QUALITY CARING
IN NURSING AND HEALTH SYSTEMS

JOANNE R. DUFFY

Implications for Clinicians, Educators, and Leaders
Quality Caring in Nursing and Health Systems
Joanne R. Duffy, PhD, RN, FAAN, is the West Virginia University Hospitals endowed professor of Research and Evidence-based Practice and director of the PhD program at the School of Nursing, located at the Robert C. Byrd Health Sciences Center, West Virginia University, Morgantown, WV. Additionally, she is an adjunct professor at the Indiana University School of Nursing in Indianapolis, IN. She has had an extensive career encompassing clinical, administrative, and academic roles. Dr. Duffy has directed graduate nursing programs in critical care nursing, care management, and nursing administration, and was a former division director of a school of nursing. She teaches nursing theory, research, and advanced leadership and directs dissertations and scholarly projects. She has held various administrative positions directing medical, rehabilitation, critical care, emergency, and transplantation nursing services at both community and academic medical centers. She also directed a Center for Outcomes Analysis, a nurse-led department for improving the quality of cardiovascular services. She has published extensively across the nursing literature, but is best known for her work in maximizing patient outcomes. Dr. Duffy was the first to link nurse caring to patient outcomes, designed and tested multiple versions of the Caring Assessment Tool (including the newest version, the e-CAT), and developed the Quality-Caring Model©, a middle-range professional practice model.

Dr. Duffy was the principal investigator on the national demonstration project, Relationship-Centered Caring in Acute Care, where the Quality-Caring Model© was evaluated at two sites. She was the principal investigator for the Telehomecare and Heart Failure Outcomes clinical trial that tested a caring-based intervention, recently evaluated the feasibility of using the e-CAT on hospitalized older adults, and is currently testing a comprehensive intervention to improve patient-centered care in the hospital setting. Dr. Duffy has participated in several multisite studies, and as a member of the West Virginia Clinical and Translational Science Institute, she conducts interprofessional translational research.

Dr. Duffy regularly leads journal clubs and assists staff nurses and nurse leaders in research and practice improvement projects. Dr. Duffy was a consultant to the American Nurses Association (ANA) in the development and implementation of the National Database of Nursing Quality Indicators (NDNQI) and was the former chair of the National League for Nursing’s (NLN) Nursing Educational Research Advisory Council. She is a Commonwealth Fund Executive Nurse Fellow, a Fellow in the American Academy of Nursing, a frequent guest speaker, a former Magnet® appraiser, and a recipient of several awards, including the American Heart Association’s Nursing Advisory Council Clinical Article of the Year Award, Virginia’s Outstanding Nurse Award, and the National Institute of Health Care Management’s Annual Health Care Research Award.

The first edition of this book, Quality Caring in Nursing: Applying Theory to Clinical Practice, Education, and Leadership, received the AJN Book of the Year award in 2009 and the model has been embraced by over 40 health care organizations, several of which have attained Magnet® status.
# Contents

*Foreword*  
Jody Hoffer Gittell  
*Preface*  
*xi*  
*Acknowledgments*  
*xv*

## Part I. Nursing and Health Systems

1. Quality, Caring, and Health Systems  
   3
2. Professionalism in Health Systems  
   15
3. Evolution of the Quality-Caring Model©  
   27

## Part II. Practicing in Quality-Caring Health Systems

4. Humans in Relationship  
   49
5. Relationship-Centered Professional Encounters  
   73
6. Relational Capacity  
   95
7. Feeling “Cared For”  
   115
8. Practice Improvement  
   137
9. Self-Advancing Systems  
   153

## Part III. Leading and Learning in Quality-Caring Health Systems

10. Leading Quality Caring  
    177
11. Learning Quality Caring  
    199
12. The Value of Quality Caring  
    231
Appendices

Appendix A: Quality and Caring Resources on the Internet  
Appendix B: Example Health Systems Using the Quality-Caring Model® as the Foundation for Professional Practice  
Appendix C: Nursing Implications of the Quality-Caring Model®  
Appendix D: Using the Caring Factors to Keep Patients Safe  
Appendix E: Using the Caring Factors to Advance Quality Health Outcomes  
Appendix F: Assessment of Professional Practice  
Appendix G: Potential Research Questions  
Appendix H: Reflections on Practice  
Appendix I: A Mother’s Reflections on Nursing  

References  
Index
Foreword

Joanne Duffy makes a compelling argument in this book—that relationships have been marginalized and no longer serve as the central organizing principle of health services. The causes are many—an excessive focus on protocols, information systems, impersonal scheduling systems, and the undervaluing of caring itself. But the consequences are deeply problematic—care that is rushed, impersonal, inadequate, and unsafe, often resulting in greater harm than good. Solutions are available, Duffy argues, and nurses in particular “are in a unique position to advance a more relationship-centric health care system.”

