EXPERIENCES OF DIRECT CARE REGISTERED NURSES USING A PROFESSIONAL PRACTICE MODEL: A QUALITATIVE STUDY

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DEDICATION

This dissertation is dedicated to my family for their love and support. Especially to my mother for encouraging all her children to take advantage of the opportunities she never had to complete an education. This is also dedicated to my nieces and nephew as a reminder you can be anything you want with dedication and determination.

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ABSTRACT

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EXPERIENCES OF DIRECT CARE REGISTERED NURSES USING A PROFESSIONAL PRACTICE MODEL: A QUALITATIVE STUDY

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Objective: The goal of this descriptive phenomenological research was to explore the individual and collective lived experiences of inpatient, direct care nurses practicing in a community-based hospital within the framework of a nursing professional practice model.

Method: A snowball sampling methodology was employed. Data were collected via semi-structured focus groups with 20 participants. Qualitative data analysis followed Colaizzi's steps to arrive at common themes and provide rich detail. Scientific rigor and trustworthiness were maintained.

Results: Six main themes emerged the described the nurses' lived experiences with the PPM.

- Foundation of care; promotion of consistent and standardized patient care.
- Professional knowledge; expanding personal knowledge and subsequent sharing of this knowledge to edify nursing peers.

- Reflective practice; change in practice and improved patient care facilitated by reflective practice and reflective thinking.
- Collegiality; PPM use facilitated interdisciplinary communication and professional growth.
- Cohesion of model components, whole PPM greater than the sum of the individual components.
- Inconsistency of use; fragmented model use and reinforcement. These themes incorporated the aspect of model use, outcomes, and opportunities for improvement.

Findings: If institutions want to implement and actively use a PPM, active promotion beyond a simple orientation is required. The PPM must be highly visible, consistently reinforced, and use continuously evaluated. Administration, managers, and nursing staff need a congruent expectation and understanding of model use and adoption. Managers should evaluate model use as part of the performance review process. Nurses should familiarize themselves with the institutional PPM, actively engage the PPM, and hold one another accountable for PPM use.

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CHAPTER I

INTRODUCTION

Focus of Inquiry

In a series of reports published from 1999 to 2001, the Institute of Medicine (IOM) heightened public awareness regarding the effectiveness and safety of the United States health care delivery system. The authors of the seminal IOM article "To Err is Human" reported an estimated 44,000 - 98,000 deaths per year in the United States due to healthcare errors, resulting in additional healthcare costs of 17-29 billion dollars per year (Kohn, Corrigan, & Donaldson, 1999). This revelation led to a national initiative to ensure patient safety and demand higher quality from the American health care system. Because nurses provide 95% of care in the hospital setting (Lash & Munroe, 2005), one approach to increase effectiveness of health care was to introduce the use of nursing professional practice models (PPMs) to facilitate care quality (Chamberlain et al., 2013). PPMs provide a framework that guides professional behavior, increases control over the delivery of care and the care environment, and enables nurses to provide higher quality levels of care that lead to better patient outcomes (Hoffart & Woods, 1996; Tinkham, 2013). Nursing PPMs have also been shown to cultivate mutual respect, collaborative decision-making, effective communication, and positive nurse-physician relationships (Siedlecki & Hixson, 2011).

Professional practice models are deemed so important that the American Nurses Credentialing Center (ANCC) Magnet® Program requires that hospitals demonstrate the presence of an established and uniform PPM to achieve Magnet® designation (Tinkham, 2013).

The Koloroutis relation based care model guides the specific PPM used by the study institution (see Figure 1).

Figure 1. Institution Professional Practice Model.

Relationship Based Care asserts effective nursing care is built on three foundations: relationships with patient, family, and community: relationship with self: and relationships with colleagues.

The six dimensions of this care delivery model include (a) leadership, (b) teamwork, (c) professional nursing practice, (d) patient care delivery, (e) resource driven practice, and (f) outcomes measurement. Leadership entails the belief that each individual nurse functions in some aspect as a leader. Teamwork is inclusive of the characteristics of accountability, professional support, successful communication, and collegial relationships. Professional nursing practice encompasses the roles of clinician, advocate, innovator, collaborator, educator, and leader. Patient care delivery is composed of nurse/patient relationships, decision-making, work distribution, communication, and evaluation/management of environment of care. Resource driven practice involves (a) prioritization to optimize overall benefit to the care delivery team as a whole, (b) outcomes measurements allows for benchmarking and (c) comparison of nurse sensitive indicators such as National Database of Nursing Quality Indicators (NDNQI), patient/nurse satisfaction, as well as Agency for Healthcare Research and Quality (AHRQ) quality indicators (Koloroutis, 2004).

While quantitative studies have explored the outcomes of PPM implementation such as increased nursing job satisfaction, increased patient satisfaction, increased nursing autonomy, and decreased nursing turnover (Scott, Sochalski, & Aiken, 1999), a phenomenological study would allow examination of this process from a different angle and contribute to a rich description of how nurses use a PPM to provide daily patient care. The goal of this descriptive phenomenological research is to explore the individual

and collective lived experiences of inpatient, direct care nurses practicing in a community-based hospital within the framework of a nursing PPM.

