An Action Approach to Redesigning

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Receptiveness to innovation is critical in orchestrating change and learning to use new technology in a redesigned work environment. The patient-centred unit redesign approach (PCURA) provides a guide for unit assessment in many healthcare settings. The backbone of the PCURA approach: work excitement and unit culture assessment.

CONSIDERED a catalyst for work redesign, work excitement is defined as personal enthusiasm and interest in work evidenced by creativity, receptiveness to learning and ability to see opportunity in everyday situations.

Some predictors of work excitement are:
--work locus of control,
--learning opportunities,
--working conditions,
--change and
--variety of work arrangements.

A work excitement tool (WEXCIT) measures level of work excitement and work characteristics and has been validated in a series of studies in acute, long-term and home care settings.

Unit culture is significantly related to level of work excitement. A nursing unit cultural assessment tool (NUCAT) assesses cultural patterns of behaviour in units in various settings in terms of:
--following orders,
--growing professionally,
--valuing technical skills,
--using professional judgement,
--preferring one's way of working,
--caring for co-workers,
--maintaining traditions,
--communicating directly,
--working under difficult conditions and
--assuming responsibility.

To introduce change the organization must be flexible, allowing walls separating groups to be knocked down and group labels such as management, professional, salaried or hourly workers erased or ignored. In such an organization the boundaries become more psychological than organizational: The old boundaries of hierarchy, function and geography disappear in a new set of relationships among managers and workers.

The essence of unit redesign in such an organization is knowing how to recognize and use the new boundaries productively.

Learning new behaviour to function in a flexible organization requires a unit culture that fosters receptivity to learning. New technologies, fast-changing markets and global competition are revolutionizing relationships in health care, making roles and tasks blurred and ambiguous.

To be productive in this new setup, all nursing personnel must take on new roles and relationships in addition to assuming responsibility for their own self-development and learning.

Over time, physicians have maintained a clinician-centred healthcare delivery model through tight control over entry into and out of health services. Such a closed system seriously limits the health services offered.

Challenged by changes in reimbursement, this model is rapidly being replaced by a patient-centred outcome-based system of seamless care that requires a new breed of nurse.

Increased knowledge and skills alone will not make this new nurse.

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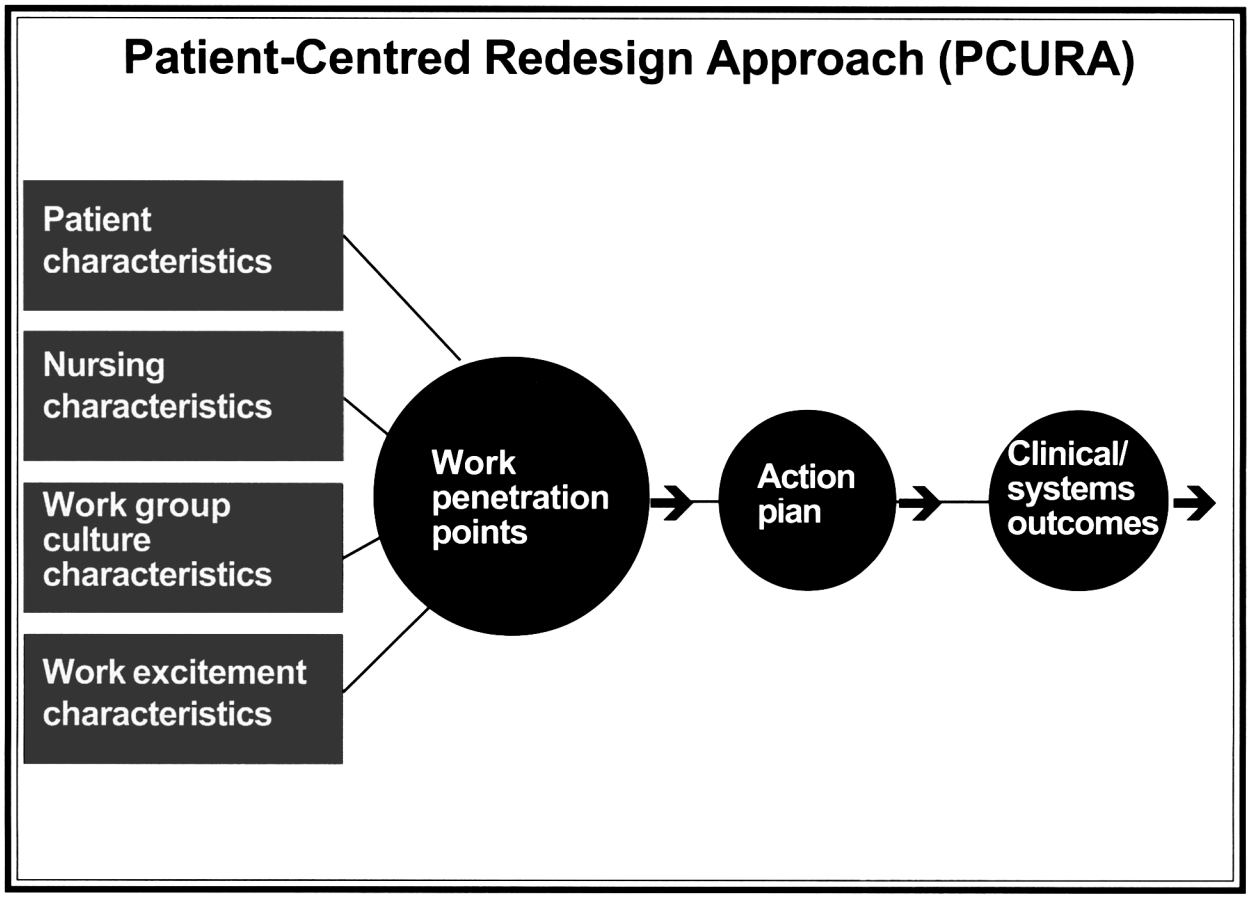
a Patient-Centred Unit



There must be a related role change, a change in self-concept whereby nurses see themselves as providers of direct care to clients and families rather than providers of services to institutions. Such a change requires learning new behaviour and a willingness to work across care settings and in flexible work groups.

