Quality Caring in Nursing

Applying Theory to Clinical Practice, Education, and Leadership

JOANNE R. DUFFY, PhD, RN, FAAN

SPRINGER PUBLISHING COMPANY
New York
Joanne R. Duffy, PhD, RN, FAAN, has over 35 years of nursing experience encompassing clinical, administrative, and academic roles. She is currently a Professor at the Indiana University School of Nursing in Indianapolis, IN, and a Fellow in the American Academy of Nursing.

Dr. Duffy has coordinated three graduate nursing programs (critical care, care management, and nursing administration) and was a former Division Director of a school of nursing. She has held various administrative positions directing critical care and transplantation nursing services as well as being the founding director of a nurse-run Center for Outcomes Analysis. She has published extensively across 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 and has designed the Caring Assessment Tool in multiple versions. She is a recipient of several nursing awards, a frequent guest speaker, and a Magnet Appraiser.

Dr. Duffy was the Principal Investigator on the national demonstration project, Relationship-Centered Caring in Acute Care, where the Quality-Caring Model© is being evaluated at two sites in terms of patient, nurse, and system outcomes. She provided direction for the Telehomecare and Heart Failure Outcomes project. She was a consultant to the American Nurses Association (ANA) in the development and implementation of the National Database of Nursing Quality Indicators (NDNQI) and is currently the chair of the National League for Nursing’s (NLN) Nursing Educational Research Advisory Council.
Contents

Foreword vii
Preface ix
Acknowledgments xiii

PART 1: NURSING’S UNIQUE CONTRIBUTION TO HEALTH CARE  1

1 Quality and Nursing Practice  3
2 A Framework for Quality Nursing Practice 27

PART 2: RELATIONSHIP-CENTERED CARING  45

3 Caring for Self  47
4 Caring for Patients and Families  63
5 Caring for Each Other  85
6 Caring for Communities  99

PART 3: THE POWER OF RELATIONSHIPS FOR ADVANCING HEALTH CARE QUALITY  111

7 Leading Quality Caring  113
8 Teaching and Learning Quality Caring 133
Contents

9    Evaluating and Researching Quality Caring    165
10   The Quality-Caring Model© Revisited    189

APPENDICES    225

Appendix A: Quality- and Caring-Based Resources on the Internet    227
Appendix B: Implications of the Quality-Caring Model©    229
Appendix C: Reflections for Clinical Practice    231
Appendix D: Using the Caring Factors to Keep Patients Safe    233
Appendix E: Course Objectives and Content Outline for a Staff Nurse Research Internship in Human Caring    235
Appendix F: Assessment of Caring Professional Practice    237
Appendix G: Potential Research Questions for Caring Science    239

INDEX    241
Joanne Duffy’s work in theory-guided caring and issues of quality caring, in education, practice, and research, spans more than two decades of scholarship and sustained focus. Her scholarship in this area has deepened and expanded with each turn of her career, culminating in this comprehensive book, which demonstrates her unique contributions to this field of increasing importance. Her book offers a coherent, theoretical, and research-guided framework for quality nursing caring in practice, education, and leadership; a foundational, timeless, yet transformative framework of substance related to caring and quality, for which systems and society yearn at this point in the history of nursing and health care.

Here, Duffy’s classic model, Quality Caring and Quality Nursing Practice (The Quality-Caring Model©), is revisited and reconsidered. It is grounded in a comprehensive framework that addresses and encompasses caring for self, patients, families, each other, and communities. The power of relationships, the teaching and learning of caring, and caring leadership are addressed in such a way that the reader is invited both into conceptual and theoretical ideas along with an opportunity to engage in specific skills of evaluating and researching caring. In this way, the book offers the most contemporary literature on caring as well as action steps for informed engagement by students and scholars alike.

Duffy’s book brings coherence and congruence between and among professional values, knowledge, and behaviors of caring in nursing and health care generally. In the end, Duffy’s “quality caring” brings new meaning to quality and to caring. At the same time, the book is both power-filled in its focus as well as empowering. Any reader of the work is invited into an open space that reconnects the heart of nursing with the heart of caring science scholarship. As a significant and timely contribution to nursing and caring science, Duffy incorporates into the book a new level of values, philosophical and ethical orientations, along with knowledge and understanding if not wisdom. Indeed, Joanne Duffy’s
work and life career in this area continue to advance and elevate nurs-
ing and quality caring to a new place in the maturity of nursing as both a
discipline and profession.