Statement of Purpose

The objective of this phenomenological research was exploration and description of direct care - inpatient nurses' lived experiences of working within the framework of a PPM. The research question was, "What are the experiences of working within a PPM for inpatient, direct care nurses?"

Rationale for the Study

The current environment of increased emphasis on health care quality and adherence to evidence based practice guidelines has produced a new generation of informed and savvy health care consumers. Nursing care in hospitals with implemented PPMs has been correlated with decreased hospital mortality, morbidity, length of stay, and cost of care (Prescott, 1993). The reformation of the United States health care delivery system will further demand inpatient nurses to function at the full scope of their practice while utilizing evidence-based practice guidelines (AHA, 2013). Literature supports a relationship between a high degree of nursing autonomy and high-quality patient outcomes (Lash & Munroe, 2005).

The United States is undergoing an unprecedented reform in health care delivery. This reform requires nurses to practice at a higher standard to meet expectations. A PPM improves nursing power and control, improves nursing care, and affects patient care outcomes. A PPM is also the fundamental underpinning required to obtain the

prestigious and highly sought after ANCC Magnet® designation. This descriptive phenomenological research will be of interest to inpatient facilities striving to implement a PPM to elevate the practice of direct care nurses.

Philosophical Underpinnings

Husserl's transcendental philosophy guided this descriptive phenomenological study of the nurses' lived experience of working within PPMs. The philosophical tenets are based on the belief that phenomenology provides pure comprehension of human experiences (Streubert & Carpenter, 2011) and that these human perceptions/experiences are worthy of scientific investigation (Lopez & Willis, 2004). Husserl viewed the exploration of experiences (essence of consciousness) as the basis of knowledge (Koch, 1995).

Husserl accepted the Cartesian understanding of the mind and body as duality, or separate natures. This idea is pivotal to the exploration of consciousness related to the identification, investigation, and description of phenomena (Koch, 1995) known by Husserl as 'things themselves' (Paley, 1997). Husserl's ideologies view the lived experience of individuals in semblance to the overall common universal human experiences known by Husserl as the "lifeworld" (Hung & Sables, 2008).

Key concepts of Husserlian phenomenology include essences, intentionality, and phenomenological reduction via bracketing. The fundamental structures of consciousness are known ontologically as essences. Husserl's describes essences as collective concepts of awareness that can be reduced into common understanding (Paley,

1997). Intentionality is based upon the epistemological assumption that knowledge begins with conscious awareness, which is the individual's lived reality. The individual and universal lived experience therefore becomes the basis of creating knowledge (Koch, 1995). Phenomenological reduction via bracketing is the practice of suspending preconceived ideas about a phenomenon/essence to achieve transcendental subjectivity (Creswell, 2013; Lopez & Willis, 2004). This bracketing process allows for an unbiased approach to the description of the phenomenon of interest (Koch, 1995).

Historically, nursing literature is replete with qualitative studies guided by the philosophical underpinnings of phenomenology (Banonis, 1989; Benner, 1985; Haase, 1987; Hilton, 1988; Loos, 1989). Oiler (1982) asserted that phenomenological methodology could be viewed as an extension of the nursing process. Descriptive phenomenology is therefore a good fit for this research that seeks to describe the essences of the lived experience of care delivery and nursing relationships within the framework of a PPM.

The phenomenon of nurses' experiences working within a professional practice model was described. Participant's spoken descriptions were collected, read, and significant statements extracted from the transcripts. Meanings were associated with these statements and organized by themes. A comprehensive written description was produced. Participants were asked to validate the research findings and any new data was incorporated into the research findings (Streubert & Carpenter, 2011).

Summary

Professional practice models promote high quality healthcare services that improve patient safety/outcomes. Nurses are in the position to function as facilitators for improving the quality of nursing care, advocating for healthy relationships, and promoting patient autonomy in healthcare. A PPM is the conduit by which these objectives can be accomplished. Nursing literature lacks enough inquiry into and description of the lived experience of direct care nurses working within the acute care hospital setting using a PPM.

Guided by the philosophical underpinnings of Husserlian descriptive phenomenology, direct care nurses using a PPM based on tenets of the Koloroutis relation based care model were asked to describe their lived experiences of nursing practice. These descriptions suggest strategies and interventions to facilitate the establishment and implementation of nursing PPMs.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this study was to explore the experiences of direct care registered nurses using a PPM. This review synthesizes the literature available regarding nursing professional practice models with attention to the experiences of inpatient direct care registered nurses implementing and using PPMs. This chapter focuses on review methods, elements of nursing professional practice, professional practice models, strategies for successful implementation, and outcomes of professional practice model implementation

Methods and Analysis of Literature Review

An initial search of English language articles from the United States, Canada, and Australia, published from 2000 through 2016, was conducted via the PubMed database. The search was limited to these countries due to use of the English language. Due to a limited initial yield, the date range was expanded to include articles from 1990 through 2016. Mesh terms searches included, nursing, attitude of health personnel, program development, models – nursing, professional staff committees, quality assurance – health care, hospital administration, and education nursing, continuing. Search terms were applied to article title, abstract, and key words. The search strategy was extended to include CINHAL, Cochrane, ERIC, ProQuest, Scopus, and OVID databases. Grey literature was included in the review. An ancestry approach and a hand search strategy were also employed. A total of 195 articles were identified from these databases.