This book resonates with a virtual groundswell of findings regarding the importance of relationships for organizational performance and for human well-being. Evidence can be found in the work of Tony Suchman, Dana Safran, and their colleagues who have studied relationship-centered care, and in the work of others who have explored the healing potential of relationships—see, for example, Understanding Healing Relationships in Primary Care by Scott, Cohen, DiCicco-Bloom, Miller, Stange, and Crabtree (2008). The evidence goes beyond the health care sector to include work from the Positive Organizational Scholarship movement based at the University of Michigan, led by acclaimed organizational researchers such as Jane Dutton, Kim Cameron, Robert Quinn, Gretchen Spreitzer, Emily Heaphy, Adam Grant, and more.

More broadly, there is a revival of interest in the power of relationships for achieving essential performance outcomes. My work with the airlines and in health care has uncovered a process called “relational
coordination,” a mutually reinforcing process of communicating and relating for the purpose of task integration, and has produced evidence that these relational dynamics of shared goals, shared knowledge, and mutual respect have powerful effects on the achievement of quality and efficiency outcomes, and on the well-being of workers themselves. Positive relationships are not just “nice to have,” they are essential for achieving the very performance outcomes that we are desperate to achieve. Moreover, relational coordination as a validated network measure has proven to be highly useful for contributing to the evidence base, and for providing organizations with a diagnostic tool to inform their change efforts.

Duffy’s Quality-Caring Model© is comprehensive, indicating that the positive relationships that matter go beyond relational coordination among care providers to include relational coproduction with patients, families, and the broader community—and relational leadership to support and sustain both of these dynamics. Her Quality-Caring Model thus resonates strongly with the Relational Model of Organizational Change.

Ironically, it is in the name of quality assurance and cost reduction that relationships are often put aside, even though the evidence suggests that we do so at our peril. By sacrificing relationships as a luxury, we have laid the groundwork for disintegration, fragmentation, and system failure. The very relationships that appear to be a luxury that we simply cannot afford in these challenging times are in fact the underpinning for systems thinking, for organizational cohesion, and for healing itself.

Therefore, I view this book as a call to action. Given the historic connection of nursing with caring, Duffy is probably correct in stating that nurses are in a unique position to reclaim this value and help to move it back to the top of the policy and leadership agenda—doing so for themselves, for their patients, and for their colleagues in the broader health care team. It is possible that caring lost its position as a highly visible pillar of the nursing profession as part of a broader effort to gain professional parity with physicians and other health professionals, who were doing just fine by associating themselves with science and technology rather than caring. Moreover, it is well documented by Joyce Fletcher and others that caring work has been historically undervalued because of its association with the feminine and domestic spheres of life. No wonder, then, that nursing perhaps underplayed its historic connection with caring in an effort to gain respect as a profession.
But the timing may now be ideal—given the confluence of the empirical evidence, the system breakdowns, and the policies that increasingly hold organizations accountable for adverse outcomes—for the nursing profession to lead the way forward, to reinvigorate caring relationships as a central organizing principle of our health care system.

Jody Hoffer Gittell
Author of *High Performance Healthcare: Using the Power of Relationships to Achieve Quality, Efficiency and Resilience*
Professor of Management, Brandeis University
Executive Director of the Relational Coordination Research Collaborative
Preface

Patients and families continue to suffer today not only from their illnesses but from the health care system itself. Despite expansive quality improvement programs and dedicated financial resources expended in the past 15 years, the U.S. health system still inflicts unnecessary harms, does not consistently deliver patient-centered care, and does not focus on the fundamental caring processes that undergird. The complexity of health systems themselves, with the constant emphasis on procedures, protocols, diagnostic testing, medications, tasks, technology, and costs, has marginalized relationships as the central organizing aspect of professional practice. Evidence of this can be found in numerous professional publications, anecdotal evidence from patients and families, and empirical studies.