Jean Watson, PhD, RN, AHN-BC, FAAN
Distinguished Professor of Nursing
Murchinson-Scoville Endowed Chair in Caring Science
University of Colorado, Denver
College of Nursing
and
Founder/Director
Watson Caring Science Institute
Boulder, Colorado
www.uchsc.edu/nursing/caring
www.watsoncaringscience.org
jean.watson@uchsc.edu
Patients and families are suffering today not only from their illnesses but from the health care system itself. Fragmented processes, medical errors, and lack of caring relationships with their health care providers create uncertainty, unnecessary stress, discomfort, functional decline, dissatisfaction with care, and unnecessary financial burdens. Evidence of this can be found in conversations in hospital waiting rooms, newspaper articles, consumer magazines, and professional journals. Dedicated time spent with patients and families at the bedside, in medical offices, at nursing homes, or schools is limited and often rushed and impersonal. Patients and families, at some of the most vulnerable times of life, are frequently left to wonder if they are safe and who will be there for them when they need it most. The foundational caring value of health professionals has been marginalized as modern health care, with its emphasis on diagnostic testing, medications, and procedures, has shifted its attention to tasks, technology, and costs.

This incongruity between the professional values and behaviors of health care professionals is serious and may be linked to poor health care outcomes. Not only has the reduced time spent “in relationship” challenged patients and families but health care providers themselves, particularly professional nurses, who may be jeopardizing their professional integrity (acting in accordance with the core values of one’s profession, such as the value of caring in nursing) leading to dissatisfaction and lack of motivation surrounding work. This is particularly difficult for the new graduate nurse who has been educated “to care” and then finds himself/herself working in a department that is rushed, has little supportive infrastructure, is focused on throughput and staffing, and offers 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, are in a unique position to advance a more relationship-oriented health care system. Through
theory-based practice models, values-based curricula, and relationship-centered leadership (including redesigned patient care delivery systems and governance models focused on the primacy of relationships), the gap between professional values and professional practice can be narrowed. Never has it been more important to advance this agenda, for nursing itself may be in jeopardy.

This book provides an overview of the 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 nursing’s significance in improving the quality of the health care system. Additionally, it is a call to professional nurses, all nurses, to action. Safe, quality health care and meaningful work are at stake.

Through exploration of 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, community, patients and families, and the health care team are illuminated and redefined for current practice. Applying the model in practice, education, and leadership offers possibilities for caring-healing-protective environments where genuine professional nursing can flourish. Using the model as a foundation for research may point to new evidence of nursing’s contribution to quality health care.

Part 1 focuses on nursing’s unique contribution to health care and highlights the value of nursing to the current quality crisis. It reviews the original Quality-Caring Model®, a postmodern middle range theory of caring. Part 2 concentrates on those relationships necessary for quality caring. Relationships with self, patients and families, members of the health care team, and the community are described using great detail and examples. Part 3 centers on the application of quality caring in clinical practice, nursing education, research, and leadership. Finally, the future of nursing and health care is forecasted as complex, interactive, and integrative. Using this background, the Quality-Caring Model® is revised.

**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. 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 while 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, educators, and nurse leaders, they are not mutually exclusive and may be used by nurses in many different roles. The Appendices provide additional resources for those interested in caring clinical practice, education, and leadership.

The text begins with disturbing facts about quality and the state of professional nursing practice particularly in hospitals; yet, the value of professional nursing to quality health care and society is repeatedly emphasized. Using this period of disillusionment in health care as an opportunity for growth, professional nurses at all levels are called to remember and renew their commitment to caring relationships as the cornerstone of their practice.
To the five men in my life . . . my husband, Steve, who embodies caring and has lovingly cared for me during our long marriage; my son, Kevin, who values history and the arts and who uses humor to lighten my world; and my three baby grandsons—Matthew, Brian, and Jake—who delight me with their smiles and hugs. And to my two daughters . . . Erin, who now shares the wonder of motherhood with me; and Meghan, who appreciates the French heritage of her grandmother, my mother, who is with God, watching over us all.
Nursing’s Unique Contribution to Health Care
Quality and Nursing Practice

Quality in a product or service is not what the provider puts in. It is what the customer gets out.

—Peter F. Drucker

**Keywords:** quality, health care, nursing

**THE CRISIS OF QUALITY IN HEALTH CARE**

In the now famous Institute of Medicine (IOM) reports, health care quality and safety threats were widely acknowledged (IOM, 1999, 2001). In fact, it was estimated that almost 100,000 Americans die annually in hospitals due to errors. In another report, it was recognized that 18% of hospitalized patients experience a serious medication error (Davis et al., 2004). Furthermore, using the Centers for Disease Control (CDC) reported health care–associated infections, an estimated 1.7 million infections and 99,000 associated deaths occur each year (Klevens et al., 2007). A landmark RAND corporation study completed in 2006 reported that Americans only receive half of recommended medical care and that having health insurance was not a ticket to quality care (Asch et al., 2006). Reports of Americans choosing hospitals in other countries are rising (Corchado & Iliff, 2007), and in one northeastern state, a teaching
hospital was fined for operating on the wrong side of patients’ heads for the third time (Associated Press, 2007b). A surprise Joint Commission check at another prominent northeastern hospital found numerous problems with medication safety and inconsistent handwashing (Kowalczyk, 2007). And, in long-term care, “serious problems concerning quality of care . . . continue to affect residents of this country’s nursing homes” (IOM, 2001, p. 2). On November 29, 2007, the U.S. federal government publicly listed 54 nursing homes as the worst in their states in order to stimulate improvement in their services (Associated Press, 2007a).

