PROFESSIONAL PRACTICE MODELS IN NURSING

SUCCESSFUL HEALTH SYSTEM INTEGRATION

JOANNE R. DUFFY

SPRINGER PUBLISHING COMPANY
Professional Practice Models in Nursing
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Dr. Duffy was the recipient and principal investigator for two federally funded demonstration projects: Relationship-Centered Caring in Acute Care and Improving Safety and Quality in Vulnerable Acute Care Patients Through Interprofessional Collaborative Practice, and has been the principal investigator on externally funded studies of hospitalized older adults, those with heart failure, tool development, nurses’ caring competencies, evidence-based practice, and academic–service partnerships. She has also consulted on studies related to organizational leadership and management of critical care units, patients’ perceptions of safety, health literacy, and alarm safety. 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. Dr. Duffy is the author of numerous publications, including two books and several book chapters. Her book Quality Caring in Nursing: Applying Theory to Clinical Practice, Education, and Research received the American Journal of Nursing (AJN) Book-of-the-Year award in 2009. She is a former Commonwealth Fund Executive Nurse Fellow, a recipient of several nursing awards, a fellow of the American Academy of Nursing, and she serves on several editorial review boards. Dr. Duffy currently teaches graduate-level nursing research and data analysis for clinical and administrative decision making; regularly consults with health systems regarding evidence-based practice, research, and professional practice model integration; and is a frequent guest speaker.
Professional Practice Models in Nursing
Successful Health System Integration

Joanne R. Duffy, PhD, RN, FAAN
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As a “seasoned” nurse executive, I frequently count my blessings, crediting the many nurse mentors, role models, and experiences I have interacted with for informing my administrative practice. As a nurse executive of a Magnet®-designated organization and the editor-in-chief of The Journal of Nursing Administration, I am often called upon to mentor nurses for leadership roles or to disseminate information through publications. This work, Professional Practice Models: Successful Health Systems Integration, by Dr. Joanne R. Duffy, should serve as a reference guide for nurse leaders, new nurse executives, and all faculty. Rarely has there been a comprehensive work of this magnitude produced to provide intense and practical direction for so many levels of practice.

As Dr. Duffy states in her text, we are undergoing rapid change in health care delivery. One stressor impacting the survival of nursing leadership and administrative practice is the impending number of experienced and highly successful nurse executives who are retiring or leaving their roles. This book by Dr. Duffy is a must-read for new nurse leaders following in our footsteps. It will enable them to increase their knowledge of the systems and processes required to implement, sustain, and measure professional nursing practice while providing a strategic framework to guide strategies for patient care.

Many experienced nurse executives have programs and initiatives in place to enhance the adoption of evidence in practice; however, few can show sustainable outcomes and consistent implementation of these practices by clinical nurses and leaders. This book will help provide practical guidance to support an understanding of roles in the implementation of professional nursing practice and the resultant application of evidence at all levels, including for students, clinical nurses, researchers, faculty, and nurse
leaders. By sharing this book with others, nurse leaders can move through an organized planning process to develop structures for their own nursing organizations.

As an editor, I frequently receive manuscripts from writing teams presenting examples of innovations and improvements in care delivery. Few organizations have developed comprehensive practice frameworks to move beyond episodic projects toward sustainable change. Dr. Duffy provides a step-by-step guide for a more thoughtful approach through her practical implementation advice, case studies, and suggestions for systematic measurement and dissemination.

As an international researcher focused on the implementation of caring in practice, Dr. Duffy interweaves this component into the book. Caring practices and principles have been adopted by many organizations as a cornerstone of their nursing philosophy. Dr. Duffy provides a guide to take this well-known and proven theoretical principle and use it in understandable and easily demonstrable practice behaviors to support professional practice models.

Lastly, this comprehensive work supports our transition to new models of care, including population health. Nurse leaders are being challenged to assume new roles and develop new competencies. Through Dr. Duffy’s work, the essentials of professional nursing practice will be developed, enhanced, measured, and preserved, contributing to new levels of wellness for our communities across the continuum.

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Foreword

The health care delivery system is undergoing extraordinary transformation shaped by changes in financing, access to services, availability of health professionals, and consumer demands. Nursing must be prepared to build on its professional practice model to generate innovative programs that enable nurses to practice efficiently and effectively. It is essential that members of the health profession work to improve the quality and safety of services that consumers receive. Professional practice models provide the framework for nurses to plan, deliver, and evaluate interventions that result in positive clinical and service outcomes. The multiple examples presented in this publication, Professional Practice Models in Nursing: Successful Health System Integration, are valuable resources for executives, nurse leaders, educators, and advance practice and staff nurses to create and deploy professional practice models to meet health system demands. The book is organized with powerful “Lessons Learned” stories for readers’ consideration in their practice. Practice models that are person centered and evidence based are the basis for the delivery of excellent nursing care for all who trust us with their lives within and outside acute care settings.

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Health care is changing before our very eyes; in fact, we won’t recognize it 10 years from now. The forces at play accelerating this transformation include moving from fee-for-service to value-based purchasing, the aging of the population, and the often unimaginable pace of technology development. Nurses, as the largest profession within health care, have an opportunity to be leaders in this transformation. One of the recommendations listed in the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* (2010) is to prepare and enable nurses to lead change. Harnessing the full potential of each and every nurse in the United States can improve the value of the entire health care system.

Practicing nursing at its full potential is best accomplished with a professional practice model fully integrated in places where nurses work. As of this writing, there are 423 Magnet®-designated facilities in the United States, and evidence continues to show that these health systems have lower mortality rates than their non-Magnet counterparts (Friese, Xia, Ghaferi, Birkmeyer, & Banerjee, 2015). An essential component of Magnet designation is having a robust, fully implemented professional practice model. *Fully implemented* is the key. The situation surrounding practice models is not unlike the famous strategic plan in which hours are spent crafting the words just right and then the plan lands in a file until it is time to review the plan’s progress several years later. Professional practice models also face the same risk when a lot of time is spent selecting the tools and educating the nurses but little is done to hardwire the model into true everyday practice.

Dr. Joanne R. Duffy is an authority in developing practice models. Her Quality-Caring Model® has been successfully implemented in settings
large and small. This text effectively creates a blueprint for how to make this process as meaningful as possible regardless of the model chosen or the type of organization considering the model. As an executive at Children’s Mercy–Kansas City when it was receiving its first Magnet designation in 2003, I have seen firsthand the impact that can be made when these broad steps are followed.

One of the key points that is often missed and that Dr. Duffy clearly illustrates is the critical importance of evaluation. Historically, nurses and others focus a great deal on process measures. Although an important consideration, these measures mean little without strong evaluation of outcome measures. Process measures are important; however, the ultimate value of nurses practicing to their fullest potential is demonstrated through improved outcomes of care. This is an important means by which the value and contribution of nurses is better understood and viewed as more than just a component of the bed charge.

Dr. Duffy’s blueprint is helpful whether you are a chief nursing officer (CNO), a Magnet or quality-improvement (QI) coordinator, an educator, or a student. The changes in health care will cause some organizations to make decisions that are reactionary and financially based. Nursing is always at risk in these situations because it represents a large proportion of labor expenses in a health system. A well-established professional practice model can help guide the organization generally, and nursing leadership specifically, to collaboratively make the best decisions possible while ensuring positive outcomes for patients and families.

