IMPLEMENTATION OF THE PRIMARY CARE NURSING MODEL IN AN ACUTE INPATIENT REHAB UNIT

Laurie Murray, BSN, RN, CRRN

VISION

In 2007, Crittenton Hospital Medical Center initiated the implementation of the Relationship-Based Care practice model. Each unit proceeded to develop their own vision which would drive practice based on relationships. The Unit Practice Council’s vision for Rehab is “Guiding and supporting patients, families, caregivers and each other to reach our fullest potential through caring, collaborative relationships, one step at a time.”

INSPIRATION

The inspiration for our vision and then project came from our Chief Nursing Officer who remains the driving force for changing our hospital into a Relationship-Based Care culture. The challenge for our unit was to implement changes that reflected our unique vision statement. The CNO had suggested that an important initiative for building strong relationships is through primary care nursing.

INFRASTRUCTURE

The Rehab unit is unique and especially suited for primary care nursing because:

- it practices under a collaborative structure in which several different disciplines work closely to provide optimum patient care
- the average length of stay is 13 days which allows for a close relationship to develop
- we work 8 hour shifts which means we see the patient more often
- we are paired and partnered with not only our CNAs, but also therapists and social workers
- we see the patient more often which time key points were provided to every nurse. The patient’s Care Plan is implemented and managed by the patient’s primary nurse because:

  - We are a 24 bed acute Rehab unit
  - There are four patient “teams” designated by colors
  - Each team consists of: RN, PT, OT, SW, CNA, TR, SLP (if needed), and diettitian
  - Each team’s patients are in sequential rooms.
  - Each team meets in our dining room for a daily morning huddle to discuss patient care for that day
  - Each team holds a one hour family conference for all the patients in that team, every week

Due to the lack of private rooms, sometimes patients are moved from one team to another during their stay. In order for the “original” primary nurse to provide continuity of care, the RN might have to go to more than one daily team huddle & family conference hour and have patients scattered around the unit. The unit educator contacted the nurse manager of a similar Rehab unit that has been practicing primary care nursing for over 40 years. One key statement made by this manager was “If the patient were to be transferred off your unit, you would provide continuity of care through your hand-off report. If the patient changes teams, requiring a different primary nurse, that same process would work.” The UPC decided that patients would be assigned a primary nurse dependent on the “team” that is a patient upon admission is assigned a room based on availability and patient needs.

EDUCATION

All nurses on the unit attended a Primary Care Nursing workshop conducted by the hospital. This training was continued by the nurse educator for the Rehab Unit, who provided the nurses with a brief synopsis of the evolution for the primary nurse model, a guideline for implementation of the model on the unit and a checklist for both the primary nurse and associate nurse to follow. As in any change, there was some struggle and confusion, at which time key points were provided to every nurse. The patient’s Care Plan is implemented and managed by the patient’s primary care nurse in collaboration with the patient and patient’s family. Each patient’s whiteboard at the foot of their bed has a picture of their Primary Nurse with the Primary Nurse’s name (in the team color).

REFERENCES

Koloroutis, Mary. (2007). Relationship-Based Care, A Model for Transforming Practice. Minneapolis, MN.
Manthey, Marie. (2002). The Practice of Primary Nursing. Minneapolis, MN.

For further information, please contact:
Laurie Murray, BSN, RN, CRRN
lmurray@crittenton.com

EVIDENCE

In order to validate the effectiveness of primary nursing on the unit, the nurse educator developed a Patient Questionnaire wherein each month she sits at the patient’s bedside and asks the patient if they know the name of their primary nurse. To the dismay of everyone, less than 50% of our patients could name their primary nurse. We realized that to the patients, the primary nurse was the nurse that cared for them for that day and that primary nursing should be “invisible” to the patient because if we, as nurses, are acting as the primary nurse correctly, our patients would see no difference when another nurse cares for them. The primary nurse’s key focus is to coordinate the care of the patient, act as the patient’s advocate, and make sure that communication is open and active between all team members. We had succeeded in making this an invisible system that worked extremely well for our unit. When an associate nurse cared for the patient, the patient didn’t notice a difference in the care being delivered. This meant that we were communicating our patients needs effectively; they evaluated us on the relationship of caring we delivered to them. Equally rewarding, we realized that we were delivering a caring relationship for our patients that is seamless to them, across all shifts and disciplines.