Needless pain, disability, anxiety, and additional costs attributed to poor-quality health care threaten Americans as they age, attempt to manage chronic illness, and deal with issues such as violence, obesity, and substance abuse. What is even worse is that several years after these reports highlighted the rising health care quality crisis, many Americans say they do not believe the nation’s health care has improved; in fact, 40% believe it has gotten worse (Clancy, Farquhar, & Sharp, 2005).

Since 2001, quality improvement initiatives and research have documented that while many indicators of quality are improving, many more remain problematic. For example, in a recent supplement to the Joint Commission Journal of Quality and Patient Safety (Institute for Healthcare Improvement, 2007), authors cited fatigue, inadequate nurse staffing levels, and emergency department crowding as persistent threats to patient safety, and the 2007 Health Grades Hospital Study reported that “significant variation in the quality of care provided by the nation’s hospitals has persisted over the last eight years despite numerous quality initiatives at the hospital, local, state and federal levels” (p. 4). For example, among the 18 conditions studied during the prior year, 266,604 potentially preventable deaths occurred among Medicare recipients (Health Grades, Inc., 2007). Additionally, hospitals located in the East North Central region (Illinois, Indiana, Michigan, Ohio, and Wisconsin) had the best performance, while hospitals located in the East South Central (Alabama, Kentucky, Missouri, and Tennessee) had the worst performance with respect to risk-adjusted mortality. And in the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) annual report, although measurable improvement in quality and safety was noted, much room for improvement remained (JCAHO, 2007). In this report, consistent performance in several quality measures was less than expected, and continued variability in performance of hospitals by state was noted. In long-term care, the problem is much worse. In a government report of nursing home inspections, more than
22% actually caused harm to their residents (General Accounting Office, 2003).

Although the Agency for Healthcare Research and Quality (AHRQ), the JCAHO, the Institute for Healthcare Improvement (IHI), and the National Quality Forum (NQF) are making great strides through funding research and setting quality standards, the value of the American health care system has declined. It suffers from an older industrialized model, lack of communication and coordination, major safety concerns, inconsistent follow-up, insufficient numbers and education of workers, poor reimbursement systems, and lack of concern for the individual being treated. Most disturbing is this last component. In a recent account of his hospitalization, a national radio talk show host said, “the nurse didn’t help, he just stood there and drummed his fingers against the door, made no eye contact, and walked in front of me.” And when the same patient expressed his fear about his inability to breathe, another nurse replied, “you look like you’re breathing fine to me” (Beck, 2008). The radio host went on to describe his fear of the night, the constant messages that he didn’t matter, and his loss of dignity as his wife was forced to clean him in a dirty shower stall. While admitting that he was taking several pain killers, the radio host called this lack of patient-centeredness a “compassion pandemic” and went on to say that he experienced the health care system at its very worst.

Health care today is rushed, impersonal, and often stress-provoking. For example, it is still the norm to see a health care provider in a busy office/clinic for a few minutes at best and leave without questions answered, adequate knowledge, lack of understanding in self-care, or prevention of future illness. Hospital emergency department overcrowding and long delays are common (Trzeciak & Rivers, 2003), and access to inpatient beds often requires multiple phone calls and often painfully long waits in hallways. Sick persons are expected to obey the rules set by hospital staff; for example, the timing of procedures. A male patient recovering from thoracic surgery recently relayed that he was awakened at 3:15 A.M. on his second postoperative night for a chest X-ray because “we had time to do it.” Communications and handoffs between hospital departments and nursing shifts are often inaccurate or untimely resulting in missed or lost information, many times influencing errors (Hughes & Clancy, 2007). The individualized human concern and relationship context one would expect from health care professionals is frequently forgotten in the busyness of modern health care systems. Furthermore, mutual decision making about the care received or alternatives to
suggested care are almost nonexistent. In the business world, such lack of attention to customer expectations and needs would most certainly lead to bankruptcy and eventual collapse!

So, despite the most costly health care system in the world, the U.S. health care enterprise underperforms and, some would say, even causes harm to patients and families. The reality is that American health care professionals remain in denial about the quality of care they provide and the somewhat overt problems that plague the system. The education of physicians and nurses, while slowly changing, remains fact-based and rule-dominated; providers themselves are overworked and do not regularly practice their own self-caring; hospitals and long-term care facilities are slow to change; and reimbursement pressures plague the system.