Consequently, dedicated time spent with patients and families at the bedside, in health professionals’ offices, at nursing homes, schools, or clinics is limited and often rushed and impersonal. Multiple nameless caregivers, system-created schedules, and lack of caring relationships with health professionals create uncertainty, unnecessary stress, discomfort, limited participation in decision making, dissatisfaction with care, and unnecessary financial burdens. Patients and families, at some of the most vulnerable times of life, are forced into dependency, reluctantly adapting to expectations of the system, and are frequently left to wonder whether they are safe and who will be there for them when they need it most.

This incongruity between the relational core of health services and the needs of patients and families is serious and may be linked to poor health outcomes. Not only has the reduced time spent “in relationship”
challenged patients and families but health professionals themselves, leading to dissatisfaction, diminished personal health, and lack of engagement in the work. The complexity of today’s bioscientific-technological health systems often renders professionalism and teamwork obscure. And, although most health professionals strive to improve, many do not regularly incorporate best evidence or timely practice improvement into their workflow. Relationships among health professional students, faculty, and clinical preceptors are, in some cases, considered uncivil and leadership practices at all levels are not routinely attending to the fundamental relational nature of health system work.

This is particularly difficult for new health professionals who have been educated “to care” and suddenly find themselves working in health systems that do not advance relationships, have little supportive infrastructure, are focused on throughput and costs, and offer few incentives for professional development. Nurses, who are the largest group of health care providers and are with patients and families for the longest periods of time, are in a unique position to advance a more relationship-centric health care system.

This book provides an overview of the continuing quality crisis in health care, a theoretical foundation for action and application at several levels. The intent of the book is to raise awareness of the significance of caring relationships in improving the safety and quality of health systems. Additionally, it is a call to health professionals, particularly nurses, to action. Safe, quality health care and meaningful work are at stake. Through exploration of several theoretical concepts drawn from multiple sources, a model is revealed that has the capacity to honor nursing’s most deeply held value: caring. The important relationships with self, the community served, patients and families, and the health care team are illuminated and redefined for current practice. Applying the model in clinical, educational, and leadership practice offers possibilities for advancing the value of the nation’s health systems. And, using the Quality-Caring Model as a foundation for research may point to new evidence regarding the contribution of caring relationships to quality health outcomes.

Part I focuses on the continuing problems inherent in complex health systems, including the continuing, disturbing facts about safety and quality and the state of professional practice, particularly in hospitals. The text continues by describing the evolving Quality-Caring Model, a postmodern middle-range theory that emphasizes the value of caring relationships to quality health outcomes. It is a hope-filled approach that is repeatedly emphasized throughout the text with specific exemplars. Part II concentrates on those relationships necessary
for quality caring, namely, relationships with self, patients and families, members of the health care team, and the community. Concepts in the model are described in depth with case studies and examples. And the system characteristics of relational capacity and practice improvement are addressed. Finally, self-advancing systems—those that naturally evolve with attention to caring relationships—ends the section. Part III centers on leading and learning in quality-caring health systems with emphasis on those relational processes that enhance professional practice. To conclude, the future of self-advancing systems—those that add value—is tied to the caring relationships that nurses have always known to be the real foundation for professional practice.

**HOW TO USE THIS BOOK**

The text is intended for use by nursing students, particularly graduate students, and nursing scholars as well as clinical nurses, nurse educators, nurse researchers, and those in nursing leadership positions. Health professionals in other disciplines may also find it helpful. Each chapter contains an introductory section followed by specific narratives holding new information or applications. Areas of special emphasis are boxed to highlight their importance, although specific Calls to Action are included at the end of each chapter. The text offers multiple case examples and includes reflective questions and applications for use in formal education programs, continuing education, workshops and conferences, and general clinical practice. Although these additions are organized for students, nurses in clinical practice, educators, and nurse leaders, they are not mutually exclusive and may be used by health professionals in many different roles. The appendices provide additional resources for those interested in caring relationships in health systems.

Using this period of transition in health systems as an opportunity for advancement, health professionals at all levels are called to remember and renew their commitment to caring relationships as the cornerstone of their practice. In particular, professional nurses, the largest group of health professionals, who are educated “to care” and spend the most time with patients and families, are called to advance a more relationship-centered health system by practicing from a quality-caring base, educating and leading professionalism starting at the undergraduate level, and leading accountable health systems where high-quality relationships flourish.
First and foremost, thank you to those patients and families who crave caring relationships with their health professionals, and who stand to gain the most from them. To them, I owe my deepest gratitude for helping me learn life’s most significant lessons.

Second, to Steve, for steadfastly caring for me as I continue to advance quality caring, and to Emily and to John, her cousin, who continuously remind me of promising futures and caring adventures.