At this point, the search was further refined to include only nursing and healthcare journals relevant to registered nurses practicing in inpatient acute care due to an overly broad article and journal selection. The article abstracts were reviewed to determine if they met eligibility criteria of content being relevant to elements of nursing professional practice, professional practice environments, or nursing professional practice models. The sampling frame included articles considering PPMs in the acute inpatient care settings, specialty areas of practice, and outpatient settings. Specialty areas of practice and outpatient settings were included for consideration with the rationale that information from those settings may also be applicable to the implementation of PPMs in the acute inpatient care setting. Employing a more restricted search resulted in identification and selection of the 45 most relevant articles for this review. Articles selected for inclusion comprised both qualitative and quantitative studies that related to development, implementation, and outcomes of PPMs as well as descriptions of professional practice model implementation that included recommendations for successful implementation. Twenty-three articles met the inclusion criteria and were included in this review.

Selected articles focused primarily on general acute inpatient care settings and included primary and secondary research articles as well as expert/authority opinions. Nine articles were research articles with variables related to PPMs (Elliott, Walden, Young, Symes, & Fredland, 2017; Harwood, Ridley, Lawrence-Murphy, Spence-Laschinger, White, Bevan, & O'Brien, 2007a; Harwood, Ridley, Lawrence-Murphy, Spence-Laschinger, White, Bevan, & O'Brien, 2007b; Ingersoll, Schultz, Hoffart, & Ryan, 1996; Kramer & Schmalenberg, 2003; McGlynn, Griffin, Donahue, & Fitzpatrick,

2012; Pierce, Hazel, & Mion, 1996; Spence Laschinger, Shamian, & Thompson, 2001; Storey, Linden, & Fisher, 2008). Eleven descriptive articles offered expert/authority opinions (Hodge, Campbell, & Tobar, 2016; Duffy, Baldwin, & Mastorovich, 2007; Arford, & Zone-Smith, 2005; Berger, Conway, & Beaton, 2012; Erickson & Ditomassi, 1998; Girard, Linton, & Besner, 2005; Latta & Davis-Kirsch, 2011; O'Rourke, 2003, 2006; Tinkham, 2013, 2014). One article compared five PPMs (Hoffart & Woods, 1996). One article presented a concept analysis of practice models (Chamberlain, Bersick, Cole, Craig, Cummins, Duffy, & Skeahan, 2013). One literature review contained a synthesis of key components of professional practice models (Slatyer, Coventry, Twigg, & Davis 2015).

Relevant data retrieved from the articles were organized into an Excel matrix. Headings included reference, year, key words, type, study design, population, sample, level of evidence, journal, findings, and limitations. Themes emerging from the analysis of literature included: elements of professional practice and PPMs, strategies for successful PPM implementation, and outcomes of model use (job satisfaction and quality of care).

Elements of Professional Practice and Professional Practice Models

PPMs are the culmination of a patient centered approach grounded in point of care leadership and professional behaviors (Chamberlain et al., 2013). A useful professional model of practice is also based upon the behaviors of participation in the establishment of a learning environment, communication, and role competence (O'Rourke, 2006). Common elements of professional practice include leadership,

accountability, engagement, collaboration, and competence subsequently resulting in quality of nursing care (Arford & Zone-Smith, 2005; Berger et al., 2012; O'Rourke, 2006).

Leadership, a key professional practice element, was a common component of professional practice models. Latta and Davis-Kirsch (2011) depicted leadership as components of PPMs composed of shared governance, leadership development, and succession planning guided by the overall nursing strategic plan for an organization. Hoffart and Woods (1996) endorsed a decentralized approach to leadership enabling direct care nurses to make organizational decisions affecting patient care. Shared governance supported the professional practice environment promoting collective decision making with input from direct care nurses (Berger et al., 2012). Slayter, Coventry, Twigg, and Davis (2015) found leadership in relationship to PPMs extended from high-level organizational leaders to bedside nurses. Professional practice models empowered direct care nurses to lead care.

Accountability, an essential professional practice attribute, is incorporated into PPMs and is based on the authority and responsibility implied by standards and scope of professional practice (O'Rourke, 2006). Fundamentals of nurse accountability include self-direction, application of theory, evidence-based practice, and provision of care (O' Rourke, 2003). Professional practice models clarify nursing roles and responsibilities, supporting the autonomy of nurses (Harwood et al., 2007b). Berger et al. (2012) indicated accountability is inclusive of teamwork, collaboration, leadership, and best practice.

Engagement as evidenced by an organizational commitment to professional practice is crucial to achieve an environment supportive of a PPM (Arford & Zone-Smith, 2005). Practice models facilitate engagement of nurses by demonstrating how PPMs support the nurse patient relationship (Chamberlain et al., 2013). These models holistically represent the fragmented and sometimes imperceptible work of nurses to reinforce a connection between the work of the nurse and the work organization (Erickson & Ditomassi, 1998).