**QUALITY AND PROFESSIONAL NURSING PRACTICE**

As the largest group of health care professionals, nurses contribute in positive and negative ways to the health care quality problem. Nurses have intimate knowledge of patient needs, and the continuous interactions nurses maintain with patients and families uniquely position them to positively influence their hospital experiences and resultant outcomes. In fact, the IHI’s *Transforming Care at the Bedside* initiative supports that “RNs play a central role in ensuring the quality of hospital care” (Rutherford, Lee, & Greiner, 2004, p. 2). While few reports were found in the professional literature regarding poor nurse quality, perceptions of a decline in quality among hospital nurses and patients have risen in recent years.

In 2001, the Milbank Memorial Fund published a report by Dr. Claire Fagin of the University of Pennsylvania to document these perceptions. The report synthesized research studies, newspaper and magazine articles, and personal experience to conclude that “there is considerable evidence that nurses and families are very concerned about the erosion of care and fearful about hospital safety” (Fagin, 2001, p. 3). One aspect of the report suggested that the reduction in the amount of time professional nurses spend in direct patient care was a cause. The growing use of unlicensed assistive personnel (UAP) since the mid-90s has contributed to this perception. Coupled with the nursing shortage (Beurhaus, Donelan, Ulrich, Norman, & Dittus, 2005), the perception persists that professional nurses are less involved with direct care and more often observed administering medications or supervising others in
direct care (Duffy, Baldwin, & Mastorovich, 2007). Personal experience by this author and others substantiates that hospital professional nurses have little time to spend listening to patients’ concerns, coming to know them as unique human beings, educating them about their illnesses, and attending to their needs for comfort, support, and security. In fact, some health care providers advise taking another health professional or reliable family member to the hospital during admissions to ensure high-quality care (Consumer Reports, 2003; Trafford, 2001).

A doctorally prepared nurse speaking at a national conference recently recounted her experience with her mother who was admitted to an acute care hospital for a surgical procedure (Amendolair, 2008). The mother was limited in her hearing, and the nurses, who used a computer to document assessment data, faced the computer rather than the patient each time they inquired about her last bowel movement. The patient could not hear them so she didn’t respond, and the nurses did not validate the patient’s answer, so they charted seven times over the course of three days that she had a bowel movement when, in fact, she had not. Eventually, the patient became impacted.

Another nurse wrote of her experiences receiving nursing care after major surgery for uterine cancer in a major teaching hospital. “From admission through discharge, I was appalled with the lack of knowledgeable and compassionate care . . . unfortunately, I had to provide the knowledgeable component for my own care. For example, I diagnosed my paralytic ileus, since not one nurse placed a stethoscope on my belly to assess for bowel sounds after major abdominal surgery, and I kept track of my own intake and output and determined when I was dehydrated” (Todaro-Franceschi, 2007, p. 230). She went on to say it took her a long time to heal, and she was saddened by the state of nursing she experienced.

In one grounded theory approach to better understanding patients’ experiences of “not so good” nursing care, the author found that care delivered routinely, that was unrelated to patient needs and performed in an impersonal manner, was considered by patients to be of lower quality (Attree, 2001). Using a convenient sample of 80 patients and 30 nurses in acute care, a descriptive study in Sweden found that “RNs had considerable difficulty identifying the needs of their patients,” and emotions/spirituality and nutrition had the lowest ratings (Florin, Ehrenberg, & Ehnfors, 2005, p. 9). In another Swedish descriptive study, patients reported care quality in the emergency department as fairly good with several areas needing improvement (Muntlin, Gunningberg, & Carlsson, 2006).
An important U.S. study of the quality of nursing care found significant variations in nursing care quality (Chang et al., 2002). Using a retrospective medical records peer review process, 291 heart failure (HF) and 283 stroke patients’ records were randomly selected from 5 states. Trained nurse peer-reviewers used a quality rating scale based on the nursing process to evaluate the overall quality of nursing care. Findings revealed that systematic variations in nursing care were linked to hospital type (smaller hospitals provided significantly worse nursing care) and geography (more rural locations were associated with worse nursing care); furthermore, variations in care were more pronounced in HF patients than those patients with strokes. Although the sample of records is from the 1980s, this study is important because it documents nursing variation in care for the first time and demonstrates the inconsistent application of the nursing process. With the current approach to assigning some clinical responsibilities to unlicensed assistive personnel, the nursing shortage, and higher acuity in American hospitals, one would suspect that these problems persist and may even be worse.

Kalisch (2006) used a qualitative approach to determine whether opportunities for nursing care were regularly overlooked and the reasons for such missed care on American hospital medical-surgical units. Using two hospitals and focus group interviews with nurses and nursing assistants, Kalisch found nine areas of regularly missed nursing care. They were: ambulation, turning, feeding, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance. Although limited by the sample, this study’s results are profound in that the reasons for missed care were often related to the nurses themselves. For example, ineffective delegation, “it’s not my job syndrome,” habit, the amount of time involved, and denial were cited as some reasons for missed care. Furthermore, these areas of omitted nursing care may have untoward effects on patient outcomes. This study’s results point out that, in this sample, behaviors traditionally associated with good nursing care were often overlooked or not completed and that nurses failed to follow up on delegated tasks and used denial as a coping mechanism to deal with missed care.