And, finally, to all the professional nurses who “live” quality caring each day—practicing, teaching, researching, and leading—they have afforded me the opportunity to directly observe my nursing dream come true!
Nursing and Health Systems
America’s health care system is neither healthy, caring, or a system.
—Walter Cronkite

PERSISTENT CRISIS OF QUALITY IN HEALTH SYSTEMS

The U.S. health care system continues to experience unprecedented safety, quality, and cost concerns as individuals age, their requirements for acute and chronic services increase, and organizations struggle to meet the demanding criteria required for continued accreditation and certification (Jack et al., 2009; Robert Wood Johnson Foundation, 2011). Since the early Institute of Medicine (IOM) safety and quality reports (IOM, 1999, 2001), major efforts and the consumption of massive resources have been expended to measure, improve, and increase access to health care. Yet, recent research reveals that although some progress has been made, the U.S. health care system remains error prone, lags behind other countries in quality outcomes, and costs too much (Fineberg, 2012; McMahon & Chopra, 2012).

Adverse events in hospitals (not to mention nursing homes, home care, clinics, schools, and outpatient centers) remain a major source of harm, death, and disability for Americans. In fact, in a 10-hospital study in North Carolina using a stratified random sample and 2,341
admission records, no significant changes in the overall rate of harms per 1,000 patient-days were identified over 6 years (from 2002–2007). Despite a 96% rate of hospital enrollment in a national improvement program and extensive participation in statewide safety training programs and improvement collaboratives, North Carolina hospitals in this sample incurred common harms to patients during hospitalization and little evidence of improvement was noted after major improvement initiatives (Landrigan et al., 2010).

A United States Department of Health & Human Services (HHS) report by the Inspector General on Medicare patients revealed that of the nearly 1 million beneficiaries discharged from hospitals in October 2008, about one in seven experienced an adverse event, 13.5% experienced an event that led to temporary harm, and 44% of these were preventable and accounted for $324 million (Department of Health & Human Services, 2010). Even more astounding, the Inspector General recently reported that hospital staff did not report 86% of adverse events, although nurses reported the most events (Department of Health & Human Services, 2012). Likewise, a scorecard of local health performance found access, quality, costs, and health outcomes vary significantly from one local community to another. In addition, the observed variance was often two- to threefold for the key indicators examined (The Commonwealth Fund, 2012).

In nursing homes, quality and safety concerns have been long-standing issues. Although the IOM first published Improving the Quality of Care in Nursing Homes in 1986, common problems associated with the quality of care in nursing homes, such as pressure ulcers, malnutrition and dehydration, use of physical and chemical restraints, incontinence, pain management, and quality of life, persist (IOM, 1986; Werner & Konetzka, 2010). Older adults frequently bounce between nursing homes and hospitals for health care, experience poorer outcomes of care compared to other groups, which are not always the result of illness, but rather consequences of the hospitalization itself, often resulting in new disabilities, nursing home placements, unanticipated interventions, and significant financial burden. For example, functional decline (changes in physical status and mobility) while being hospitalized has been reported as high as 34% to 50% and is identified as the leading complication of hospitalized older adults (Kleinpell, Fletcher, & Jennings, 2008). Up to 56% of hospitalized older adults experience delirium at some point during their hospital stay (Inouye, 2006), and almost 46% of older persons admitted to the hospital report pain. Of these, 19% report moderate to severe pain and 12.9% experience uncontrolled pain (Desbiens, Mueller-Rizner, Connors, Hamel, & Wenger, 1997).
In a recent AARP bulletin, a front-page caption read, “The worst place to be when you’re sick and how to protect yourself” (Greider, 2012, p. 1). The article goes on to state that hospitals are “plagued by daily errors that cost lives” (p. 10) and lists several ways patients can protect themselves from hospital errors. IOM’s latest report, “Best care at lower cost” (IOM, 2012), discusses how the many missed opportunities for improving health care lead to unnecessary suffering, needless deaths, and resource waste.

Although the value of the American health system remains stagnant, new strides are afoot to transform this lagging system. Recently, calls for efforts to share accountability for high-quality care among all providers, disciplines, and associated health care organizations have been raised with the aim of lowering costs and improving quality (Fisher & Shortell, 2010; McClellan, McKethan, Lewis, Roski, & Fisher, 2010; Shortell et al., 2005). Labeled accountable care organizations (ACOs), such shared accountability for health services is a provision of the recent health care legislation (Section 3022 of the Patient Protection and Affordable Care Act [ACA]). Providers and organizations that successfully work together, measure, use and share information, and manage costs will reap benefits such as a portion of the savings, continued Medicare reimbursement, and additional patient volume.