An integrated and successful implementation of a professional practice model also ensures that important nursing values and how care is actually delivered are aligned between leaders and practicing nurses. If practicing nurses and nurse leaders make decisions together based on the professional practice model, this collaboration provides an opportunity for open discussion and creates a mutually beneficial and respectful relationship that is transparent and patient centered. Unfortunately, I often hear examples from around the country in which practicing nurses have inappropriate workloads and little support. This leads to disillusioned nurses who suffer from disengagement and ultimately moral distress and caregiver fatigue. A professional practice model can be the framework for productive dialogue that prevents these ill effects. In a time when there is a call for interprofessional teamwork in health care, it is imperative that we have our own profession in order.
FOREWORD

Professional Practice Models in Nursing: Successful Health System Integration is an important text for those wanting to better understand this topic. The principles, rationale, best-practice examples, and reflective questions include crucial information needed to fully integrate professional practice models. The author delivers one of the most important works on this topic to date.

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Preface

Central to the advancement of a health system is its workers, who today face many challenges, including less time with patients and families, burdensome regulations and increased documentation requirements, an aging and transcultural peer group, looming retirements, inadequate training and continuing development, and, at times, uninspiring leadership, all of which contribute to work-related stress. Professional nurses, the largest category within this group, face their own disciplinary issues of professional identity, entry into practice, delegation and accountability for care assigned to unlicensed personnel, integrating evidence-based practice into clinical workflow, and continuous change. As a result, nurses often find themselves practicing repetitive and often uninteresting work that is disconnected from its disciplinary source. And nurse leaders struggle to integrate large-scale change, oftentimes doing so imperfectly. Although the American Academy of Nursing’s Magnet® program has enabled many health systems to distinguish themselves as exemplary in nursing practice by meeting several criteria intended to support nursing autonomy, empowerment, innovation, and high-quality patient care, there remains considerable controversy over the meaning of exemplary nursing practice and, in particular, how professional practice models as one source of evidence are successfully integrated into health systems.

As of this writing, over 423 health care organizations are currently designated as Magnet organizations (with many more on the “journey”). A key component of this recognition for excellence in nursing is exemplary professional practice as evidenced by a professional practice model that delineates the role of nursing, its relationships with others, how it is applied and continuously revised in everyday practice, by what means decisions about practice are made, how superior nursing practice is recognized and rewarded, and, most important, how nursing professional practice influences patient outcomes.
To meet requirements for Magnet designation, health care organizations expend valuable resources creating, implementing, and showcasing professional practice models, albeit using no coordinated or consistent approach, and often without attention to evaluation or dissemination of results. As a consequence, considerable variation in implementation and full enculturation exists, translation to the bedside may be lacking, limited empirical evidence of the value of professional practice models to patients or nurses has been revealed, and nurses and nurse leaders often become frustrated in their attempts to integrate such models throughout health systems.

The incongruity between the intent of professional practice models and the reality of health systems to integrate them into practice is notable and may be linked to worker dissatisfaction. Not only has professional practice model integration not been optimized, but improved outcomes as a result of their assimilation into nursing practice have not been adequately demonstrated, leaving the discipline without important evidence of the models’ contribution.

Although most professional nurses and their leaders strive to practice in accord with professional values, many find themselves beleaguered with the challenging task of translating a multicomponent framework into long-standing hierarchical structures (aka compliance cultures) using traditional processes, particularly given the current realities of today’s health care system. More specifically, in the midst of struggling to deliver high-value services, increase market share, and engage employees, many nurse leaders find themselves attending to elaborate performance improvement systems, expensive renovations, new regulations, and designer technology versus the practice of professional nursing. And registered nurses, who make up the largest of health professions and who spend the longest periods of time with patients and families, have a great need to practice from a disciplinary base, strengthen their accountability for quality patient outcomes, and find meaning in their work.

This book provides an overview of nursing professional practice models; their potential value to patients, nurses, and health systems; an orderly process of ensuring their translation into daily workflow; and the requisites for demonstrating their impact. The text highlights the contribution that exemplary professional nursing practice can make to patients, families, professional nurses, and the health care system, given a systematic and thorough approach to its integration. *Professional Practice Models in Nursing: Successful Health System Integration* builds on the professional literature, the author’s experience integrating professional practice models, and emphasizes a
systematic, evidence-based approach that takes advantage of nurses and nurse leaders working side by side in mutually beneficial relationships to promote optimistic and prosperous futures.

The intent of the book is to raise awareness of the significance of nursing professional practice models for improving the value of health services. Additionally, it is a resource for nurses and nursing leaders as they go about implementing such models, for students who are learning about nursing or health systems administration, and for educators who are teaching such content. Through the lenses of innovation theories, evaluation models, implementation and dissemination frameworks, and exploration of selected concepts such as individual adoption and organizational enculturation, the progression of professional practice model integration is presented. The importance of evaluation, sustainment, and generating impact is illuminated with multiple examples.

This author’s knowledge about successful integration comes from a combination of the inclusion of her middle-range theory into many professional practice models throughout the country, successful national demonstration projects, her firsthand experience working with health systems as they implement and evaluate professional practice model integration, and her knowledge and practical application of theory and evaluation methods. Lessons from the field and reflective questioning, incorporated throughout the text, provoke important observations and useful insights that are beneficial for contemporary nurses and nurse leaders.

Part I focuses on the definition, value, and disciplinary need for professional practice models, and includes practical steps required in preparation for model integration. It is intended to provide a better understanding of professional practice models and to facilitate commitment to action. The next section is the mainstay of the text and, using various frameworks, discusses the processes of innovation and transformation that health systems experience as professional practice models are successfully integrated. It includes the design, implementation, evaluation, adaptation, adoption, and enculturation processes. The emphasis of Part II is eventual enculturation and it fulfills this purpose through repeated examples and exemplars, concentrating on the nurse–nurse leader relationship and associated strategies. The how-to’s of values clarification, choosing a theoretical framework, specific implementation strategies, maintaining the momentum, and tipping points and milestones are addressed. It is important to note that evaluation and revision of professional practice model implementation, an often underrepresented aspect, is described in detail with attention to the author’s personal
experiences. Part III centers on sustaining the "transformed culture" and spreading professional practice models through specific communication mechanisms, and special relationships and practices. This part of the book concludes with a chapter on creating impact—influencing change beyond the doors of a single organization—adding value, and building an impressive future. Examples and other resources are presented in the appendices.

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 at all levels. Magnet coordinators and health professionals in other disciplines may also find it helpful. Each chapter contains objectives, insets, a section called “Learning From the Field,” key summary points, and reflective exercises designed to provoke thinking and application. As a whole, the text offers multiple examples and practice insights from diverse community and academic health centers, helping readers relate to the content. The appendices provide additional resources for those interested in implementation strategies and assessing the progression of professional practice model integration in their health systems.