In another qualitative study in Iceland, subjects who experienced nurses who provided bad quality care described the nurses as indifferent, having no initiative, or having a negative attitude (Thorsteinsson, 2002). Those subjects also described poor quality nursing care as producing negative effects such as anger or stress. Newspaper accounts of poor quality nursing care in hospitals and nursing homes are abundant, and many
have been attributed primarily to the recent nursing shortage. However, experiences with noncaring nurses have been documented for a long time. As early as 1986, noncaring behaviors by nurses were cited in the professional literature (Reiman, 1986). In this report, Reiman described a nurse’s interaction with a 21-year-old woman with lupus erythematosus as discouraging. She went on to say, “it is frightening to realize that at a time when patients are so vulnerable, nurses are perceived as doing those very things that make patients even more vulnerable” (p. 33). Kelly (1988) reported that noncaring behaviors by hospital nurses existed and accounted for needless patient and family anxiety. The descriptions of nursing behaviors as rough, causing unnecessary pain, and void of concern resulted in loss of human dignity for the patients in this sample. Lastly, Proudfoot (1983) spoke to nurses as having “hurry sickness.”

One would have to ask, “Has anything changed?” Despite almost three decades of study of the essential caring behaviors required for expert nursing practice (Benner & Wrubel, 1989; Boykin & Schoenhofer, 1993; Leininger, 1998; Roach, 1984; Swanson, 1991; Watson, 1979, 1985), caring practices by professional nurses remain problematic. They are present but hidden in daily practice by some nurses, kept separated from the “doing” aspect of nursing, and seemingly absent in others. Along with the decrease in numbers of professional nurses and the rushed, task-oriented, impersonal nature of health care, it seems as if caring in nursing has been devalued. In reality, the very foundation of the profession may be broken (see Figure 1.1).

So, while solid evidence about inadequate nursing care is limited, perceptions exist among nurses, physicians, and patients and families about the declining professional nurse role particularly in hospitals. Quantitative evidence from which to judge the nature of nursing quality or its relationship to patient outcomes has been scarce.

**INDICATORS OF NURSING QUALITY**

Indicators, or measures, that specifically reflect nursing care are considered nursing-sensitive and are used to evaluate and demonstrate to the public how nursing contributes to the quality and safety of health care recipients, particularly those who are hospitalized. Dr. Norma Lang pioneered the quality assurance effort in nursing beginning in the early 1970s, developing a model of nursing quality assessment, publishing in peer-reviewed journals, and conducting numerous workshops advocating
for a standardized nursing language and consulting in both nursing education and nursing service (Lang, 2003). She helped enhance the knowledge of evidence-based nursing and provided a lens from which to view and improve nursing quality.

In 1995, the American Nurses Association (ANA) embarked on a study of nursing-sensitive indicators from which they could track data linked to nursing care. Using a series of focus groups and a Delphi approach, the ANA identified 10 indicators for acute care while an additional 10 indicators for community-based nursing were added in 2000 (Gallagher, 2005; Gallagher & Rowell, 2003). (See Tables 1.1 and 1.2 for a list of the ANA indicators.)

The ANA’s investment in the program *Patient Safety Nurse Quality*, a national comparative database of nursing-sensitive quality indicators intended to measure the impact of professional nurses on health care outcomes, is used by hospitals to improve the quality of their nursing services. The database, known as the National Database of Nursing Quality Indicators (NDNQI), uses the structure, process, and outcomes indicators that reflect nursing’s contribution to patient care (ANA, 2000;
### Table 1.1
**AMERICAN NURSES ASSOCIATION’S ACUTE CARE NURSING-SENSITIVE INDICATORS**

<table>
<thead>
<tr>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing hours</td>
</tr>
<tr>
<td>Nosocomial infections</td>
</tr>
<tr>
<td>Nurse satisfaction</td>
</tr>
<tr>
<td>Patient injuries (falls)</td>
</tr>
<tr>
<td>Pressure ulcers</td>
</tr>
<tr>
<td>Staff mix</td>
</tr>
<tr>
<td>Patient satisfaction (overall)</td>
</tr>
<tr>
<td>Patient satisfaction (education)</td>
</tr>
<tr>
<td>Patient satisfaction (nursing care)</td>
</tr>
<tr>
<td>Patient satisfaction (pain management)</td>
</tr>
</tbody>
</table>


### Table 1.2
**COMMUNITY-BASED, NONACUTE CARE INDICATORS**

<table>
<thead>
<tr>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain management</td>
</tr>
<tr>
<td>Consistency of communication</td>
</tr>
<tr>
<td>Staff mix (use of services)</td>
</tr>
<tr>
<td>Client satisfaction</td>
</tr>
<tr>
<td>Prevention of tobacco use (risk reduction)</td>
</tr>
<tr>
<td>Cardiovascular prevention (risk reduction)</td>
</tr>
<tr>
<td>Caregiver activity (protective factors)</td>
</tr>
<tr>
<td>Identification of primary caregiver (protective factors)</td>
</tr>
<tr>
<td>ADL/IADL (level of function)</td>
</tr>
<tr>
<td>Psychosocial interaction (level of function)</td>
</tr>
</tbody>
</table>

Donabedian, 1966). This initiative has led to the Nursing Care Report Card for Acute Care with standardized data submission forms and routine reporting (ANA, 1995). More than 1,200 U.S. hospitals participate in the project, now housed within the ANA’s National Center for Nursing Quality, and annual conferences are held to assist users and showcase the latest research.

