

Comparative Models of Nursing Care Delivery

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Introduction

Nursing [care delivery models](#) organize how responsibility, authority, communication, and clinical work are distributed among nurses and other members of the care team. The model selected by a hospital unit affects continuity, accountability, workload, teamwork, and the patient's understanding of who is responsible for care. During an observation in a general hospital emergency department, nurses appeared to use a largely functional model. At the beginning of the shift, staff received defined tasks and moved among patients to complete those tasks rather than assuming comprehensive responsibility for one patient. This arrangement can help a crowded department use specialized skills quickly, but it also creates risks when information and responsibility become fragmented. Comparing functional nursing with team nursing, total patient care, and primary nursing suggests that an emergency department is best served by a flexible team-based model with clearly assigned patient accountability. (Yoder-Wise)

The Observed Functional Model

In functional nursing, work is divided according to tasks. One nurse may administer medications, another may perform assessments or procedures, and another may document or coordinate discharge activities. A charge nurse or manager assigns responsibilities and oversees completion. This model developed partly as a way to use a mixed workforce efficiently when staffing and resources were limited. Its central strength is specialization: staff members can become efficient at a defined activity and complete it for several patients. (Yoder-Wise)

The observed emergency department reflected several features of this model. Nurses gathered at the beginning of the shift, received assignments, and circulated from patient to patient. Care was episodic because patients arrived with immediate needs, changed condition rapidly, and often required several interventions in a short time. The charge nurse maintained an overview of department flow and communicated with staff. In a busy environment, this arrangement can support rapid task completion and allow scarce skills to be directed where they are most urgently needed.

Advantages of Functional Nursing in Emergency Care

Functional allocation can be useful during periods of extreme demand. If many patients require intravenous access, medication, or a time-sensitive procedure, assigning a capable nurse to that activity may reduce delay. New or less-experienced staff can also perform appropriate tasks under supervision while registered nurses focus on assessment and clinical judgment. The model provides visible lines of authority, and the charge nurse can redirect personnel as the waiting room, resuscitation area, and treatment spaces change.

Standardization is another possible advantage. When one person performs the same procedure repeatedly, technique may become consistent. Supplies and equipment can be organized around the work, and managers can estimate staffing needs from task volume. These efficiencies are important in emergency care, where crowding and unpredictable arrivals place constant pressure on time.

Risks of Fragmentation

The same division that improves task efficiency can divide the patient's story. One nurse may know the presenting complaint, another the medication response, and another the discharge plan, while no single nurse integrates all of the information. A patient may repeat the same history several times or receive inconsistent explanations. Subtle deterioration can be missed when each staff member focuses only on the assigned task. Accountability can also become unclear: everyone completed a component, yet no one recognized that the components did not form a safe plan.

Emergency departments are especially vulnerable to handoff and communication failures because care is fast, interruptions are frequent, and several disciplines work simultaneously. AHRQ's TeamSTEPPS framework identifies communication, team leadership, situation monitoring, and mutual support as essential to safe, efficient, patient-centered care. Functional nursing can operate safely only when these team processes compensate for its fragmentation. A checklist of completed tasks is not a substitute for shared understanding of diagnosis, risk, response to treatment, and the patient's next step.

Team Nursing

Team nursing assigns a group of personnel to a set of patients under the leadership of a registered nurse. The team may include registered nurses, licensed practical or vocational nurses, nursing assistants, and other personnel, with duties allocated according to competence and scope of practice. Unlike a purely functional model, the team is accountable for the complete care of its patient group. The leader develops or coordinates plans, monitors changes, supports team members, and

communicates with physicians and other disciplines. (Cioffi et al.; Fairbrother et al.)

Research cited in the original essay found that movement from individual patient allocation toward team nursing could improve staff satisfaction, support, and retention in acute settings. Team nursing may also help less-experienced clinicians learn from experienced colleagues and can distribute workload when patient acuity is uneven. In an emergency department, a team can be assigned to a physical zone or pod. One registered nurse may lead care for several rooms while colleagues divide assessments, medications, procedures, and flow activities.

The model nevertheless depends on leadership and communication. A team name alone does not create collaboration. If briefings are absent, roles are vague, or the leader is overloaded, team nursing can become functional nursing under a different label. A safe model requires an explicit plan for each patient, regular updating, closed-loop communication, and clear escalation when a team member recognizes risk. (Agency for Healthcare Research and Quality)

Total Patient Care

Under total patient care, one registered nurse provides most or all nursing care for assigned patients during a shift. The nurse assesses the patient, plans and performs interventions, coordinates with other professionals, educates the patient, and evaluates outcomes. This produces direct accountability and can strengthen the therapeutic relationship. The patient knows which nurse is responsible, and clinical information is less likely to be scattered among several people.

The original essay recommends total patient care as an improvement over the observed functional model. Its advantages are substantial, but full application in an emergency department can be difficult. Patient arrivals are unpredictable, acuity changes quickly, and one nurse may suddenly be occupied with a resuscitation while other assigned patients still require attention. Rigid one-nurse-to-one-patient responsibility can reduce flexibility and may be unrealistic when staffing is constrained. The useful principle is not that the assigned nurse must personally perform every task. It is that one registered nurse should maintain accountable oversight of the patient's assessment, priorities, communication, and transition.