Little has been done in terms of generating evidence for particular professional practice models and, in most health systems today, nurses still practice according to the biomedical paradigm amid the complexities of technology, multiple procedures, throughput, workflow, and supervisory roles. Although many health systems have embraced a more disciplinary perspective in their quest for nursing excellence, there remains considerable variation and, in some cases, utter confusion about the nature and full enculturation of professional practice models. In fact, many are confused about just what a professional practice model is and how it can enrich the practice of nursing as well as positively impact patients and the larger health system. A systematic approach to professional practice model integration fills a void in the literature by offering an established approach to implementation, suggesting methods for evaluation and revision and providing both practical lessons from the field and opportunities for reflection. This volume consolidates available information on the topic in one place, ultimately guiding nurses, nurse leaders/administrators, and educators in the process of translating professional practice models into clinical workflow, advancing nursing practice, and improving the quality of patient care.
Comprehensive integration of professional practice models offers possibilities for improving health outcomes, strengthening professional nursing practice, and providing exciting opportunities for ongoing research that will provide empirical evidence of their value. Especially during this period of transition in health systems, the challenge to nurses and nurse leaders at all levels is to ensure congruency between professional nursing values and professional practice. In doing so, they will preserve the timeless values that undergird nursing, deliver high-value services to patients and families, and provide meaningful work for practicing nurses.

Joanne R. Duffy
Acknowledgments

Thank you to all the smart, creative, and caring nurses—the most valuable health system resource—who have touched me in so many ways throughout the years. You know who you are, for we share many fond memories, amazing war stories, heartrending moments, and a common disciplinary connection. I watch in admiration those of you who are still “in the trenches” providing direct care to our most vulnerable; to others of you who are now retired but caring for grandchildren, parents, or “giving back” in some other way; to those who are instilling disciplinary values to our future graduates while pursuing important research questions; and to those inspiring nurse leaders who have challenged me in some way. Your professional contribution to patients, families, and society is profound, continuing to shape healthier lives. To you, I owe my deepest gratitude for providing me with a listening ear, the courage to persist, many laughs, and meaningful work that has made all the difference!

And to those nurses from all levels of health care who have voluntarily contributed to this book through “Learning From the Field” entries, you have enriched the text immensely. To all of you, your perspectives and wisdom provide the readership with valuable insights and lessons learned that would not otherwise be shared.
The Importance of Professional Practice Models: Appreciating Significance

KEY WORDS
Professional nursing practice, health system value, professional practice model (PPM) integration

OBJECTIVES
By the end of this chapter, the reader will be able to:

1. Describe the current context of professional nursing practice
2. Articulate how professional practice models (PPMs) contribute to health system value
3. Evaluate the preparatory steps for PPM integration

REALITIES OF PROFESSIONAL NURSING PRACTICE
RNs are practicing today in complex workplaces where financial pressures, regulation, advanced technology, looming retirements, globalism, acutely ill patients with never-ending needs, and multigenerational differences are commonplace, creating both demanding challenges and emerging opportunities. Difficulties, such as decreased resource allocation, overemphasis on routine tasks and documentation, employee disagreements, lack of support from ancillary services, compassion fatigue, and, most disheartening, uninteresting work, leave professional nurses frustrated and oftentimes yearning
for alternative employment. Compounding this are the myriad organizational changes that leaders are demanding, many times without adequate evidence of their benefit.

To better understand the increasingly complex context of professional nursing practice, attention to the characteristics of individual nurses (education, credentials, unique life experiences, demographics), the characteristics of patients and families (acuity, age, life experiences, comorbidities), and the context (type of organization and its culture, how nursing is expressed and upheld, available resources, leadership, the nature of inquiry and creativity fostered, and relationships among the health care team) is warranted. These factors greatly influence professional nursing work, including its effectiveness in influencing positive patient outcomes. Although some of these factors are not under the direct control of nursing (e.g., patient characteristics), individual characteristics of nurses and how nursing is expressed and upheld in an organization are usually the purview of nursing.

Typically, some individual nursing characteristics become known during the hiring process, provided the process is thorough and can distinguish candidates who display professional behaviors, are nurturing, value lifelong learning, practice accountability, and can work together in teams from those who do not exhibit such characteristics. Once on board, individuals who tend to be more flexible, handle feedback positively, maintain their expertise, can regulate their emotions, are self-aware, and who cultivate relationships tend to perform better and are more engaged (Fujino, Tanaka, Yonemitsu, & Kawamoto, 2014; Schutte & Loi, 2014); these individuals exhibit high emotional intelligence (Goleman & Sutherland, 1996). These emotional characteristics can be influenced through ongoing continuing education, effective mentoring, specific professional development programs, and work experience; in essence, individual nurse characteristics can be molded by the context in which the nurse works (Goleman, Boyatzis, & McKee, 2013).

The expression of nursing professional practice in an organization, however, reflects how nursing is considered, conveyed, and claimed in an organization.

If nursing is considered a “profession” and its major concepts and scope are made explicit, the resultant practice will likely manifest specific values, activities, and interactions that reveal the full extent of nursing knowledge and skills.
For example, nurses who understand what concepts define their practice and who know the range of activities and interactions expected are more likely to adhere to those notions and perform accordingly. An example of this is demonstrated in a health system that distinguishes the use of the nursing process to provide holistic care that effectively meets patient and family needs, ensures that direct care nurses are engaged in practice improvement by participating in performance improvement or research councils, and enables interprofessional interactions characterized by inquiring, collaborative relationships. Such practice fosters creative patient-centered solutions. Typical performance in such a health system would be demonstrated by nursing actions, such as problem solving, analyzing, monitoring, teaching, counseling, decision making, improving, and relating, whereas fragmented, mechanistic-type work is likely minimized. When the major concepts and range of activities that comprise nursing are carefully considered, higher level professional knowledge and skills, for which nurses have been educated, may be better manifested.

These actions are conveyed to a health system through verbal and written statements, such as philosophies, clinical and system-wide policies, and marketing materials, as well as processes such as nursing representation on system-wide committees.

Conveying the scope and concepts that ground nursing practice in an organization implies written, face-to-face, formal, informal, electronic, group and individual communication and dissemination mechanisms that allow for questioning and feedback to ensure adequate appreciation of the role.

How a health system organization claims nursing professional practice is made visible through its hiring practices, performance expectations, professional development programs, and advancement criteria. Such processes, when infused with articulated nursing concepts and the full range of activities that professional nurses are educated for, tend to be reinforcing. Professional nursing practice that manifests in this manner is advocated for, defended, and rewarded, upholding the professionalism associated with nursing work. Although the context of nursing work is complex and dynamic, how it is expressed and upheld in an organization is an opportunity to create the energy for professional, interesting, and meaningful work (see Table 2.1 for a summary of these processes).
I. FROM AWARENESS TO COMMITMENT

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THE VALUE OF PROFESSIONAL PRACTICE MODELS

Value connotes worth or merit of something (in this case a professional practice model [PPM]) and may also be associated with significance.

Professional practice models demonstrate nursing’s contribution and project nursing’s identity in an organization. As such, they hold value to patients, nurses, the discipline, and the organization.

Patients and families directly benefit from receiving care by nurses who practice under a PPM. More specifically, they can expect more commitment to professional values, accountability, ongoing competence, continuity, nurse input and collaboration on the interprofessional team (advocating for them), and creativity. Such behaviors translate into more robust decision making through increased reliance on evidence; caring for the “whole person”; individualized and participatory activities; new ideas solicited and welcomed; and full application of nursing’s values, knowledge, and skills. Although little is known about whether PPMs actually improve patient outcomes (because few have studied this), it is rather intuitive that nurses who practice to their full extent would be a driving force in the attainment of health outcomes.

