to patient centred care and ensures clear accountabilities:

1. Each patient is assigned one nurse per shift (RN or RPN) who works to his/her full scope of practice and is responsible and accountable for delivering the total nursing care required by that patient;
2. The patient's assignment to a RN or RPN is based on the level of complexity of the patient's condition, care requirements and predictability of the patient's outcomes, with RNs assigned the total nursing care for complex or unstable patients with unpredictable outcomes and RPNs assigned the total nursing care for stable patients with predictable outcomes;
3. Patients whose condition is unclear remain under the care of a RN to prevent shifting patients back and forth between RNs and RPNs; and,
4. Unregulated staff assists the RN or RPN as appropriate and under supervision, without disrupting the continuity of care provided by the assigned nurse.

This contrasts with team nursing, where three different roles – RNs, RPNs and unregulated providers – each provide one component of nursing care. The result is fragmentation of care where the incidence of medication error increases, assessments are overlooked and patient safety is put at risk.^{31 32 33}

While sometimes introduced under various names for the sake of innovation and cost-cutting, team nursing is neither new nor cost-effective. Team nursing was the prevalent form of nursing care delivery model prior to the advent of primary nursing in the 1980s. Since then, primary nursing, where RNs are assigned responsibility for a caseload of patients, has been the dominant model of nurse deployment in hospitals.³⁴ While sometimes looked to in aid of hospital re-engineering efforts, the team approach has not proven to save costs.³⁵

In fact, the assumption that RN care is financially unsustainable is not supported by the evidence. Research relates increases in RN staffing levels with reducing hospital lengths of stay, thereby saving both lives and money.³⁶ A higher proportion of RNs can prevent adverse events that prolong a patient's hospital stay. Also, the higher knowledge and skill levels of RNs can lead to more effective nursing care and lower patient resource consumption.³⁷ A US study found that increasing the proportion of RN time over LPN time without increasing overall nursing hours both reduces hospital mortality and cuts costs.³⁸ Hospital administrators seeking to cut costs should be looking at strengthening the full-time RN workforce.

Pillar 3: Workforce Stability

Continuity of care and caregiver must be supported by full-time employment practices in all sectors. A level of 70 per cent full-time employment for all nurses is considered the minimal condition for ensuring continuity of care and continuity of caregiver for patients.³⁹

Evidence shows that workforce stability, with higher proportions of full-time RN staff, is significantly associated with continuity of care and continuity of caregiver, and with lower mortality rates and improved patient outcomes.^{40 41 42} Conversely, excessive use of part-time and casual employment for RNs is associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work,⁴³ disengagement among nurses, and lack of continuity of care for patients.^{44 45}

RNAO has long advocated for 70 per cent full-time employment for all nurses.⁴⁶ Full-time employment of RNs increased from a low of 50 per cent in 1998 to 65.4 per cent in 2009. Full-time employment of RPNs increased from 48.3 per cent in 1998 to 58.6 per cent in 2009.⁴⁷ This is dramatic progress that has resulted in better retention, better

quality of patient care and more people wanting to enter the profession.

Additional Organizational Processes

Additional organizational processes that strengthen patient/client centred care in hospitals and strengthen inter-professional collaboration include: nurse managers with a span of control that supports their engagement with staff;⁴⁸ in-person nurse to nurse shift handovers;⁴⁹ ⁵⁰ frequent nursing rounds and interdisciplinary rounds where all health disciplines discuss patient care in a culture of shared decision-making;⁵¹ and better utilizing the knowledge and skills of registered nurses in different roles, such as Clinical Nurse Specialists (CNSs).⁵²

RNAO recommends that hospitals centralize Alternate Level of Care (ALC) patients into one or more dedicated units, rather than having those patients dispersed across all units. In this way, ALC patients who are stable with predictable outcomes would receive their entire care needs from a primary RPN who is accountable for the entire care process. ALC units should also have the appropriate level of RN staffing to care for patients whose conditions require the knowledge and competencies of a registered nurse.

Conclusion

Evidence is overwhelming that nursing models of care that advance continuity of care and continuity of caregiver from the most appropriate nurse ensures safe, high-quality patient centred care. The most appropriate nurse, RN or RPN, is assigned based on the patient's complexity and care needs and the degree to which the patient's outcomes are predictable.

Rolling back the clock to models of care delivery that are variations on "team nursing" result in fragmented care and are detrimental to patients and to nurses. Deskilling patient care by lowering the RN-

to-patient ratio compromises nursing practice and patient outcomes.

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