In 2004, the NQF published a landmark report documenting a set of 15 nursing-sensitive performance measures endorsed through consensus. The voluntary standards were intended to be used by providers to identify opportunities for improvement so that consumers and purchasers of care could assess the quality of nursing care in hospitals (NQF, 2004). (See Table 1.3 for the complete list of performance standards.)

In a review of these standards three years later, the NQF found that several of the standards are in use, but because of some of the challenges they pose in collection and reporting, the extent to which they are used is not clear. Although the sample size was small and the results not generalizable, findings from this NQF report revealed 50% of the respondents adopted 7 (or half of the standards), while only 13 of 31 (or 42%) collected all 15 (Kurtzman & Corrigan, 2007). One recommendation from these results that purports to reflect nursing’s impact on high-quality care through public reporting and incentive systems has led to a revision of Medicare reimbursement for patients with hospital-acquired adverse outcomes. Beginning in October 2008, Medicare will eliminate additional payments for several inpatient conditions that are traditionally associated with high-quality nursing care (Robert Wood Johnson Foundation, 2007). This ruling promises to affect hospital organizational priorities and the work lives of professional nurses. It will also showcase indicators of nursing quality that for the first time will be tied to reimbursement and may be publicly available.

Nursing research and the measurement of nursing quality in acute and nonacute settings have increased considerably over the last few years. For example, evidence now exists linking nurse staffing and selected quality indicators (Aiken, Clarke, & Sloane, 2002a, 2002b; Aiken, Sochalski, & Lake, 1997; Dunton, Grajewski, Taunton, & Moore, 2004; Needleman & Buerhaus, 2003; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002), the educational level of hospital nurses and selected patient outcomes (Aiken, Clarke, Cheung, Sloane, & Silber, 2003), the nurse work environment and patients’ satisfaction with their nursing care (Vahey, Aiken, Sloane, Clarke, & Vargas, 2004), nurse staffing and the quality of nursing care in hospitals (Sochalski, 2004), and the working
hours of nurses and patient safety (Rogers, Hwang, Scott, Aiken, & Dinges, 2004). In the nonacute environment, evidence points to specialized advance practice interventions and improved patient outcomes and health care costs (Brooten, Brooks, Madigan, & Youngblut, 1998; Brooten et al., 2001; Brooten, Youngblut, Deatrick, Naylor, & York, 2003; Brooten, Youngblut, Kutcher, & Bobo, 2004; Naylor et al., 1999). While this research is significant, much more needs to be done to demonstrate nursing’s link to quality health care, including more widespread dissemination (Naylor, 2003).
From the patient’s point of view, quality nursing care is primarily process-oriented, most notably “being with.” In their study of 1,470 acute care patients, Lynn, McMillen, and Sidana (2007) found that technical competence was assumed and the process aspects of care were most often cited as indicators of nurse quality. However, current evidence shows that registered nurses (RNs) spend less than half their work time in direct patient care at a time when patients are living longer with cyclical chronic diseases and are expected to engage in self-care (Duffy, 2005; Hendrickson, Doddato, & Kovner, 1990; Linden & English, 1994; Urden & Roode, 1997). While staffing may be a factor in nursing quality, other factors such as motivation, leadership, educational preparation, the work environment, or culture may also contribute to nursing quality. The focus on task-completion, documentation, and technical competence has curbed the processes of nursing, such as mutual problem-solving, encouragement, continuous monitoring, ongoing evaluation, teaching-learning, coordination, and intervening in a compassionate manner.

THE VALUE OF PROFESSIONAL NURSING PRACTICE

The word value connotes worth, and as such, the question being asked today is, “in an economically constrained system, what is the significance of professional nursing?” After all, other professionals are often seen providing aspects of health care such as respiratory care, physical therapy, occupational therapy, and social work services. Patient care technicians have been trained to provide hygienic care and even ambulate postoperative patients. When posed the question in a recent graduate class of practicing RNs, the answer was “we spend the shift passing meds” (personal communication, The Catholic University of America, 2006). When reminded that medication techs could be trained in that behavior, the RNs in the class were astounded! On the face of it, it appeared as if professional nursing was almost nonexistent in acute care. In some cases, it is.