For nurses, a professional practice model depicts the major values and beliefs about nursing, identifies the parameters of nursing practice, including its responsibilities and authority for patient care, explicitly describes the systems for how nursing work is operationalized, and acknowledges expert practice.

Table 2.1 Organizational Expression of Nursing Practice

<table>
<thead>
<tr>
<th>Nursing Practice</th>
<th>Health System Processes</th>
<th>Resulting Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considered</td>
<td>Nursing is thought about as a professional discipline (i.e., knowledgeable, competent, adheres to code of conduct and national standards, accountable)</td>
<td>Nursing activities and interactions exhibit the full extent of nursing knowledge, skills, and values</td>
</tr>
<tr>
<td>Conveyed</td>
<td>Verbal and written materials concerning nursing reflect its professional nature</td>
<td>Organization-wide appreciation of the professional practice of nursing</td>
</tr>
<tr>
<td>Claimed</td>
<td>Talent acquisition, performance expectations, and advancement criteria reflect professional ideals</td>
<td>Professional nursing practice is defended, advocated for, and upheld at all levels of the organization</td>
</tr>
</tbody>
</table>
2. THE IMPORTANCE OF PROFESSIONAL PRACTICE MODELS

PPMs offer nurses a way to appreciate their role expectations; facilitate a common language that is useful for communication; enable connections with patients, families, and others on the health care team; accelerate documentation; frame nursing interventions; and improve their practice. In essence, PPMs attend to the “voice of the nurse,” empowering the nurse to advocate for patients and families, fulfill societal expectations, creatively innovate, and advance.

Professional practice models support health systems by translating nursing concepts to the bedside, specifying the standards for nursing practice, enhancing communication, and reducing practice variation.

Although some practice variation may be beneficial, too much reduces effectiveness and efficiency. Take, for example, the routine of handwashing. In one Australian study using 30 nurses, the level of variation among and between nurses’ reported practices and local policies was widespread and it extended across all aspects of handwashing practices—duration and extent of handwashing, type of solution, and drying method used (Morritt et al., 2006). It was proposed that nurses made their own risk assessments based on the proximity of the procedure to the patient. Despite the fact that hand-hygiene compliance has been continually taught and reinforced among health care providers and is linked to reduced hospital acquired infections and resultant costs, compliance with hand-hygiene guidelines has remained low (Larson, 2013; Sahay, Panja, Ray, & Rao, 2010). Thus, practice variation in this case may negatively impact patient and cost outcomes.

Contrarily, carefully establishing what nursing is and how it is operationalized in an organization may improve patient outcomes (e.g., safety, clinical outcomes, and the patient experience of care) and reduce costs (length of stay, supplies, and procedures). Additionally, because nursing practice is aligned with professional values, more satisfied and engaged employees may result, adding value to both patients’ and health systems’ portfolios. Nursing leaders and hospital administrators, who facilitate resources and provide the means for integration, can embrace PPMs as a way to increase organizational value.

From a disciplinary perspective, PPMs add value by providing clarity in terms of core competencies and role accountability (e.g., delineate differences and similarities among professional, technical, and assistive roles), may improve transfer of information and collaboration within clinical
teams, provide a method for evaluating performance, allow for benchmarking among similar organizations, and frame professional development programs, including credentialing and self-regulation. Such transparency informs nursing curricula, professional standards, practice improvement, and even research funding priorities.

Based on the obvious value of PPMs to patients, nurses, health systems, and the discipline, it is reasonable to assert and pursue their integration as nursing responds to the current challenges in health care. Through PPMs, an organization’s values and mission are made explicit, shaping resultant policies, including the compensation and advancement structure, resource use, the type and quality of services it offers, and ultimately the bottom line! For health care systems, that bottom line is improved patient outcomes, satisfied, engaged employees, and reasonable expenses. Committing to a PPM, however, requires an understanding of the process, including appropriate preliminary work, to satisfy the conditions for successful integration.

THE PROCESS OF PROFESSIONAL PRACTICE MODEL INTEGRATION

Just as the management of patients and families is moving toward a coordinated continuum of care, nursing is shifting its thinking from separated, geographic settings and task-oriented procedural functions to interdependent, coordinated professionals working together over time to meet unique, yet ultimately common, goals. Integration has been defined as “the collaboration and linkages between and across organizational functions as well as organizational partners, including customers and suppliers” (Teixeira, Koufteros, & Peng, 2012, p. 73). This definition implies a rich network of collaboration and information sharing among individuals and departments, increasing transparency and feedback and the likelihood of mutual problem solving. It also connotes better performance in terms of quality and innovation. Successful internal integration helps create unity among employees and alignment with the organization’s mission. External integration refers to the collaborative involvement of others, such as academicians, other health systems, customers (patients and families), and even vendors, where trust, commitment, and information sharing become the norm.

Integration of PPMs establishes harmony among nurses, nurse leaders, various departments, other health care providers, patients and families, and the overall health system, provided it is successful.
2. THE IMPORTANCE OF PROFESSIONAL PRACTICE MODELS

The overall aim of integrating a professional practice model is to create a core platform of acceptable knowledge, behaviors, and values that define nursing practice and from which performance, specifically related to patient-centered health outcomes, can be optimized.

Professional practice models offer a shared mental image of the way nursing practice “could be” that drives interpretations and meanings, creates strong connections, and ultimately informs behaviors, shaping a coevolutionary culture (Korte & Chermack, 2007).

Approaching integration in a systematic manner starting from assessing readiness to demonstrating stakeholder value is essential to its success.

In Figure 2.1, the integration process outlined in this text is depicted. It has been carefully thought out and applied in multiple health systems. The remainder of this chapter focuses on the preintegration phase and Chapters 4 through 9 will be devoted to the remaining phases.

PREINTEGRATION: PRACTICAL PREPARATORY STEPS

Nursing leaders are frequently faced with organizational change and its repercussions, especially those changes that involve modification of nursing practice or clinical workflow. The ability to adapt to such changes and alter the way nursing practice has been performed for decades requires a nimbleness that few health care organizations can quickly assemble. As a result, change
Table 2.2 Preparing for Professional Practice Model Integration

- Assess readiness
  Use internal and external evidence
- Conduct gap analysis (compare actual versus desired nursing practice)
- Anticipate costs
  
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is often incomplete, partially implemented, or abandoned altogether. In fact, in Senge’s familiar *Dance of Change* (1999), the failure of most change initiatives to succeed at the “hoped-for” results, despite significant commitment of resources, is reported to be widespread. Kotter (2014), the well-known change expert, suggests that overcoming such setbacks requires fundamental shifts in thinking and doing—indicating that what is needed are dynamic, more flexible networks of individuals, who exhibit passion for innovation, are open to outside perspectives, appreciate human connections, and celebrate wins.

To be better prepared for the various nuances associated with integrating a PPM, nursing leaders should carefully consider how well they and their employees will accept and welcome the model (see Table 2.2). Such consideration generally consists of assessing evidence of readiness followed by a comprehensive strategy to alter existing practice.

