Execute Change in the Delivery of Care

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 Working as an agency nurse at various facilities located in Michigan has its challenges in adapting to multiple different environments in providing care to those in need, primarily inpatient long-term acute care and rehabilitation services to the chronically critically ill. At the same time working to ensure high quality health care and cost effective outcomes. It is a complex system made up of subsystems. The subsystems are the nurses and various care teams responsible to provide care to an individual while focusing on objectives and achieving a common goal developed between the team and the patient. The environment and the characteristics of the system thinking, with a proposed plan to execute change in the delivery of care to achieve outcomes are explained in this paper.

**Current Care Delivery Model**

 Providing care at one facility in particular comes to mind. At this facility multi-interdisciplinary teams provide care to individuals to improve their quality of life. One would assume that the interaction between team members would be a smooth process. Chronically critically ill patients are complex and require exceptional teamwork to achieve successful outcomes.

 How one organizes to deliver care is crucial in providing quality care. How the team, in particular the nurse caring for the patient, interacts and communicates with the physician and other team members is vital. Communication is the key to how successful the organization functions and determines the effectiveness of interventions provided to the patient. Unfortunately, this facility talks highly of teamwork but they are stuck to total patient care when it comes to delivery care models. This may be due to the shortage of nursing staff, and the high turnover rate.

 This facility/unit strives on communication. It is a twenty-bed unit. Leadership management is located directly on the floor. Management consists of the nursing officer, director of quality management, and director of respiratory services. Also included in the staff are clinical liaison, admissions/case management, admissions coordinator, discharge planner, wound care nurse, charge nurse, staff nurses, patient care technicians, unit secretary, respiratory therapist, occupational therapist, physical therapist, speech therapist, dietician, and a pharmacist. Additionally, with the complexities chronically critically ill patients have, there are multiple physicians, hospitalists, specialists; other departments such as radiology, laboratory, and surgery interrelated with the care of the patient. These distinct disciplines and departments are all subsystems of the facility/unit system (King, 2006).

Recognizing a systems theory tenet of interrelated subsystems, open to the environment and multiple inputs - the more disciplines (subsystems) involved with the care of the patient, the more likely that communication becomes a challenge and more susceptible to failure or breakdown. Adaptive processes to support communication are in place. For example, every morning shift huddle occurs and pertinent information is discussed. Such information includes: fall risk patients, possible discharges, possible admits, and any other important information that needs to be related to the team. Every Tuesday the interdisciplinary team meets and discusses individual care, the plan of care, and progress with the patient and families.

 Adding to the complexity of the system, this facility has recently gone to electronic medical record system. Unfortunately, only parts of the records are electronic. The parts that can be viewed electronically are medications, vital signs, intake, output and sepsis screen. The other parts of the records are located in multiple areas. There is a separate chart located in the hall by the patient room with the twenty-four hour nursing assessment sheet that is eight pages in length, respiratory monitor sheets, wound care documentation, physical therapy and occupational therapy documentation from the last few days. There is a chart located at the nurses’ station with demographic information, consents, history and physical, orders, physician progress notes and consultations. There is another chart at the nursing station that holds all the old twenty-four hour nursing assessment sheets. If that is not cumbersome, then there is a filing cabinet which holds old medical records from the transferring facility. Finally, there is another computer system that is accessed to locate the results of laboratory test, radiology test, and any microbiology results. This has created a chaotic and complex process in providing accurate effective patient care and a total breakdown in the communication process.

**Characteristics of Systems Thinking**

Peter Senge described, “System thinking is useful for describing a vast array of interrelationships and patterns of change. Ultimately, it helps us see the deeper patterns lying behind the events and the details” (Senge, 1990, p. 3). Using system thinking will provide a framework for developing a process change in the communication system.

 Senge stated, “The bottom line of systems thinking is leverage. We must see where small actions and changes in structures can lead to significant, enduring improvements” (Senge, 1990, p. 4). Organizing the patient records may seem to be a small task, but doing so will create a huge improvement on communication and the quality of patient care and outcomes, not to mention times saved by all members of the interdisciplinary team.

 Another characteristic of system thinking is mental models. “Mental models are deeply ingrained assumptions, generalizations, or even pictures of images that influence how we take action” (Senge, 1990, p. 1). Mental models can affect behavior and how one feels about the company. If new insights are implemented and are able to manage time more effectively, then moral and satisfaction will overall be boosted.

**Execute Change to Achieve Outcomes**

To implement change that affects the entire interdisciplinary team (system composed of all the distinct disciple subsystems) will take a team effort in developing a process that will be beneficial to all parties. Having a shared vision is vital. “In fact, the whole idea of generative leaning will seem abstract and meaningless until people become excited about some vision they truly want to accomplish” (Senge, 1990, p. 7). Setting up a committee for developing the change and taking suggestions from all parties to create the best possible solution will help create a shared vision. “As people talk, the vision grows clearer, enthusiasm for its benefit builds and the vision starts to spread in a reinforcing spiral of communication and excitement” (Senge, 1990, p. 8.)

 In a busy acute long-term care facility where communication is vital, by cohorting the medical records to one or two areas instead of five or six will reduce chaos (number of inputs) and produce success (transformation) for not only the interdisciplinary team but will also improve the quality of outcome for the patient (output). Senge (1990) noted that by using systems methodology individuals, teams, and organization can learn how to structure the details into a coherent picture of all the forces at play….and in the end, position our health care system/units for success, growth, and viability into the future.

References

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