Collaboration is another common element of professional practice and PPMs. Berger et al. (2012) highlighted the strategy of teamwork to create a shared vision statement and promote collaboration to foster a professional practice environment supportive of a PPM. Leadership structures such as shared governance promote collective decision-making and collaboration (Berger et al., 2012).

Competence is a common component of professional practice. Competence in the context of a PPM is not only composed of knowledge, technical skills, critical thinking, and decision making but also the desire and propensity to share and further develop one's self and others (Girard et al., 2005). Professional practice environments and models require leaders to be supportive of the culture with actions that reward, and sanction based on competency (Arford & Zone-Smith, 2005).

In summary, literature regarding components of PPMs is primarily derived from expert opinion evidence regarding nursing professional practice and professional practice models. The literature reflects an inconsistent definition and use of the terms professional practice, professional practice model, and professional practice environment

resulting in confusion regarding what defines a professional practice model (Latta & Davis-Kirsch, 2011; Pearson et al., 2006; Storey et al., 2008). Chamberlain et al. (2013) completed a concept analysis to clarify the confusion and misuse of the terminology by describing uses of PPMs, practice model attributes, and related concepts. Some confusion is also encountered because PPMs are uniquely developed to reflect the nursing values of each institution (O'Rourke, 2003). Subsequently, the advantage of uniformity of PPMs amongst organizations is lost.

Strategies for Successful Implementation of a PPM

Professional practice models are of little value without successful model implementation and integration in which administrators and nurses subscribe to the model and use it to guide practice. Much of the literature contains expert opinions regarding strategies for successful implementation of a PPM addressing model development, education, dissemination, and integration. Berger et al. (2012) stressed the importance of foundational knowledge of the definition and purpose of a professional practice model, the use of focus groups in the developmental phase, a team approach, and adequate education, dissemination, and integration into clinical practice. Arford and Zone-Smith (2005) propose that successful implementation of a PPM requires a foundation inclusive of a structural definition of nursing work, competencies, and scope.

Model development is the first step in preparing for PPM implementation. Girard, Linton, and Besner (2005) suggested linking the PPM to competencies, job descriptions, and ongoing education plans. Successful development of a PPM includes adopting a model that staff can easily understand and articulate (Tinkham, 2013).

Effective communication of the PPM components and purpose as well as a team approach is conducive to establishing a PPM (Tinkham, 2014). Hoffart and Woods (1996) recommend selection of a model reflective of the values and relationships of nursing as well as identification of a patient care delivery system congruent with a transformational management approach supportive of recompense for professional practice. Hodge, Campbell, and Tobar (2016) described the successful use of nursing salons (meetings) as an approach to encourage staff nurse engagement in the development of a PPM by cultivating reflection on professional practice in the institution. The authors encourage scheduling salons for an extended period at various times to allow participation from all interested nurses regardless of the shift worked.

Commonalities of successful implementation of a PPM include participative leadership, staff engagement, participatory model development, model education, clear delineation of patient centered responsibilities and roles, subsequently leading to model integration into daily nursing patient care delivery. Following adoption of the quality caring model, Duffy, Baldwin, and Mastorovich (2007) described implementation of a PPM as a mechanism to effectively organize patient care delivery in a large acute care facility. Leadership and staff engagement, in depth model education, participatory model development, and clear delineation of patient centered roles and responsibilities resulted in a patient centered practice environment focused on caring and healing. This foundation allows the organization to provide uniform delivery of value-based nursing care.

Latta and Davis-Kirsch (2011) identified determination of appropriate education strategies and emphasis to provide a clear connection between existing nursing processes and structures to the PPM as a challenge to successful implementation. A comprehensive education approach including PPM presentation at hospital wide, shared governance, and unit-based staff meetings along with identification of PPM champions can facilitate implementation (Berger et al., 2012).

Successful implementation of a PPM depends on sound dissemination strategies (Latta & Davis-Kirsch, 2011). Erickson and Ditomassi (1998) indicated that successful implementation of a PPM is dependent upon individual nurse engagement and articulation of the model. Berger et al. (2012) identified promotion of teamwork as a strategy to create a shared vision that supports collaboration and transformational leadership as key components of professional practice, which lead to successful implementation of a PPM.

Integration of the PPM into practice is dependent on many factors; however, organizational commitment is a critical facilitator of implementation (Arford & Zone-Smith, 2005). In a qualitative study, Storey, Linden, and Fisher (2008) examined successful PPM implementation by interviewing four nursing directors working in a women's hospital in the Northeastern United States. Four themes were identified including aspirational practice, moving nursing practice to a higher level, modeling behaviors by leadership, and integrating the model into practice. Aspirational practice addressed the need to incorporate growth and improvement into practice through reflective practice, maintaining currency, and interdisciplinary practice. Moving nursing

practice to a higher level occurred through setting high expectations, encouraging additional education, motivating nurses, and appreciating the efforts taken. Modeling behaviors by leadership through embracing change, finding resources for practice, and increasing staff nurses' positive perceptions of leadership competence was a critical factor. Integrating the model into practice increased the visibility of the model, shifted the mindset of nurses to discuss nursing issues, and to incorporation of evidence based nursing and research. Limitations of the study included the small sample size and single study setting. Themes needed further development. Research rank of the study was Level VI (Polit & Beck, 2013).