Two forms of readiness evidence are especially helpful to better understand how well prepared an organization is to integrate a PPM. Foremost is the external evidence—that comes from the scientific literature and other organizations—augmented by the internal evidence generated from the integrating organization itself. Using both forms of readiness evidence creates comprehensive and compelling substantiation of an organization’s preparedness for practice change.

**Assessing Internal and External Evidence for Readiness to Commit**

**External Evidence**

External evidence refers to the scientific literature and, in this case, to other organizations that have experience with components of the PPM in question.
Because PPMs are organization specific, only those components, such as the nursing theoretical base, specific patient care delivery systems, or shared governance approaches, may be represented in the literature. A review and appraisal of the literature pertinent to these components may provide evidence for a particular model component in terms of its possible inclusion, how easy it might be to implement and adopt, and how effective it was related to patient, nurse, and system outcomes. Another source of external evidence includes other health care organizations that use possible model components. By collecting stories and experiences from those organizations, one can elicit the quantity and types of organizations (e.g., community hospitals, academic medical centers, or free-standing clinics), patterns, and lessons learned. Finally, examining state nurse practice acts, standards of practice, and pertinent professional society documents provides additional evidence for consistency. Compiling such evidence provides a persuasive argument for selecting one model component over others.

**Internal Evidence**

Organizational readiness refers to members’ change commitment and their efficacy in implementing organizational change (Weiner, Amick, & Lee, 2008). Or stated another way, organizational readiness refers to the degree that organizational members are psychologically and behaviorally prepared to integrate a new way of working. Transitioning to a PPM is smoother when organizational readiness is high and more problematic when the transition is viewed negatively or the organization just does not have the resources to successfully integrate it.

Because integration of a PPM into a health system is really about transforming a culture, evaluating whether or not a system stands prepared is paramount. Being prepared will support the process by ensuring that attitudes and suitable motivation exist in enough quantity to participate with the integration process and render it sustainable. The complexity of a PPM is critical for deciding whether or not it is appropriate for an organization to use. For example, some organizations design elaborate PPMs undergirded by complicated and language-sensitive theoretical concepts. Such models may inhibit full integration by creating unnecessary educational and resource requirements. Understanding this complexity is important to organizations in order to reduce the risk of wasting precious opportunities and resources, and/or harming existing nursing practice. It can also help to learn whether the leadership capacities of effective communication, facilitation, flexibility and responsiveness, evaluation, and staying the course are available in sufficient amounts to sustain the practice change.
Evaluating current conditions (existing structures, leadership, organizational culture, job descriptions), attitudes (political will, employee and leadership motivation, commitment), and resources (knowledge and skills, funding) of key stakeholders at all levels in an organization is important in order to understand whether the whole system or any of its component parts are ready. To do this, key stakeholders will need to know the scope of the PPM, including the requirements for personal, leadership, and contextual change. Lack of the right conditions, attitudes, or resources often creates barriers to optimum integration. Thus, understanding what and where these barriers are can provide valuable guidance for integration. For example, an identified barrier may have to be dealt with first, or the initiation of the model may have to be altered in order to “work around” an existing barrier that cannot be surmounted.

To assess organizational readiness for a PPM integration project, there are several questionnaires or tools that can be used to generate evidence of internal readiness (Holt et al., 2010). For example, the Magnet® gap analysis tool provides a short series of questions that are very specific to the program criteria and address some aspects of professional practice (American Nurses Association [ANA], 2014). Others are also available that assess readiness more broadly, such as the theory-based Organizational Readiness to Change Assessment (ORCA; Shea, Jacobs, Esserman, Bruce, & Weiner, 2014), which has two subscales: change commitment and change efficacy. Still other measures are available that speak to specific factors, such as employees’ beliefs (Armenakis, Bernerth, Pitts, & Walker, 2007), or are unique to the health care context (Gustafson et al., 2003). Both employees and leaders alike should be the focus of such evaluations in order to obtain a more robust understanding of readiness to commit. Once this external and internal evidence is available, fully analyzed, and disseminated, organizational leaders will have a better notion of how well prepared they are for PPM integration.

**Analyzing the Gaps in Nursing Practice**

Actual performance (nursing practice) and desired performance (nursing practice guided by a PPM) of an organization represent a gap or a difference that provides additional data for leaders to use to evaluate the time and resources required to achieve full integration. Conducting such a gap analysis requires documentation followed by a leadership response.

Gap analysis usually starts with articulating the desired state. In this case, what would professional nursing practice look like after full integration of a PPM? For example, who would the practitioners be (characteristics,
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credentials), what would they be doing (job descriptions), when and where would they perform their work (scheduling and assignments), and how will that work be accomplished (workload, delegation patterns, interprofessional teams)? Next, it is necessary to document the current state with respect to each of the elements articulated in the desired state. This includes identifying who has the knowledge of the current state to answer such questions and determining how best to acquire this information. In some cases, there may be existing written records (e.g., staff schedules) or organization-wide documents (e.g., job descriptions) that can be used. In other cases, interviewing or assembling focus groups may elicit such information.

Once data is collected, quantifying it or collapsing it into categories of gaps, such as gaps in knowledge or gaps in resources, is crucial for clearly identifying the discrepancies between “what is” and “what should be.” Although there is no one way of presenting discrepancies, it is important to display them in an organized manner. Finally, brainstorming together to develop strategies to “bridge the gap” or resolve discrepancies requires thoughtful dialog, creativity, and accountability, ultimately enabling the project’s success. It is essential to assign the work to specific individuals with associated due dates in an effort to ensure accountability for the process.

Although assessing readiness evidence and conducting a nursing practice gap analysis are good ways to prepare for professional practice model integration, too much detail can overwhelm others, whereas too little detail will not provide enough information for strategy development. Thus, the goal is to include just the right amount of data to justify moving forward or pausing for a while to strengthen current conditions so successful integration can occur.

Using a shared, easily accessible electronic data file to identify key areas that are currently missing or inadequate, but that are needed for successful integration of practice change, represents an efficient way to prepare for successful integration.

Anticipating the Costs of Professional Practice Model Integration

Although adopting a PPM may offer a competitive advantage to health systems, it comes with a price. At present, cost pressures for health systems are escalating as decreased reimbursement rates, higher labor prices, lower
patient volume, electronic health record implementation, the unknown out-
lays associated with the Affordable Care Act, free care, and other expenses intensify. In fact, the shift toward value-added care (health outcomes achieved per dollar spent; Porter & Tiesberg, 2006) has substantially raised awareness regarding the impact of nursing practice on costs. Thus, prior to integrating a PPM, anticipating its costs is most beneficial.

How costs pertaining to PPM integration are most often delineated (e.g., direct, indirect, opportunity, or maintenance costs) provides a logical starting point. Direct costs are those tangible expenses, such as the cost of new equipment, salaries and benefits related to hiring additional employees, engaging consultants, supplies and marketing materials, and any required travel expenses, that are directly related to the PPM. Indirect costs are those intangible outlays that affect the entire organization such as charges for telephone and computer use, utilities, library resources, administrative overhead, or rental equipment. Opportunity costs refer to the costs of not implementing a PPM or how monies appropriated to PPM integration could otherwise be spent. In other words, if nursing practice remains stable in a certain health system while other close competitors are incorporating a more professional way of practicing, how will the estimated dollar value of that missed opportunity affect future revenue streams? It could also mean what the organization could have done with the available resources if they did not pursue the PPM. For example, if a health system spent a large amount on PPM integration and then was not able to offer wage increases for 2 years, how that decision affects employee morale vis-à-vis local competitors might be a consideration. Finally, maintenance costs refer to the expenses associated with sustaining the PPM after full integration.