The reality today is that nursing is in crisis. Not only is the profession suffering from a worker shortage, some would say it has lost its soul (Duffy & Hoskins, 2003). As more and more of its traditional
activities have been progressively given away to other health professionals and increasing reliance on tasks has emerged, nursing seems to lack a unique function. The very essence of nursing (caring) (Watson, 1979, 1985) is not routinely honored in the day-to-day activities of professional nurses. Yet, nursing remains the primary reason patients come to hospitals; their roles in assessing and continuous monitoring, clinical decision making, providing comfort, educating patients and families about their illness, and maintaining a safe and therapeutic environment are paramount.

Aiken (2005b) states that the two most important functions of nurses, that of surveillance for early detection of adverse events, complications, and medical errors as well as mobilizing institutional resources for timely intervention and rescue, are keys to safe and quality health care outcomes. Furthermore, professional nurses are often the “coordinators” of services between multiple members of the health care team. In this function, nurses collaborate with others and often negotiate difficult relationships. Yet, sadly, professional nurses are often observed doing countless tasks such as administering medications, supervising others, and documenting. And while these are certainly aspects of the role, the unique characteristics of initiating, cultivating, and sustaining caring relationships with patients and families as a foundation for clinical decision making are oftentimes lacking (Duffy & Hoskins, 2003).

A public opinion survey sponsored by the Robert Wood Johnson Foundation (RWJF; 2006) found that “Americans consider nursing a vital component of quality health care” (p. 1). Recent research has renewed the interest in professional nursing as an important contributor to safe and quality care. More specifically, the risks of death and failure to rescue patients from complications increase by 7% every time one patient is added to a hospital nurse’s workload (RWJF, 2006). Additionally, a 10% increase in a hospital’s proportion of nurses with bachelor’s degrees decreases mortality and failure to rescue by 5% (RWJF, 2006). These data provide important quantitative evidence of the value of professional nursing and ensure that nursing remains on the national health care agenda (Aiken, 2005a). While the numbers and educational credentials of nurses seem to be linked to important health outcomes, understanding how the processes of nursing or specific nursing actions...
influence patient outcomes will enhance the knowledge base regarding
the value of professional nursing care.

Preliminary research has indicated positive relationships between
caring nurse–patient relationships and specific patient outcomes (Burt,
2007; Duffy, 1992; Latham, 1996; Swan, 1998; Wolf, Colahan, & Costello,
1998; Yeakel, Maljanian, Bohannon, & Coulombe, 2003). Although these
studies are limited by sample size and methodology, there is a grow-
ing group of hospital and nursing administrators who have adopted car-
ring professional practice models as the foundation for nursing practice
(Dingman, Williams, Fosbinder, & Warnnick, 1999; Duffy, Baldwin, &
Mastorowich, 2007; Watson, 2006). These models emphasize nursing’s
primary role as relationship-building and provide the infrastructure to
facilitate the authentic work of nursing. Patient, nurse, and system out-
comes in institutions using a nurse caring model will demonstrate nurs-
ing’s unique value to the health care system.

OPPORTUNITIES FOR ENHANCING THE
QUALITY OF NURSING PRACTICE

The increasing evidence that nursing is a worthy contributor to safe and
quality health care is long overdue. While nurses have always known that
they are the frontline advocates for high quality and safe care, evidence
supporting this link was weak. Continued, methodologically strong re-
search is crucial for enhancing the quality of nursing practice. For ex-
ample, testing theory-based professional practice models and nursing
interventions focused on patient safety and quality in various patient
populations is urgently needed to showcase the efforts of professional
nursing. Dedicated nursing research teams with expertise in differing
populations who are committed to safety and quality questions working
efficiently could expedite such studies. Participatory action research and
demonstration projects involving practicing staff nurses using academic/
service partnerships may facilitate more creative solutions that can be
implemented and evaluated sooner.

Strengthening the nursing workforce through education by provid-
ing meaningful experiential opportunities that enable practicing staff
nurses to complete baccalaureate degrees efficiently will add to the pro-
portion of more educated nurses. Certification credentials and continu-
ing education in information technology and research skills will enable
RNs to capitalize on existing evidence. Although presently underfunded,
more nursing educational research will be needed to build a portfolio demonstrating how nurses learn best and what personal characteristics of nurses most impact safe and quality health care (National League for Nursing, 2007).

Migrating away from fact-based learning to values-based learning will help nursing students examine their own values and those of their chosen profession. Caring, as the most often described value associated with nursing, must remain a major thrust of nursing education. A strong liberal arts foundation combined with caring competencies and experiential learning methods will strengthen tomorrow’s professional nurses. Frequent opportunities for critical reflection (both individual and group) will enhance self-awareness and contribute to more caring practice (Bulman & Schutz, 2004). Strong student–faculty relationships of a caring nature will demonstrate to students the essential core value of nursing. Using caring student–faculty relationships as the core of learning may decrease student anxiety and create more cohesive learning (Pullen, Murray, & McGee, 2001; Schaffer & Juarez, 1996). This includes caring in Web-enhanced environments. While the use of technology offers opportunities for efficiency (Simpson, 2008), it can best do so when applied within a caring framework. Finally, educational program evaluation including student caring competencies will better inform faculty how to revise curricula to meet the caring learning needs of students (Duffy, 2005).