One example of how this new legislation will be enacted is the provision in the law for the reduction in the reimbursement for 30-day hospital readmissions in those patients with heart failure, acute myocardial infarction (AMI), or pneumonia. In anticipation of this, most hospitals have written objectives for reducing preventable readmissions of patients with heart failure or AMI, but the implementation of recommended practices varies widely (Bradley et al., 2012). In fact, by July 2012, Medicare had notified more than 2,000 hospitals—including some nationally recognized ones—that they will be penalized (two thirds of the hospitals whose readmissions they reviewed; Rau, 2012). Of these, a total of 278 hospitals would lose the maximum amount allowed under the health care law: 1% of their base Medicare reimbursements.

Another important provision in the law is labeled partnership for patients (Centers for Medicare & Medicaid Services [CMS], 2011). This strategy is aimed at reducing preventable hospital-acquired conditions or complications that occur during transitions in care and the U.S. Department of Health & Human Services is providing resources to support demonstration projects in this effort. Another provision of the ACA established the Patient Centered Outcomes Research Institute (PCORI), which is focused on comparative effectiveness research that will support better evidence for clinical practice. Pay-for-performance programs and value-based purchasing are further provisions expected
to reimburse and reward hospitals that attain certain quality scores and provide better care for the five most prevalent conditions.

Prompted by this legislation, health systems are scrambling to examine their existing programs and processes and to create new approaches in anticipation of considerable change. The role of the professional nurse in such a transformed system is being carefully scrutinized.

**QUALITY AND PROFESSIONAL NURSING CARE**

Simultaneous with this new legislation, the IOM of the National Academies, in collaboration with the committee on the Robert Wood Johnson Foundation on the Future of Nursing, has released its summary report on the future of nursing. This 2-year national discussion included public forums, site visits, assessments, and individual testimony, all taking place in parallel with the national congressional health care reform debate. The consensus report, “The Future of Nursing: Leading Change, Advancing Health” (IOM, 2011), recommended four key improvements:

- Nurses should practice to the full extent of their education and training.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
- Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
- Effective workforce planning and policy making require better data collection and information infrastructure.

The report highlights nurses’ fundamental role in transforming the health care system and offers specific recommendations for action, including the key message that strong leadership is necessary to effect significant change in health care systems. The report holds that professional nurses must assume accountability for high-quality care, including “taking responsibility for identifying problems and areas of waste, devising and implementing plans for improvement, tracking improvement over time, and making necessary adjustments to realize established goals” (IOM, 2011, p. 8). Furthermore, the report advocates nurses as decision makers who shape health policy while serving on committees, boards, and commissions, and who understand and use data across the health professions to improve patient care. The call for an expanded scope of practice for nurses will require a critical mass...
of professional nurses who have the necessary education and competencies to collaborate with physicians, other health professionals, and administrators to develop new systems of care delivery and generate performance data that will stimulate the practice changes necessary to improve the health of U.S. citizens.

As wonderful as this report is, nursing practice continues to undergo persistent quality difficulties and some indications suggest that it has worsened in recent years. Anecdotal evidence of this can be found in an essay from a “secret shopper” at a hospital. In this article, a nurse who was visiting her 80-year-old mother after emergency surgery was frustrated at “a pain rating of 8 despite a completed rounding sheet, lack of caring behaviors, a developing wound infection, nurses who answered questions with ‘because the doctor ordered it or I don’t know this patient,’ lack of hand washing, a nurse leader who made rounds daily with a clipboard hastily asking if things were OK …” (Samuels, 2009, p. 51). These actions left the nurse with the impression that registered nurses (RNs) at this organization did not understand their power to influence the patient experience, nursing leadership did not really listen or attend to patient/family needs, and helping patients feel important or that they mattered (an important aspect of caring) was not considered a valued professional behavior.