To summarize, successful implementation of a PPM requires intentional development and planning strategies. Development of a PPM should be founded in clear definitions of nursing work and professional practice (Chamberlain et al., 2013). Implementation of a PPM is supported by having a well-developed model based upon collaboration of direct care nurses and leadership at all levels of the organization (Girard et al., 2005). PPMs must be simple and easy for staff to articulate (Erickson & Ditomassi, 1998; Tinkham, 2013). O'Rourke (2006) described the use of socialization and role competence as tools to aid the implementation of a professional practice model and (2003) identified a need for core competencies supported by evidence based best practices. The literature included many expert opinion articles with descriptions of PPM implementation within an organization. Limitations noted were low level of evidence, with only one qualitative study identified. No accounts of direct care nurse experiences with implementation of a PPM were noted in the literature.

Outcomes of PPM Use - Job Satisfaction and Quality of Care

An important reason for shifting to the use of PPMs is to improve nurse measures such as job satisfaction, perceptions of autonomy, and nurse empowerment. Quantitative studies have explored the outcomes of PPM implementation such as nursing job satisfaction, nursing autonomy, and nursing retention (Scott et al., 1999). Harwood et al. (2007a, 2007b), quantitatively and qualitatively examined renal nurse perceptions of quality of care post PPM implementation in an acute care renal unit of a university-based teaching hospital located in Canada. The quantitative portion of the study (Harwood et al., 2007a) used a "then and now" design with a convenience sample of 31 renal nurses from a population of 81 renal nurses within the organization. Two instruments were employed for data collection. The Nursing Work Index Practice Environment Scale (NWI-PES) is a 31-item tool with five subscales (policy development, quality of care, manager ability, nurse support, allocation of resources and nurse/physician relationships) rated via a 4-point Likert scale (strongly agree to strongly disagree). The Conditions of Work Effectiveness Questionnaire-II (CWEQ - II) is a 12-question tool with six subscales (opportunity, information, support, resources, formal power, and informal power). Paired t-tests showed significant improvement in the quality of care subscale of the NWI-PES (p =.005) and organizational relationships on the CWEQ - II (p = .016) post model implementation. Harwood et al. (2007b) described the qualitative portion of the study as semi-structured interviews with ten participants to explore the impact of the PPM. Themes identified were (a) Attunement, with the subthemes of familiarity /knowing the patient, and going the distance, which derived from nurse's descriptions of the positive

influences of a PPM upon nurse patient relationships. (b) Patient outcomes, with the subthemes of consistency and continuity of care, and autonomy/taking the initiative, which derived from nurse's descriptions of how the PPM guided care that resulted in beneficial patient outcomes. (c) Rewards, with the subthemes of satisfaction/accountability, and empowerment/input derived from descriptions of how the PPM increased nurse awareness of role accountability that led to increased accountability and job satisfaction. (d) Facilitating systems, with the subthemes of communication, support, and assignment related, which derived from nurse's descriptions of facilitating patient care. Elliott et al. (2017) qualitatively examined the lived experiences of nurse practitioners practicing within the framework of a PPM using semi-structured interviews of 11 nurse practitioners across inpatient and outpatient at a large children's hospital located in the southwestern United States. Themes identified included (a) transforming professional practice, (b) cultivating the inner self, and (c) mentoring professional transitions. The researchers concluded that a professional practice model influences role transition and professional development.

Satisfaction is considered reflective of the work environment, attitudes, behaviors, and personal characteristics of an individual (Manojlovich & Laschinger, 2002). Kramer and Schmalenberg (2003) suggested control over nursing practice influences job satisfaction and nurse perceptions of quality of care. Kramer and Schmalenberg (2003) further asserted a PPM leads to increased job satisfaction. Their study used a serial case study design with a sample of 279 nurses from a population of nurses employed in fourteen Magnet® designated hospitals in the United States. Data were obtained via a

structured interview guide for control over nursing practice, the Essentials of Magnetism List, and two questions (one measuring job satisfaction and the other measuring the nurse perception of quality of care on their unit) using a 10-point rating scale. In the qualitative portion of the study, Kramer & Schmalenberg (2003) identified two dimensions of control over nursing practice; “the presence of a visible, recognized, and functioning organizational structure” and “ownership of issue, problem, and solution” (p. 440). Correlation coefficients revealed job satisfaction was significantly correlated to control of nursing practice (p = .01) in twelve of the fourteen research hospitals and (p = .05) in one of the research hospitals. Spearman Rho values ranged from r_s .64 -.78 in nine of the hospitals, indicating a strong relationship, and in three of the hospitals ranged from r_s .80-.89, indicating a very strong relationship. Perceived quality of care was significantly correlated to control of nursing practice (p = .01) in eight of the research hospitals. Spearman Rho values ranged from r_s .61 -.75 in seven of the hospitals, indicating a strong relationship, and in one hospital it was r_s .59, indicative of a moderate relationship.