Nurses holding leadership positions (at all levels) must ask themselves on a daily basis if they are staffing for safe and quality care. Routine involvement in overseeing the quality of nursing care, including making assignments based on competency for specific clinical situations, rounding, and actively seeking to improve nursing care, must become the primary focus of nurse leaders. Within this primary focus of continuously seeking to improve quality, nursing leaders must value nurse caring by ensuring that the majority of nursing time is spent in direct care activities. According to Aiken (2005b), “good nurse–patient relationships are at the heart of safe and effective hospital care” (p. 186). Redesigning the work environment to provide more time for direct RN–patient interaction is vital. According to the Institute for Healthcare Improvement’s Transforming Care at the Bedside, a goal of clinicians is to spend 70% of time in direct patient care (Rutherford, Lee, & Greiner, 2007). Such redesign requires rethinking the work content of RNs so that patient needs are primary. Enhancing the work environment to include focused reminders for centering, creating places for reflection and
regrouping, and innovative opportunities for on-the-spot problem resolution will boost nurses’ autonomy and position them to more effectively influence decisions. Finally, stimulating career development activities that incentivize caring praxis are long overdue.

At the practice level, nursing is at a crossroads in its professional evolution. In one respect, it has become devalued and relegated to task-oriented service. On the other hand, professional nursing is on the brink of reclaiming caring as the basis of practice, questioning how care is delivered, and assuring that nursing care is grounded in scientific evidence. It is within this realm of nursing that its future can be secured and its recipients honored. The relational aspect of nursing is highly valued by patients and families; it must receive equal if not more priority in the workplace (Bikker & Thompson, 2006). With the patient and family at the core, nurses who practice from a caring base will advance the vital relationship between patient and nurse. Such an emphasis fosters a sense of “feeling cared for” from which safe and quality health outcomes can flourish.

According to Ponte et al. (2007), professionals who acknowledge their unique role, commit to continuous learning, demonstrate professional demeanor, and strive to be inspirational enjoy the benefits of a powerful practice. Taking the risk to renew the commitment to caring and center nursing practice on relationships offers the high road toward an influential practice that will prevail.

SUMMARY

In this chapter, the far-reaching crisis of health care quality has been reviewed. Of particular concern is the slow progress toward its improvement despite the added attention by research and accreditation agencies. Health care quality in the United States has declined in value over the years, and many are in disagreement about its future. Professional nursing, the major health care discipline, is increasingly perceived as less engaged with those they care for; in fact, regularly missed nursing care was described and rationalized in one study, and noncaring nursing behaviors have been detailed since the 1980s. Reporting of nursing-sensitive health care indicators has assisted in generating evidence of nurse quality, and recently, reimbursement systems (Medicare) have added some of them to their incentive procedures. It is only a matter of time until other payors do the same. Professional nursing is in a posi-
tion to significantly impact the health care system. Through relationship-centered practice, education, and leadership, the amount of time spent in caring interactions can profoundly benefit the quality and safety of American health care.

**CALLS TO ACTION**

*Nursing’s future is dependent on a spirit of caring inquiry—practicing from its caring base while simultaneously grounding it in empirical evidence.* Notice what you are doing and what you are NOT doing.

**Reflective Questions/Applications for Students**

1. What is your perception of nurse quality?
2. Discuss the state of quality in your health care institution.
3. Are there opportunities for missed nursing care in your institution? What are they? How can these missed opportunities be embraced by the nursing staff?
4. Does professional nursing remain a significant force in today’s health care system? How?
5. Describe a noncaring nursing situation you have encountered. What happened? How did you react? What would you do now given the same situation?
7. Define participatory action research.

**Reflective Questions/Applications for Nurse Educators**

8. What is values-based learning?
9. What nursing educational research is being conducted at your university?
10. Reflect on the nature of student-faculty relationships at your university. How does it inform your teaching?
11. What learning outcomes are regularly reported by your university? How are they used to refine curricula?
12. How do you assess caring competence in nursing students?

Reflective Questions/Applications for Nurse Leaders

13. How would you rate nursing quality at your institution?
14. What must be implemented at your facility to ensure that RNs spend more time in direct patient care? How would you start? Who would you include?
15. What career development activities/programs are utilized at your institution to recognize and renew nursing’s caring core?

REFERENCES


Ponte, P. R., Glazer, G., Dann, E., McCollum, K., Gross, A., Tyrrell, R., et al. (2007). The power of professional nursing practice. Online Journal of Issues in Nursing,