Other reports of recent poor quality nursing care can be found in abundance through publicly accessed journals as well as the professional literature: poor support for breastfeeding in the United States (Centers for Disease Control and Prevention [CDC], 2011), stolen patient identities in a south Florida emergency room (LaMendola & Gehrke-White, 2012), failure to protect the dignity of older patients and ensuring sufficient food and water in England (Campbell & Meikel, 2011), multiple stories of personal harm to individual patients (“Health Care for All,” 2012), poor discharge preparation (Jack et al., 2009), and poor nursing care in acute inpatient psychiatric units (compared to other hospital units) assessed by nurses themselves (Hanrahan & Aiken, 2008). A common theme in all of these reports is lacking, limited, or missed basic nursing care.

A well-known nurse researcher who studies the quality of nursing care shared her story of inpatient care while she was a patient for 7 days in an acute care U.S. hospital. In intense pain at an unfamiliar hospital, this nurse waited several hours for medication, had practically no hygiene care, encountered staff members who repeatedly scolded her for making a mess of her many tubes, did not receive any ambulation or record of intake and output, and no discharge planning. Consequently, rehabilitation for deconditioning after discharge was required. This experience corroborated the research she was conducting on missed nursing care.
Missed nursing care is defined as any aspect of required patient care that is omitted (either in part or in whole) or delayed (Kalisch, Landstrom, & Hinshaw, 2009). Although not an adverse outcome per se, missed nursing care appears to be occurring on a regular basis in hospitals everywhere. According to Kalisch et al. (2011), we have allowed a “culture of missing care” to evolve over time and nurses who have practiced more than 20 years point to a major decline in completeness of nursing care over the last several decades. Missed nursing care is considered an error of omission that potentially leads to negative outcomes, varies across hospitals, and is impacted by several variables (Kalisch et al., 2011).

In a secondary analysis of 10,184 nurses in 168 acute care hospitals in the United States, the proportion of missed nursing care ranged from 26% to as high as 74%, even after adjusting for patient characteristics and the care environment (Lucero, Lake, & Aiken, 2010). In the same study, nurses themselves reported on unmet care and adverse events, such as medication errors, nosocomial infections, and falls. Interestingly, the unmet care needs fell in the categories of patient teaching, discharge planning, comfort, inadequate patient–nurse interactions, oral hygiene and skin care, adequate documentation, and updating care plans. “Evidence from this study suggests that unmet nursing care needs were significantly associated with adverse patient events in acute hospitals” (p. 2192) and suggests that nursing care in hospitals plays a significant role in quality outcomes.

The concerning range of unmet nursing care needs reported in this study may not represent the totality of unmet care needs but represents the need to drastically alter how nursing is practiced!

Because their continuous interactions and intimate relationships with patients and families uniquely position nurses to positively influence experiences of care and other significant health outcomes, nurses could harness and leverage that power to their advantage.

Instead, one has to wonder sadly why nurses have allowed the gradual decline of professional caring behaviors, particularly in hospitals. Is it protective in some way? Is the incessant focus on specific quality indicators set by others so pervasive that the patient’s view is not considered important? Is the transition to electronic health records
or other new initiatives getting in the way? Do those who assist or support nursing understand and value the connection between basic nursing tasks and health outcomes? Are nurses just plain tired?

**IMPROVING QUALITY IN NURSING AND HEALTH SYSTEMS**

Nursing-sensitive indicators are used widely today by many organizations, accrediting agencies, and insurers as measures of nursing care quality. This set of performance indicators, first developed by the American Nurses Association (ANA, 1995), provides internal and benchmarking information related to nursing care. Described in detail in the first chapter of *Quality Caring in Nursing* (Duffy, 2009b), many organizations have used these indicators to improve their performance and now receive reimbursement on adequate attainment of several of them, for example falls and pressure ulcers.

Another gold standard of nursing excellence and patient quality has been the attainment of Magnet® designation. Some research has confirmed that Magnet-designated hospitals provide positive work environments for nurses and may improve nurse satisfaction; however, research on patient outcomes in Magnet hospitals is unclear. For example, using bivariate and multivariate analyses, comparisons of patient outcomes in the University Health Systems Consortium and nurse staffing in general units and intensive care units (ICUs) of Magnet and non-Magnet hospitals revealed that non-Magnet hospitals had better patient outcomes than Magnet hospitals (Goode, Blegen, Park, Vaughn, & Spetz, 2011). Thus, more research is necessary to better understand the relationships between Magnet designation and patient outcomes.

Although striving for excellence through the attainment of external designations and certifications and routinely examining internal performance is laudable and oftentimes required, the use of external evidence—such as that found in the professional literature, in the form of practice guidelines and research—provides a more comprehensive evidence base from which to activate practice changes. One example of this is the international interest in nursing shift report.