Typically, PPM integration carries some elements of all four costs. For example, direct costs may involve dedicating a salary portion of at least one or, in many cases, several champions to facilitate model development and integration, hiring a consultant to direct and inspire employees and provide guidance on implementation and evaluation, costs for the development of an acceptable diagram that depicts the chosen model, employee educational expenses, evaluation costs, and employee travel to other sites and/or conferences. Indirect costs may include additional space for practice model activities while the missed opportunity of not adopting a professional practice must be analyzed in terms of an organization’s standing among a group of competitors. Ongoing costs, such as annual continuing education,
consultations, and evaluation, must also be considered. Thus, fully anticipating the costs helps to prepare for better integration and sustainable results of PPMs.

**SUMMARY**

In this chapter, the realities of current nursing practice were described in light of ongoing change. How nursing practice is expressed in an organization offers an exciting opportunity to depict how the practice of nursing contributes to the system while simultaneously showcasing how meaningful nursing work might be. The value of PPMs to nurses themselves, patients and families, the health system, and the discipline as a whole was discussed and made explicit through several examples. The process of integration, including the preintegration phase of assessing readiness and anticipating the costs, was explained.

**REFLECTIVE APPLICATIONS**

*For Students*
1. How do the realities of nursing practice discussed in this chapter compare to your notions of nursing?
2. What do you consider “interesting” nurse work?
3. Discuss whether nursing is a profession. Provide a rationale for your view.
4. What specific ways do you think a PPM adds value to patients and families? Why?
5. How would you go about gathering external data to support a PPM? How would you appraise it?
6. Develop a template useful for those completing a gap analysis.

*For Clinical Nurses*
1. What components of nursing work are “interesting” to you? Why? What suggestions do you have to provide RNs with more interesting work?
2. Analyze how your organization expresses nursing. Be specific—how is it considered, conveyed, and claimed? Does this affect nurses’ views of their role? Does it affect patient care? Is it consistent with the professional roles, responsibilities, and relationships of professional nurses?
3. What sources of internal data are available at your organization to prepare for PPM integration? What could you do to help your organization prepare?
4. To prepare for PPM integration, what internal data are you currently aware of that might affect the model’s success?

For Nurse Leaders
1. How do you provide interesting work for the nurses in your organization? What components are you involved in? How could you better advance an interesting work environment?
2. What components of PPM preparation worry you the most? Why?
3. Create a plan for gathering internal and external data, completing a gap analysis, and determining costs for PPM integration at your organization. Share it with other leaders.
4. Think about the internal characteristics at your organization. Are you ready for PPM integration? Why or why not? What can be done to increase readiness?
5. What “takeaways” from this chapter were most meaningful to you?

For Nurse Educators
1. Describe how the content in this chapter can be best translated to undergraduate and graduate students.
2. Using role modeling as a strategy, how could aspects of this chapter be demonstrated? What will you do? How will you ensure that cognitive, behavioral, and affective ways of learning are incorporated?
3. Develop a teaching strategy for helping graduate students understand the preparatory requirements of PPM integration.
4. How would you evaluate the chapter objective: “articulate how PPMs contribute to health system value”?

LEARNING FROM THE FIELD: THE VALUE OF PROFESSIONAL PRACTICE MODELS

Professional practice models (PPMs) are important because they provide the overarching conceptual framework for nurses, nursing care, and interprofessional patient care. They are quite literally the road map for excellence in care delivery—describing and depicting how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality of care.

Demonstrated excellence in exemplary professional practice (the desired result of PPM integration) enables nurse autonomy, accountability, and authority, which positions nurses to advocate for patients. Indiana University Health believes that nursing is a profession, not an occupation,
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and members of the nursing team are clear on the difference. A robust PPM, supported by theory, centers the care delivery model that is grounded in a strong mission, vision, and a set of core values. Thus, a PPM supports nurses and team members as they deliver patient care.

In doing so, PPM support practice that is consistent with the tenets of the profession, including essential values such as altruism, equality, esthetics, freedom, human dignity, justice, and truth. Most important, PPM equally embody the rights of patients and the rights of nurses, enabling shared decision making at all levels, as well as ongoing professional development.

Evaluation of PPMs, both formally and informally, through established structures and processes, including shared leadership/governance mechanisms, provides evidence of system value and the basis for continuous improvement. Measurement elements should include patient satisfaction; evidence-based practice; RN professional development; RN reward and recognition; safe, timely, efficient, effective, and equitable patient-centered care; and RN satisfaction with decisional involvement, team relationships, resource adequacy, management, and workplace safety. Health systems and nurses desperately need these data to demonstrate their contribution to the highest quality of care.

Linda Q. Everett

REFERENCES

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CHAPTER 3

Professionalism, Interprofessionalism, and Leadership: Commitment

KEY WORDS

Professional practice, interprofessionalism, leadership, commitment

OBJECTIVES

By the end of this chapter, readers will be able to:

1. Differentiate between the terms *professional* and *being* professional
2. Apply the principles of interprofessionalism to the professional practice of nursing
3. Evaluate how the professional practice of leadership is tied to nursing professional practice models (PPMs)
4. Examine individual and leadership commitment to professional nursing practice

THE PROFESSIONAL PRACTICE OF NURSING

The practice of nursing is grounded by the American Nurses Association’s (ANA) seminal documents: *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015), *Nursing: Scope and Standards of Practice* (ANA, 2010a), and *Nursing’s Social Policy Statement* (ANA, 2010b) and further influenced by individual state nurse practice acts. These documents define nursing and nursing practice, describe how nursing practice fulfills society’s mandate, present standards and competencies that influence the professional role of nursing,
explain regulations that guide professional practice, and establish the ethical base for all nurses regardless of setting. Furthermore, the documents highlight the mutually beneficial relationship between society and the nursing profession (i.e., nursing’s response to societal needs). Thus, individual professional nurses are responsible not only for their own behaviors but also to the needs of society or the community served. This “contract” that exists between nursing and society provides the authority to practice professional nursing.

In Nursing’s Social Policy Statement (ANA, 2010b), theory application and use of research serve as the basis for nursing actions (or interventions) whose aims are to “protect, promote, and optimize health; to prevent illness and injury; to alleviate suffering; and to advocate for individuals, families, communities, and populations” (p. 10), leading to beneficial outcomes. Throughout these various documents, elements of accountability, including current licensure, delegation issues, continuous improvement, and leadership, are repeatedly presented. Understanding the content of these professional documents and “applying” them to everyday practice, however, are two different phenomena.

The shifting focus toward health system value (the Triple Aim; Institute for Healthcare Improvement [IHI], 2007) demands sophisticated application of professional nursing behaviors (e.g., being professional). Being professional relates to behaving in a manner that is expected of a professional (e.g., acting in accordance with the seminal documents previously described) as well as sustaining effective interactions, reliable behaviors, and autonomous commitment to continuous improvement (Wilkinson, Wade, & Knock, 2009).

