The Universal Nurse Model: Using Systems Thinking to Improve Health Workforce Efficiencies in Kyrgyzstan

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Activity Impact

After the implementation of the Universal Nurse pilot model:
1. The nurse workload standards were revised downwards from 40, depending on the severity of the patient and location within the hospital, each nurse was not assigned from 8 to 12 patients per universal nurse and 3 in the Intensive Care Ward.
2. The functional responsibilities of nurses were redefined to focus on the patient, including teaching and counseling patients, conducting sanitary and anti-epidemic (prevention) measures, observation and care of patients, providing pre-hospital (nursing) medical care to patients in emergency/non-emergency conditions, and providing psychological support to patients.
3. Nurses worked in accordance with the requirements of the hospital's Standard Operating Procedures and in compliance with the requirements of infection prevention and control with heightened workload and more functional responsibilities.
4. Nurses closed adhered to the stages of the nursing process: nurses independently assessed the patient's condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result. With the change in patients' condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result. With the change in patients' condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result. With the change in patients' condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result. With the change in patients' condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result. With the change in patients' condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result. With the change in patients' condition, made a nursing diagnosis, planned, implemented the plan, and evaluated the result.
5. Nurses maintained patient charts at the bedside of the patients, ensuring continuity in the "nurse-physician" work. Doctors noted that the patient card provided significant help in managing the individual patient care plan, and the card contained all necessary information for dynamic monitoring and adjustments of drug therapy during rounds on the patient's health status, translating to time-saving for the doctors and nurses. There are plans to transfer the patient record into electronic format in the future.

Implementation of the model was carried out in stages:
1. Analysis of nurses' work in pilot hospitals;
2. Calculations of the norms of nurses' workload;
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5. Evaluation of the implementation of the pilot project of the "Universal Nurse" and associated processes.

Evidence

Health Outcomes
- Patient to nurse ratios decreased significantly, greatly improving the quality-of-care patients received and the amount of time spent with patients. From the high of 40 patients per nurse at the height of the pandemic, the universal nurse model decreased the ratio to 8-12 patients.
- In the Intensive Care Unit, the patient to nurse ratio decreased from 8:1 to 3:1, greatly improving the level of attention each patient received.
- The rate at which all assigned nursing tasks were completed during a shift period increased from 40% to 90%.

Health Systems
- After the adoption of the universal nurse model, nurses and patients reported that care was more patient-centered and the quality of care was greatly improved.
- Nurses were able to provide continuous care to their patients, including nutrition and lifestyle recommendations to focus on long-term care and prevent post-hospitalization medical complications.
- The Kyrgyz health system was more resilient and able to scale up to support health emergencies like COVID-19.

Facilitators

The introduction of the Universal Nurse model was initiated by the Ministry of Health in Kyrgyzstan and the USAID-funded LHSS project supported this initiative in line with the project's systems approach to solving health challenges.

The Chief Specialist of the Ministry of Health, who supervises nursing issues, Gulnara Asynbekova visited Lithuania in 2017 and observed that nurses were involved in all stages of patient care throughout the entire hospital stay. Upon returning, she advocated for changes to the nursing practice in Kyrgyzstan. However, her efforts to change the division of labor did not gain traction until the staffing challenges of the COVID-19 pandemic. COVID-19 hospital "red zones" began rapidly filling up with patients needing constant monitoring. Her 2020 assessment by the Department of Health found that vast COVID-19 patient care procedures were not being followed.

Challenges

One key challenge to implementation was the long-standing, task-oriented human resources structure that assigned three different types of nurses, each with separate responsibilities, to care for a single patient. The previous staffing model was not able to surge to the patient numbers observed in health emergencies such as COVID-19. With the scaled nursing model, when the patient load dramatically increased, it was impossible to properly attend to COVID-19 patients or coordinate care across the health worker team.

Another key challenge was that in the hospitals selected for the pilot, there was an understaffing of nurses and an overloading of ward with patients. In most wards, the space and equipment of the wards did not meet the requirements for distancing and staff to patient ratios. There was a large flow of visitors to the wards that regularly damaged patient care. Additionally, most of the nurse’s time was spent on writing off medicines and medical devices.

Lessons Learned

Several key lessons were learned throughout the design, implementation, and scale up of this model:
1. The pilot hospitals already had Standard Operating Procedures for nurses that were developed as part of the Swiss health care project, which led to increased willingness among the Ministry of Health and hospital administrators to make staffing changes.
2. There was high interest and commitment from the Ministry of Health to strengthening the nursing process in health emergencies as part of global health security preparedness efforts.
3. In the peak of the pandemic, structural issues with the health system exposed major weakness that needed to be addressed in future strengthening efforts, including: nursing shortages, high patient burdens, lack of medications and Personal Protective Equipment, and emotional burnout among nurses.
4. When nursing roles were divided, nurses were not able to spend the majority of their time focused on the patient with the high burden of paperwork and coordination.
5. Focusing on the quality of care to patients was the best entry point to encourage uptake among hospital administrators.

Activity Description

The Ministry of Health implemented the Universal Nurse Model aimed at optimizing the work of nursing professionals and improving both the quality of nursing care and the safety of the hospital environment. Specific objectives included:
1. Rational staffing;
2. Redistribution of functions and work planning;
3. Reduction of unproductive costs of nursing time.

The implementation of the new model was a significant change for the health system. The Universal Nurse Model had a positive impact. It allowed for the effective use of nursing resources, improving the quality of patient care. Nurses were better able to focus on patient care, ensuring a higher level of quality and safety. The new model also led to increased job satisfaction among nurses due to the enhanced ability to provide comprehensive care.

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