Variation in nursing shift report has been well documented and although many organizations are actively working on improving nursing shift report, there are no high-quality studies that guide nurses on how best to provide a shift report (Wolverton et al., in press). Yet, various nursing shift report strategies are being used throughout the country, oftentimes without an evidence base or proper evaluation, which may be unnecessarily expending resources. Another example is
the known link between health care worker fatigue and patient safety (Scott, Rogers, Hwang, & Zhang, 2006). The practice of working long shifts contributes to high levels of worker fatigue and reduced productivity, impacting patient safety, yet nurses and nurse leaders continue to support, hire, and promote 12-hour shifts (that frequently extend to 16-hour or longer shifts). Heeding recent research findings may promote a healthier, safer work environment for both patients and nurses.

To significantly improve quality and better meet patient needs (and ultimately patient outcomes) in a timely fashion, new ways of quality improvement are needed (Devers, 2011). Active learning communities at the unit/department level and multisite improvement collaboratives that regularly generate, value, and rapidly use internal and external evidence to improve practice are necessary. For example, a 12-hospital performance improvement collaborative worked together to improve patient–nurse relationship quality by routinely examining and disseminating data, benchmarking, and recommending improvements (Duffy & Brewer, 2011). Importantly, valuing and including the patient’s perspective in this project provided the data required for several practice changes.

Assessing the quality of and continuously improving the patient–nurse relationship are crucial concerns for health systems today as evidence is beginning to mount that the quality of patient–nurse relationships is linked to important safety and quality outcomes (Duffy, Kooken, Wolverton, & Weaver, 2012a). In a literature review, Brady et al. (2009) stated, “Nurses … are the medium through which other professionals and staff interface with patients. Thus, surveillance of the entire patient experience is implicit in the role of the professional nurse” (p. 162). Little data are routinely collected informing RNs of the quality of the patient–nurse relationship, yet “RN’s represent a continuous and stabilizing force that engages patients, monitors and validates their progress, provides encouragement, ensures dignity and confidentiality, guarantees safety, coordinates care among multiple health care providers, and performs specialized interventions. The patient–nurse relationship thus provides the context for care as vulnerable patients and families depend on RNs for safe and high-quality services” (Duffy & Brewer, 2011, p. 79).

Attending to the regular evaluation and improvement of the patient–RN relationship may demonstrate the significance of the RN’s role in the provision of patient-centered care and facilitate the attainment of high-reliability health systems, where consistently safe and high-quality services thrive.
SUSTAINING A VALUABLE HEALTH SYSTEM

Because the U.S. health system today performs at a relatively lower level than others while simultaneously costing more, the problem of sustaining a high-value system is harder. Americans still must wait long periods for office visits, tests, and procedures; read about or experience adverse outcomes such as hospital-acquired infections, bedsores, or wrong-site procedures; endure multiple providers who do not talk to one another; receive outrageous charges for services; experience sleeplessness, unnecessary pain, and anxiety during hospitalization; and worst of all, be made to feel as if they don’t matter, are unimportant, or are not invited to participate in the decision making about their health.

A sustainable high-value health system will not be realized with electronic health records, comparative effectiveness research, or new payment mechanisms alone. All of these will contribute of course, but at its core, delivering high-value health care depends on caring for patients and families. Nurses, the largest group of health professionals who interact 24/7 with patients and families, are key. The increasing evidence that caring patient–nurse relationships are worthy contributors to safe and quality health systems provides a unique, but brief, opportunity to showcase its potential. Accountability, an important aspect of professional practice, may help nurses to leverage the power that continues to be invisible and underused.

Accountability signifies intent, ownership, commitment, obligation, and willingness (Rachel, 2012), or to use a baseball metaphor, stepping up to the plate. It is no longer okay to languish in a job, to not engage in lifelong learning, to not consider caring relationships essential to professional practice, to not partner with professional colleagues, or to not participate in practice improvement. These behaviors are pertinent to the entire practice of nursing—clinical, educational, and leadership.

Strengthening the nursing workforce through advanced academic progression that is accessible, meaningful, and values based is paramount. Caring relationships, the most often described value associated with nursing, must remain a major thrust of nursing education with appropriate didactic and experiential learning opportunities to understand, cultivate, and appreciate its significance to safe and quality health systems.