Primary Nursing

Primary nursing extends accountability beyond a single shift. A primary nurse has continuing responsibility for coordinating a patient's plan throughout an admission, while associate nurses provide care when the primary nurse is unavailable. This model can improve continuity and autonomy in inpatient settings where patients remain for days or weeks. It is less naturally suited to the emergency department, where stays are shorter and patients are transferred, admitted, or discharged rapidly.

Elements of primary nursing can still inform emergency care. Naming an accountable nurse, involving the patient in the plan, and ensuring that transitions preserve the nurse's clinical reasoning are valuable. For patients held in the department for extended observation or boarding, more continuous assignment may become increasingly important.

Individual Patient Allocation and Modular Models

Individual patient allocation assigns each nurse a group of patients for the shift and resembles total patient care, although some tasks may be delegated. Modular nursing combines geographic assignment with a small team. Staff care for patients located in the same physical area, reducing travel and making communication more immediate. Many contemporary departments use hybrid arrangements because no classical model alone addresses every condition.

A pod-based emergency model can combine modular and team nursing. Each zone has a defined team, and each patient has an accountable registered nurse. Tasks can be shared according to workload and competence, but the accountable nurse integrates results and communicates with the patient. The charge nurse manages department-wide flow rather than collecting every detail of every patient.

A Recommended Hybrid for the Emergency Department

The observed department would benefit from a team-based hybrid rather than a complete replacement of task allocation. The department should preserve the ability to assign specialized tasks during surges while ensuring that every patient is linked to an accountable registered nurse and a defined team. Assignment boards or electronic tracking systems can display the responsible nurse, care zone, acuity, pending tests, and expected disposition. The responsible nurse should confirm that delegated work was completed and interpret its significance within the whole plan.

At the start of a shift, teams should conduct a brief huddle covering capacity, high-risk patients, staffing, equipment, and anticipated constraints. Within each zone, the team should identify roles and discuss unstable or complex patients. When conditions change, staff should use concise structured communication such as SBAR—situation, background, assessment, and recommendation—and closed-loop confirmation for urgent directions. These processes align with TeamSTEPPS principles and reduce reliance on informal assumptions.

Delegation and Scope of Practice

A hybrid model must respect legal scope of practice, organizational policy, and individual

competence. Delegation transfers performance of an activity but does not eliminate the registered nurse's responsibility to assess whether delegation is appropriate, provide direction, and evaluate the result. Patient acuity, predictability, complexity, and the delegatee's preparation all matter. A stable patient requiring routine assistance presents a different delegation decision from a patient with rapidly changing neurological or respiratory status.

Managers should avoid designing the model around the least expensive worker for each task. Short-term labor savings may create rework, delay, or harm when assessment and coordination are insufficient. Skill mix should be matched to patient needs and supported by adequate supervision.

Continuity, Handoffs, and Patient Participation

Emergency care includes several transitions: triage to treatment, one nurse to another, emergency department to inpatient unit, or department to home. The care model should make these transitions visible. Handoffs should include the patient's current condition, risks, treatments, response, pending results, and contingency plans. Merely listing completed tasks can omit the clinical meaning of those tasks. (Agency for Healthcare Research and Quality)

Patients and family caregivers should be included when appropriate. They can identify medication discrepancies, changes in condition, and misunderstandings about the plan. A patient-centered model tells people who is responsible, what is happening next, and whom to contact with concern. This improves experience while also serving as a safety mechanism.

Staffing, Leadership, and Work Environment

No delivery model can compensate for chronically inadequate staffing, excessive workload, or an unsafe culture. Team nursing may distribute pressure, but teams cannot provide safe care if every member is overloaded. Leaders should monitor acuity, staffing, boarding, interruptions, and missed care rather than judging performance only by the number of tasks completed. Mutual support is especially important when one member becomes overloaded; colleagues should be expected and authorized to provide backup.

Charge nurses need preparation in patient flow, conflict management, delegation, situational awareness, and escalation. They should have enough protected capacity to lead rather than carrying an assignment that makes oversight impossible. Frontline nurses should participate in redesign because they understand how formal procedures interact with actual work.

Evaluating a Change in the Care Model

Implementation should begin with baseline measurement. Relevant outcomes include medication errors, falls, delayed treatment, missed nursing care, handoff failures, patient complaints, staff turnover, overtime, and time to disposition. Staff and patients can also describe whether accountability and communication improved. Measures should be interpreted together; faster throughput is not a success if safety or patient understanding declines.

A pilot in one zone can test the hybrid model before wider adoption. Leaders should observe huddles and handoffs, review incidents, and adjust staffing and role definitions. Education alone will not sustain the change unless scheduling, electronic systems, policies, and managerial behavior support the new way of working.

Conclusion

The functional nursing model observed in the emergency department offers efficiency, specialization, and flexibility, but it can fragment information and accountability. Total patient care improves continuity but may be too rigid for unpredictable emergency demand, while primary nursing is more appropriate for longer episodes of care. Team and modular models offer the strongest foundation when they include clear leadership, communication, delegation, and patient accountability. The recommended approach is a hybrid in which every patient has an accountable registered nurse within a defined zone-based team, while specialized tasks can be shared during surges. The quality of the model should be judged by safety, continuity, patient participation, staff well-being, and outcomes rather than by task completion alone. (Yoder-Wise; Agency for Healthcare Research and Quality)

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