In fact, being professional is hard work that some would say does not occur at a single point in time (e.g., during an educational program) but develops over time, maturing with knowledge, experience, and ongoing self-awareness.

Being professional encompasses specialized knowledge and skills, collaborative interpersonal approaches, responsiveness and revision of how one is perceived by others (e.g., physical appearance, stance, displays of human respect and compassion), ongoing improvement, and informed decision making. The term professional comportment has been used to describe this phenomenon and is defined as a “dignified manner or conduct” (Clicker & Shirey, 2013, p. 107) that is equal in importance to technical tasks.

Being professional is associated with knowledge of one’s work (Drucker, 1994, 1999), which is important not only because it is tied to disciplinary
ideals, but also because it adds value to those served as well as to the associated organizations. For example, how is a patient or family’s experience shaped by a disheveled nurse with a passive stance versus a professional-looking nurse with an optimistic stance? Although anecdotal, many patients have reported to this author a remarkable difference in their willingness to disclose, adhere to the plan of care, or to trust health care providers based on their appearance and behavior alone. Thus, professional comportment must be developed and nurtured in health systems in order to successfully deliver care aligned with patients’ preferences and values.

In the *Blueprint for 21st Century Nursing Ethics: Report of the National Nursing Summit* (Johns Hopkins University School of Nursing and the Berman Institute of Bioethics, 2014), nurse leaders acknowledged the ethical challenges that nurses face in everyday practice, but also committed to strengthen nursing’s ethical foundation in order to meet the challenges facing health systems. In particular, they spoke to strengthening the context, clinical practice, education, research, and policy related to professional practice. Ideas, such as more intentional practice, accountability and personal responsibility, interdisciplinary efforts, acknowledging moral distress among nurses, the availability of adequate resources, and building on existing work—all features of professional practice models (PPMs)—were advocated.

Although most health professionals value their own disciplinary expertise and judgment, and display this through independent actions, working as a collaborative team member is also part of professional practice. It is only recently, however, that health professionals have embraced interprofessional practice to the extent that it is a crucial element of training programs. Fostering interprofessionalism through collegial actions that ultimately enhance patient outcomes is an expectation of professional nursing practice (Interprofessional Education Collaborative Expert Panel, 2011).

**INTERPROFESSIONALISM**

Interprofessional collaboration is crucial for meeting society’s expectations for enhancing health. The World Health Organization (WHO) defines interprofessional collaborative practice as a process whereby multiple health workers from different professional backgrounds provide comprehensive services by working with patients, families, caregivers, and communities to deliver the highest quality of care across settings (WHO, 2010, p. 13). Interprofessional teamwork, on the other hand, refers to the quality of the team process and its goals, collaboration, mutual aims, and optimal communication (Thistlethwaite & Dallest, 2014). In other words, interprofessional teamwork...
is undergirded by the relational attributes of team members, the appreciation of others’ goals, and mutual communication.

Several studies have demonstrated a link between interprofessional practice and improved patient outcomes (Reeves et al., 2009). Current delivery systems, however, frequently persist in organizing health professionals by discipline; staff work in separate clinical departments (Kline, Willness, & Ghali, 2008) that practice independently. Yet, the problems encountered by today’s patients are often so great that well-intentioned health professionals cannot resolve them alone. For example, Mazzocco, Pettiti, and Fong (2009) found that patients whose surgical teams exhibited fewer teamwork behaviors were at a higher risk for death or complications, even after adjusting for patient risk.

Despite the renewed interest in the academic preparation for interprofessional practice, translation into health systems has been slow. Cashman notes, “absent structures and systems that support interprofessional practice, professionals run the risk of reverting to old, traditional modalities of parallel practice” (Cashman, Reidy, Cody, & Lemay, 2004, p. 184). Health professionals increasingly indicate the need to collaborate but changing long-established systems has been challenging.

Carefully insisting on the inclusion of interprofessionalism in PPMs is an ethical responsibility. Building relationships through role modeling interprofessionalism and empowering others to develop flexible and effective relationships that add value (e.g., enhance patient outcomes) contributes to interprofessionalism. Helping others to identify aspects of practice that require collaboration, to accept multiple perspectives, and to continually monitor and improve practice fosters the overall goal of “what’s best for the patient,” an ideal of all health professionals.

LEADING A PROFESSION

The Institute of Medicine’s (IOM) report The Future of Nursing (IOM, 2010) advocated for nurses to take on greater roles in leading change to advance health care in America. This report called for leadership at all levels of nursing, and personal accountability for ongoing professional development, including interprofessional collaboration and coordination. More specific, the report called for transformative leadership that advances nursing’s role as a full partner. Leading in this context calls for a more actionable approach that considers patient welfare as primary, and its continued improvement over time, essential. Although all nurses are considered leaders, some have organizational responsibility for leading groups of nurses in the delivery of patient-centered
Leadership is a practice in its own right that complements clinical practice; it enjoys an evidence base and an associated body of knowledge.

care. Through repeated evidence-based work experiences, acquisition of new knowledge, and ongoing reflection, leadership proficiency evolves, supporting the hard work of health professionals in meeting society’s needs for health and wellness. As such, leadership is a lifelong process of learning, performing, pondering, and performing again.

As leaders of a profession, nurses are called to consider the patient (and by extension, the family) as their first priority and rehearse (over and over again) the practice they have been prepared to advance.

Those who formally lead the profession (such as those with administrative titles) must remember that they are “guiding a practice whose first responsibility is to patients and families, that bears responsibility for providing competent, high-quality services, and that is uniquely qualified to advance relationships that improve the human experience” (Duffy, 2013, p. 170). Thus, nurse leaders are in a unique position to facilitate professionalism by stewarding the integration of PPMs. Placing the patient and family at the center of professional practice and using their input in the choice, implementation, evaluation, revision, and adoption of PPMs supports the IOM definition of transformational leadership. Ensuring coordinated teams of professionals, who work together to achieve specific patient-centered outcomes in an efficient manner, facilitates nursing’s role as a full partner.

COMMITTING TO PROFESSIONAL PRACTICE

Professional practice models empower professional nurses by providing the foundation and infrastructure to deliver high-quality patient care. Yet, dedicating time and resources to PPM integration requires steadfastness over time, especially during stressful periods, along with continued focus on the ultimate goal(s). In essence, commitment is the glue that ensures successful integration.

Commitment is a human phenomenon that helps us organize our behaviors. Whether it is visually observed or not, commitment connotes...
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action of some sort and usually is tied to some future occurrence or outcome. Commitment in the context of PPM integration creates not only possibilities but expectations for others. Thus, without a determination about what is committed, others may not follow or share in the expectations.

Integrating PPMs in an established organization with traditional ways of practice is a long-term investment that carries upsides and downsides. For example, although initial enthusiasm might be high, as particular roles or responsibilities are eventually altered, individuals often lose interest.