We must hold each other accountable for caring professional practice, including recognizing, listening, observing, and confronting unacceptable caring behaviors and attitudes.
Although many nurse educators are working on curricular change as this text is being written, careful attention to the need for “relational capacity” (described in Chapter 6) is necessary to effectively prepare the next generation of nurses. More comprehensive and efficient program evaluation with explicit indicators of learning are needed by nurse educators to assess whether the curricula they design is meeting the needs of creating a valuable health system. Holding each other accountable by attending to the evidence related to valuable health systems, how best to help students learn, and one’s own teaching abilities will ensure responsible curricular changes and, we hope, engaged, caring nurse graduates.

Nursing leaders at all levels must hold each other and those they supervise accountable for caring professional practice. This includes consistently modeling accountability, being clear and direct in terms of what defines and is acceptable nursing professional practice, and how caring professional practice will be recognized and rewarded. Increasing time that professional nurses spend in direct patient care, insisting on high-quality patient–nurse relationships as the basis for professional practice, enhancing the work environment, stimulating career development, and demanding that those who assist professional nurses effectively contribute to the team are some approaches that nursing leaders may find advantageous. Of course, using the evidence to guide practice is paramount.

Although many recommendations were made in Fineberg’s (2012) recent Shattuck lecture calling for an accelerated rate of improvement in the U.S. health system, this last one says it all: “champion a new ethos of … professionalism that values accountability above autonomy; supports team-based care and interprofessional education; and accepts responsibility for a system to serve all patients, not only one’s own” (p. 1026). With the patient and family at its core, nurses who practice from a caring professional base will advance the value of the nation’s health system.

SUMMARY

In this chapter, the persistent crisis of health system quality has been reviewed. Of particular concern is the continuing slow progress toward its improvement, including cost-reduction efforts, despite the massive resources that have been devoted to it. The value of the U.S. health system lags behind many other countries and although recent legislation aims to improve it, improvement remains to be seen. Professional nursing, the largest health system discipline, continues to have quality problems as perceived by patients, families, and nurses themselves. In fact, a “culture of missing care” has evolved over time and now seems rather usual in acute care hospitals. Although routine evaluation of
nurse-sensitive indicators and attainment of certifications has stimulated some improvement, speedier translation of external evidence to the bedside will advance the value of nursing care even further. Attending to the routine evaluation, continuous improvement, and scientific investigation of patient–RN relationships may demonstrate the significance of the RNs’ role in the provision of patient-centered care and facilitate the attainment of high-reliability health systems. Accountable professional practice may help nurses leverage the caring power that continues to be invisible and underused to positively benefit the evolving health system.

Call to Action

The value of the nation’s health system is, in part, dependent on the accountability of its professional nurses for delivering caring patient–nurse relationships. **Accept** the responsibility for high-quality patient–nurse relationships.

REFLECTIVE QUESTIONS/APPLICATIONS

... for Students

1. What are your perceptions about the value of the health system?
2. Analyze the Patient Protection and Affordable Care Act in terms of its ability to increase the value of the U.S. health system.
3. Reflect on the role of the professional nurse in a reformed health system. How will he or she be spending the majority of time?
4. Outline your plans to acquire the skills necessary for collaboration with other health professionals and generate performance data.

... for Professional Nurses in Clinical Practice

1. Discuss the persistent quality problems in your health care institution.
2. Is there an accepted “culture of missing care”? If so, who is responsible for its evolution?
3. How or should missed nursing care be corrected?
4. How have collecting and reporting on nursing-sensitive quality indicators improved nursing care in your institution?
5. What new evidence-based nursing interventions or care guidelines have recently been introduced in your unit? Was the evidence from which they were based explicit? How have they been evaluated?
6. How do you hold yourself and fellow nurses accountable for caring relationships?

… for Professional Nurses in Educational Practice

1. Has curricular revision taken hold in your institution? If yes, what evidence did you use to shape it? How did you attend to the relational capacity of your graduates?
2. Reflect on the Affordable Care Act. How do you think your educational program will change as a result? What new knowledge and skills will be expected of nursing graduates?
3. How have the learning outcomes specified in your evaluation plan improved over the past 3 years? How does/did this inform curriculum revision?
4. How do you assess caring competence? Is it even necessary?

… for Professional Nurses in Leadership Practice

1. How has the value of nursing care improved over the past 3 years at your institution?
2. How have you articulated the role of the professional nurse at your institution?
3. Reflect on the career development activities in place at your institution. Are they working? How do you know?
4. Describe the evidence base that is routinely used to make leadership decisions at your institution.
5. How do you ensure accountability for caring patient–nurse relationships?