Ingersoll, Schultz, Hoffart, and Ryan (1996) conducted a quasi-experimental comparison group study to evaluate the effect of using an enhanced professional practice model on nurse work group relationships, facilitative leadership style perceptions, and the influence of perceptions regarding work group and leadership on level of work satisfaction. Multiple study sites included a large urban medical center (furnishing both experimental and comparison units), two community hospitals (one experimental and one matched control), and two rural hospitals (one experimental and one matched control). Participants included staff nurses working on the experimental and comparison units.

Approximately 142 nurses composed the experimental group and 143 nurses composed the comparison group over the 4 measuring periods in the study. Instruments included the Perceived Group Attractiveness and Cohesion Scale to measure work group perception, the 40-item Leadership Opinion Questionnaire to measure perceptions of ideal and actual leaders, and the Piedmont Index of Work Satisfaction and the Price Mueller Job Satisfaction Scale to measure nurse satisfaction. The extent of model utilization was measured using an adapted instrument with 0 indicating no model utilization and 8 indicating full model implementation. Baseline data collection occurred six months prior to implementing an enhanced professional practice model and then once a year over a three-year time-period post implementation. Data were analyzed using repeated measures analysis of variance to test the three hypotheses. Overall, introduction of the PPM yielded more positive perceptions regarding work groups and facilitative nurse leadership styles. Extent of model utilization influenced perceptions of work group relationship and attitudes toward facilitative leadership style. The researchers concluded that significant positive changes in perception of work group and leader might be an earlier indicator of favorable change than the outcome measure of nursing job satisfaction.

Using a cross sectional study design, Spence Laschinger, Shamian, and Thompson (2001) studied 3,016 nurses practicing in Canadian teaching, community, and small hospitals. Five variables were examined including the nursing work, work relationships, trust, burnout, job satisfaction, and quality of care. The 15-item Nursing Work Index consists of three subscales measuring nurse autonomy, nurse control over

practice, and nurse physician relationships on a 4-point Likert scale. The Interpersonal Trust at Work Scale is a 12-item instrument with four subscales intended to measure faith and confidence in work relationships, items averaged to obtain a score ranging from 1-5. The Human Services Survey is a 22-item instrument that measures three aspects of burnout on a seven-point scale. The job satisfaction instrument contains one question rated on a 4-point Likert scale. Quality of Care was measured using the sum of a three question 4-point Likert scale instrument plus the rating of one additional item on a 4-point Likert scale. Data were analyzed via structural equational modeling. The hypothesis was that highly perceived levels of organizational autonomy, control, and collaboration influence organizational trust and emotional exhaustion, ultimately affecting the outcome variables of work satisfaction and perceived quality. Results support autonomy, control of work environment and nurse physician relationships impact job satisfaction (total indirect effect .436) and nurse perceived quality of care (total indirect effect .459). Spence Laschinger et al. concluded PPMs might positively influence autonomy, control, and relationships.

To examine the relationships of job satisfaction and practice environment satisfaction, McGlynn, Griffin, Donahue, and Fitzpatrick (2012) conducted a descriptive cross-sectional study with 100 nurses working in a large academic medical center in the northeast United States. All the nurses worked on units with an implemented professional practice model. Job satisfaction and work environment satisfaction data were obtained via questionnaire and analyzed via Pearson's R coefficient. The Index of Work Satisfaction Part B assesses six components of job satisfaction using a Likert scale

with scores ranging from 1-7. The Practice Environment Scale of the Nursing Work Index consists of 31 items ranked on a 4-point Likert scale. A negative correlation existed between overall job satisfaction and satisfaction with the professional practice environment ($r = -0.49$, $P < 0.00010$). A relatively low level of nursing job satisfaction (47th percentile) was noted on the units with an implemented PPM. McGlynn et al. attributed this finding to possible staff disruption and apprehension, which at times accompanies organizational restructuring.

To evaluate the effect of a PPM on autonomy, job satisfaction, and turnover, Pierce, Hazel, and Mion (1996) conducted a prospective evaluative study with three phases and three samples of nurses ($n = 73$, $n = 72$, and $n = 69$) from a population of rehabilitation nurses in a large academic medical center in the northeast United States. Phase I occurred prior to PPM implementation. Phase II took place at 6 months post PPM implementation and Phase III was at 12 months post PPM implementation. Data were obtained pre and post PPM implementation via questionnaire and analyzed via correlations and linear regressions. The Quality of Employment Survey Work employs a 4-point Likert scale to score autonomy. Scores range from 4 (low) to 16 (high). The Work Satisfaction Scale is a 5-point Likert scale with scores ranging from 32 (high) to 160 (low). It is composed of five-subscales (pay/reward, professional status, interaction/cohesion, administration, task requirement). Nurses perceptions of autonomy increased, job satisfaction increased, and the job turnover decreased by the end of the third phase of the study. Spearman Correlation Coefficients indicated a direct relationship between perceived autonomy and overall job satisfaction (Phase 1 -.39,

Phase II -.35, Phase III -.46). Findings supported the premise that PPMs increased perceptions of autonomy.