To sustain the initial momentum, a different disposition is required—one that is less hesitant or cautious in favor of one that is more convincing or definitive. Such a stance is best held at the local (or unit) level where individual nurses who are passionate about the PPM work side by side with other nurses and can help them see the possibilities for a different, more professional practice. These nurse champions are enthusiastic, intelligent, and present opinions that others listen to. Of course, although such individuals can initiate momentum, long-term commitment is necessary, requiring an enduring presence to sustain new behaviors. Identifying and nurturing unit-level champions are key to maintaining commitment. The following exemplar represents one direct care nurse’s evolving commitment to a professional practice model:

As a BSN-prepared nurse, I learned a long time ago to be careful about trying new things. Once I became aware of our hospital’s professional practice model, I was intrigued with the idea of practicing in a way that is true to my heart, but wary of how it might change my daily routine. After all, it had taken me a little over 18 months to become comfortable with the unit. But after I learned about the professional practice model, designed by the practice council, it didn’t take much convincing for me to see how it might change practice for the better. Little by little I got involved in it by first getting educated on it, and then, following the lead of the unit charge nurse, helping with goals for implementation, redesign of the care delivery system, and eventually assisting with evaluation. More specifically, I provided input into the staffing mix, interprofessional rounds, and helped with communication. I educated the unit unlicensed assistive personnel in the revised nursing role, assuring them of their continued value to the team. This experience has reaffirmed for me that stepping out of one’s comfort zone has many benefits, for me, my co-workers, and patients. I can’t believe all I have learned. (Personal communication, September 23, 2015)
This exemplar shows the value of committed unit champions who, after identification and with a little encouragement, will help expedite integration by promoting the model at the unit level.

Finally, although unit champions are crucial to sustained commitment, those in formal leadership roles have the responsibility to psychologically align with the PPM (Herold & Fedor, 2008) and maintain a positive attitude toward the future when nursing practice will be more professionally based.

**SUMMARY**

In this chapter, the meaning of professional practice is presented in light of grounding ANA documents and state nurse practice acts. Furthermore, the phenomenon of being professional with its intended accountability for effective interactions, continuous improvement, awareness of self, and use of evidence in decision making was reviewed. The term professional comportment was defined, whereas interprofessionalism and its link to PPMs was described. Finally, leadership practice and commitment as they relate to successful integration of PPMs were explained.

**REFLECTIVE APPLICATIONS**

*For Students*

1. Review Nursing’s Social Policy Statement. How does this document help you understand your duty to society?
2. Think about the nurses you know or those you have seen in clinical courses. Are they being professional? What behaviors lead you to describe them this way?
3. Discuss the difference between professional practice and being professional.
4. How do you think others perceive you? Why is this important in patient care?
5. Explain your responsibility for collaborative practice. How would you evaluate your interprofessional performance?
6. Develop a list of behaviors you would like nurses to display that demonstrated commitment to professional practice.
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For Clinical Nurses
1. What components of your everyday work are based in the ANA documents on professional practice?
2. Analyze how your peer group conveys being professional. Be specific—what does being professional look like? Do you think such behavior affects nurses’ views of their role? Does it affect patient care? Why?
3. What does your stance say about you as a professional? How about your appearance?
4. To prepare for PPM integration, how will you facilitate nurses’ commitment to the model?
5. What behaviors do you practice interprofessionally? How could interprofessionalism be advanced on your unit?

For Nurse Leaders
1. How are the founding ANA booklets and the state nurse practice act conveyed throughout your health system? How could you better advance nurses’ understanding of these documents?
2. How do you convey being professional to those you supervise?
3. How is your leadership practice based on evidence? When was the last time you used current evidence to make a leadership decision? What was it? How did the evidence inform your decision?
4. Do patients and family members regularly contribute input to improving nursing practice? Why or why not? How could you facilitate their feedback?
5. How do you ensure that collaborative interprofessional practice is occurring in your health system? How is it evaluated and improved?
6. Are you committed to PPM integration? What leads you to answer this way?
7. Think about the characteristics of direct care nurses on your unit(s). Can you identify any early adopters? What about the early majority? Are you ready for PPM integration? Why or why not? What can be done to increase readiness?

For Nurse Educators
1. Describe how the content in this chapter can be best translated to undergraduate and graduate students?
2. What takeaways from this chapter have the most implications for education?
3. Are the ANA documents listed in this chapter used in your curriculum? Why or why not? What about the state nurse practice act?
4. How do you ensure that being professional is learned and incorporated into clinical practice?
5. What teaching strategies might best help undergraduate students understand the content of this chapter? Why?
6. How is interprofessionalism taught in your program? What could you do to enhance collaborative practice? Do you have any recommendations for fostering interprofessionalism during clinical courses?

LEARNING FROM THE FIELD: BUILDING THE CASE FOR NURSING PROFESSIONAL CAPITAL

After interviewing intensive care survivors for my dissertation research, I was buried in reams of qualitative data that represented the insight shared by patients about their perceptions of feeling safe in intensive care. Their narratives were mainly about nurses; what nurses knew, how nurses carried out their work, words nurses offered as encouragement, and how nurses could be counted on to come quickly when help was needed. It occurred to me that these patients were describing a concept that I call professional capital and were using facets of this concept to describe their nurses. Let me explain my reasoning.

Consistent with the definition of professional, nurses have a specialized body of knowledge that is learned through the study of nursing science (Merton, 1960). Through study, coupled with experience, nurses come to know their work and how to determine when it is effective and meaningful (Schinkel & Noordegraaf, 2011). Nurses place patient needs over personal and professional gain and demonstrate unrelenting ethical and moral commitment to patients by influencing public health and social welfare (Tarlier, 2004). These actions, along with relationships that are formed between patients and nurses, are noticed and valued by patients (DeFrino, 2009; Fletcher, Berg, Simmermann, White, & Behrens, 2007).

The term capital was first used in the 1800s by economists in reference to monetary and material possessions (Casey, 2008). Since then, concepts, such as human, intellectual (Covell, 2008), symbolic (Bourdieu, 1984, 1986), as well as social (Boix & Posner, 1998) have been added as prefix modifiers and used to describe people such that human capital refers to a person’s knowledge, experience, and expertise. Intellectual capital is knowledge contributed by people within an organization, which becomes evident through better quality and better outcomes. Because nurses offer considerable human and intellectual capital, they are an indispensable part
of the survival and advancement of health care organizations that seek to provide high-quality, patient-centered care. As patients recognize that an institution legitimately values and delivers quality care, the institution obtains symbolic capital. Additionally, social capital, the joint cooperation (and the joint responsibility) of all professionals within an institution who are focused on achieving common goals, is noticed and valued by patients.

Thus, the amalgamation of definitions plus quantitative polls and qualitative data serves as evidence that supports the case that nurses have demonstrated and possess professional capital in the following ways:

- Quantitative evidence has consistently shown public recognition of nurses as honest, ethical (Gallup, 2013), and trustworthy (ANA, 2013).
- Qualitative research findings have provided evidence that patients view nurses as knowledgeable and accessible and that positive patient–nurse relationships are a necessary part of quality health care (Lasiter & Duffy, 2013; Lasiter & McLennon, 2015).
- Nurses have used professional influence to improve the quality of patient care and have provided support for policies that improve health outcomes for populations.
- Nurses bring human and intellectual capital to an institution and use it to advance institutional symbolic and social capital.

The world is ready for nurse professionals who are willing to bypass self-interest and take a strong leadership stance to create a promising future for health care. Nurses are well-positioned to lead the way because they have consistent public support, have in-depth knowledge and know how health care systems work, and possess unspent professional capital. Nurses, however, must be cautious when deciding how to spend professional capital, so that the highly valued relationships that have been developed with patients are veraciously protected.

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