The Patient-Centred Unit Redesign Approach (PCURA) is a promising methodology for change in nursing practice environments because it links learning new behaviours with reasonable and obtainable outcomes (*Figure 1*). Focused interventions in response to identified work penetration points can be implemented quickly and simultaneously with evaluation of clinical and systems outcomes, thus laying the groundwork for continuous quality monitoring system that yields areas of needed improvements.

Flexible work group

THE FLEXIBLE work group model is based on the idea of assembling a patient care team according to patient needs. The model combines the best of functional team and primary or case management ideas and allows creation of work groups that can expand or decrease in size depending on patients' needs.

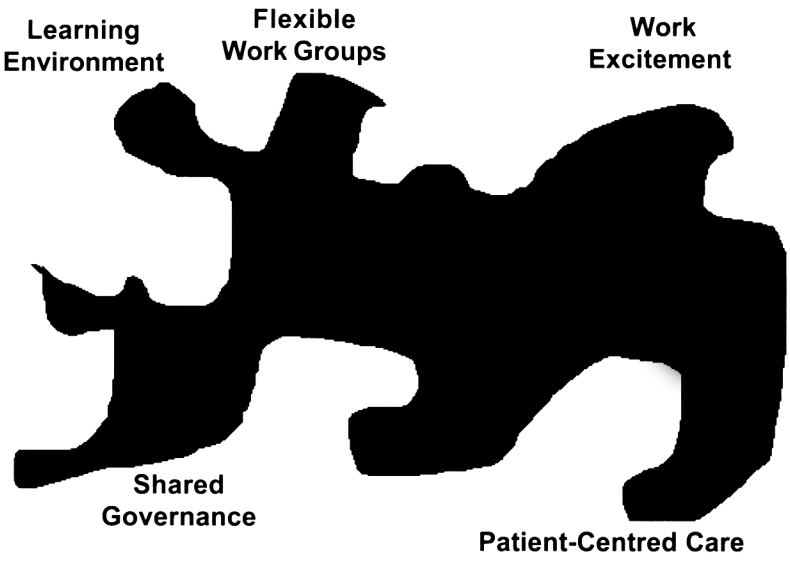
The flexible work group is defined as a patient-centred care team capable of responding or reforming when the nature of the work changes. Leadership is responsible to changing patient needs.

As the patient is regarded as an integral member and focus of the work group, direction and decisionmaking about required work is a natural right of the patient or, for that matter, of any other member.

Leadership accrues from the best mix of team skills and is fluid and free to act towards meeting the patient's dominant needs--re-

Figure 2

Organization Inflow



covery or maintenance or promotion of health.

Like an amoeba, flexible healthcare organizations are without permanent organelles or supporting structures that restrict creativity and decisionmaking. (*Figure 2*).

Patient-centred care

AN IMPORTANT part of learning how to redesign clinical work and develop clinical outcomes is understanding patient outcomes. In a patient-centred work environment, a multidisciplinary unit staff can consider the nature of the work to be done and the people and technological resources desirable to work to the best advantage of patients. Consideration should be given to:

--What work can or should be shared or done by one person,

--What work can be delegated to other people or equipment, i.e. what work could be a patient/family responsibility,

--What work should be done differently and

--What work should not be done at all.

In other words, a careful study is needed of the knowledge, skills and equipment needed to accomplish quality patient-centred care.

Successful empowered environments are built on the collaboration of multiple health-related disciplines. While earlier models focused on nursing and medicine and did not recognize the contribution of other team members, paraprofessionals or support service staff, a collaborative patient-centred practice legitimizes and sharpens the roles of each discipline. It also integrates "care" and "cure" philosophies essential in seamless care.

Collaborative patient-centred care efficiently utilizes personnel in roles they are prepared to assume. Patient/family in treatment regimens should be at all points of seamless care from entry into point of service to discharge. Patient involvement has been a part of hospital-based educational programmes but only in a passive role.

In future, patient involvement will be increasingly important and should be part of evaluation procedures as well. Clinical outcomes reflecting positive response to therapeutic measures will continue to have a major influence on reimbursement patterns.

Sharing in Practice

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influence in determining what is to be achieved.

We found improvements in practice and teaching were possible when teachers and service staff could meet on common ground and enter into an open dialogue, first to better understand and respect each other's point of view and then to address the question of how they could improve the quality of nursing care and education in their work setting.

The collaboration was not effective in achieving changes when one side dominated. The sharing of teaching and caregiving responsibilities in the service delivery setting is only a starting point, but an important point to begin the process of tearing down existing barriers and building the motivation for change from the bottom up.

My message: The challenges of today and tomorrow will not be met by a mere extension or continuation of yesterday's relationships and practice models. Clearly, new modes of professional, organizational, institutional and individual cooperation and collaboration are needed to initiate, support and sustain system-wide change.

A Treasure-Trove of Research

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