Professional practice environments and PPMs have been shown to affect job satisfaction and nurse perceived quality of care; however, limitations to each of these studies were noted. Limitations of the Kramer and Schmalenberg (2003) study include that over 60% of the nurses surveyed reported minimal or no control over their nursing practice. The Spence Laschinger, Shamian, and Thompson (2001) study was limited due to nurses employed in smaller hospital being overrepresented in sample. McGlynn et al.'s (2012) research was conducted in a single facility and the PPM had only been implemented for ten months. Pierce et al.'s (1996) study included a research setting of a single facility and a single service. Research rank of all these studies was Level IV (Polit & Beck, 2013) and thus a low level of evidence is present in the literature.

The literature contained few research articles with variables related to PPMs but primarily consisted of descriptive articles that offered expert/authority opinions. A concept analysis of professional practice models and a literature review synthesis of components of professional practice models were found. No literature was identified that described the lived experiences of direct care inpatient registered nurses using a PPM. The literature did contain a definition of professional practice, a description of professional practice models, strategies for successful implementation of a PPM, and outcomes of PPM use.

Summary

The purpose of this review was to identify literature that explored aspects of nursing professional practice and PPMs. Results indicated that the nucleus of nursing practice is not clearly supported by high-level research identifying what professional practice encompasses and barriers and facilitators to successful implementation of PPMs. No literature was identified that described the lived experiences of direct care inpatient nurses utilizing a professional practice model. Limitations of the review included scarcity in the literature regarding high-level research to describe direct care nurse's experiences of utilizing a PPM and exploration of barriers and facilitators of successful implementation of a nursing professional practice model.

Consumer demand along with the professional and ethical obligations to do no harm demands identification of strategies to promote high quality healthcare services that improve patient safety/outcomes. Nurses are in the position to function as facilitators for improving the quality of nursing care, advocating for healthy relationships, and promoting patient autonomy in healthcare. A professional practice model is the conduit by which these objectives can be accomplished. Nursing literature lacks enough inquiry into and description of the experiences of direct care nurses utilizing a professional practice model within the inpatient hospital setting. The researcher seeks to fill this nursing science gap by exploration and description of the lived experiences of inpatient nurses who utilize a professional practice model.

CHAPTER III

PROCEDURE FOR THE COLLECTION AND TREATMENT OF DATA

This descriptive phenomenological study investigated how bedside nurses use a PPM to provide nursing care. Descriptive phenomenological studies employ a scientific approach to explore the lived experiences of individuals to identify common universal essences of the experience (Creswell, 2013). The philosophical underpinnings of Husserl guided the research process. Chapter Three presents the setting, sample selection criterion, data collection procedures, and analytical processes for the study.

Setting

The setting for this project was a not for profit, large urban community-based hospital in the southwestern United States which offers both inpatient and outpatient services. The hospital was part of a not for profit organization with a total of thirteen inpatient hospitals. The hospital was a Joint Commission Accredited, Level III Trauma Center, and maintained Stroke and Chest Pain Center Accreditation. The facility employed 530 nurses and had achieved a Pathway to Excellence Designation from the American Nurses Association and Magnet® Designation from the ANCC. The Chief Executive Officer of the facility was a registered nurse. The Chief Nursing Officer directly managed twelve Administrative and Clinical Nursing Directors. Clinical

managers and supervisors reported to these Nursing Directors. There was a unit based and facility-wide nursing shared governance structure in place at this facility.

The study facility initially implemented a PPM in 2012. The implementation of the original PPM was found to have little effect on the delivery of nursing care. The PPM was re-evaluated and revised during the summer and fall of 2014 by direct care nurses participating in the shared governance Professional Practice Council. The revised PPM was introduced and distributed to the registered nursing staff January 2015 by members of the Professional Practice Council. Nursing staff were educated regarding the importance of a PPM and how direct care nurses may utilize the model. The PPM has become the focal point of nursing communication and practice.

Participants

The study population was 436 registered nurses providing direct patient care in an inpatient facility with an implemented PPM. Direct care nurses worked at least twenty hours per week in the identified facility and were employed for a minimum of six months prior to participation. Nurses who work per diem in the identified facility were excluded. Purposive sampling was used to select 20 participants. Potential participants were identified in two ways, when they responded to posted invitations to participate or when earlier participants provided them with information about participating using a snowball recruitment strategy.

Protection of Human Subjects

Institutional Research Board (IRB) approval was obtained from the University of Texas Health Science Center Houston, the study facility, and Texas Woman's University (see Appendix A). Before each focus group, an explanation of the study was given and an opportunity to ask questions regarding study participation was presented. Consent to participate in the study and consent to be audio recorded was obtained from all participants. Protection of human subjects included strategies to maintain confidentiality and privacy of the participants.

Data Collection

Following IRB approval, engagement of informal and formal gatekeepers in the study facility was obtained to facilitate introduction and access to the staff. Formal gatekeepers included the Chief Nursing Officer, the Director of Education, and the hospital Magnet Coordinator. Informal gatekeepers included members of the Shared Governance Councils as well as staff level formal and informal nursing leaders.

Data were collected through focus group interviews using a semi-structured interview guide designed to explore the experience of nurses in the personal, professional, peer to peer, nurse to patient, and nurse to community realms of nursing care provision (see Appendix B). Participation time requirement was a maximum of two (2) hours per participant.

The researcher distributed recruitment information throughout the facility via multiple methods including email and department postings as well as presentation at unit based and hospital wide nursing meetings. A snowball sampling strategy was employed to recruit additional nurses. The prospective participants were asked to contact the researcher directly via email, in person, or by telephone communication. Upon initial contact by prospective participant, the researcher distributed information about the purpose of the study, time commitment, and data collection methods. Any questions were answered. Once the prospective participant agreed to participate, a focus group date, time, and location was identified.

Focus groups were scheduled with five to seven participants and held at a private location in the facility. Telephone call reminders were made 24 hours prior to the scheduled focus group. At the beginning of each focus group, the participants received an in-depth explanation of the study. The researcher obtained informed consent from the participants on the date of the focus group. Any questions were answered. Demographic data to include gender, age, level of education, and years of experience as a registered nurse were collected using a pencil and paper form completed by the subject (see Appendix C). After the demographic sheets were collected, the semi-structured interview began. Each focus group was audio recorded. Each focus group interview was transcribed by the researcher and did not include any identifying information.

If needed, following the focus groups, participants were contacted by the researcher for clarification of any audibility problems in the audio recordings. Contact length was 5-10 minutes. Three participants (3) were brought back for a final group session, for validation and confirmation of the research findings. Participants were asked if they would like to receive study results and indicated their preference for receiving the study results (email or mail) and provided contact information. This identifiable information was maintained separately from all other study documents and destroyed after the distribution of study findings to the participants.

Data Analysis

Data were collected and analyzed using Colaizzi's qualitative methodology. Data analysis commenced after the first focus group and data collection continued until saturation was reached. Steps of Colaizzi's Method (1978):

1. Read and re-read transcripts to determine a sense for the whole content.
2. Extract significant statements from the transcripts.
3. Formulate meanings from the significant statements.
4. Organize formulated meanings into clusters and themes.
5. Integrate findings into an extensive description of the phenomenon.
6. Describe the elemental structure of the phenomenon.
7. Validate the findings of the study with a subset of the participants.

Phenomenological reduction via bracketing is a major tenet of Husserlian

phenomenology. The goal of phenomenological reduction is to achieve transcendental subjectivity (Lopez & Willis, 2004). Bracketing methodology is imperative to suspend preconceived notions of the researcher's experience with and knowledge of professional practice models. Bracketing allowed for an unbiased approach to the description of the phenomena of interest (Koch, 1995).

An audit trail recording analytic decisions was established to ensure credibility of the findings. Data were presented in aggregate form. All identifying information was removed. At study completion, the research findings were disseminated, via mail or email, to participants who indicated a preference to receive the findings.

Scientific Rigor

The plan for establishing trustworthiness and rigor included the following: 1) Establishment of credibility by prolonged engagement, persistent observation, and member checks. Prolonged engagement was obtained by allowing enough time for the researcher to develop a trusting and collaborative relationship with the participants and to collect data to the point of saturation. Persistent observation was obtained by maintaining a vigilant focus upon the relevant essences of working within a professional practice model (Polit & Beck, 2013). 2) Attainment of transferability was accomplished via obtaining thick descriptions of the phenomena of interest. 3) Maintenance of dependability was facilitated via an auditable decision trail. 4) Confirmability via reflexive journaling facilitated bracketing and was maintained (Lincoln & Guba, 1985)

Summary

This descriptive phenomenological study investigated how bedside nurses use a PPM to provide nursing care in an inpatient acute care setting. Participants were recruited from inpatient units and snowball sampling was employed. Data were collected via focus group interviews using a semi-structured interview schedule. Data collection continued until saturation was reached. Data were analyzed using Colaizzi's qualitative methodology.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this descriptive phenomenological study was to explore the individual and collective lived experiences of inpatient, direct care nurses practicing in a community-based hospital within the framework of a PPM. Data were collected through focus group interviews using a semi-
structured interview guide designed to explore the experience of nurses in the personal, professional, peer to peer, nurse to patient, and nurse to community realms of nursing care provision. Data were analyzed using Colaizzi's qualitative methodology. Data analysis commenced after the first focus group and data collection continued until saturation was reached. The description of the sample and the nurse's experiences are presented in this chapter. The findings of the study are presented in the second section and are organized by degree of model use and emergent themes.

Description of the Sample

The sample consisted of 20 participants, all of whom worked full time. Most were Caucasian females 23 to 64 years of age (M = 36, S = 10.77). Most held Baccalaureate degrees and worked the day shift (see Table 1).

Table 1

Sample Demographic Characteristics

Characteristics $N = 20$	*f*	%
Gender		
Female	16	80
Male	4	20
Race		
Asian	2	10
Black	5	25
Hispanic	2	10
White	9	45
Other	2	10
Shift		
Day/Evening	17	85
Evening/Night	3	15
Degree		
Associates	3	15
Baccalaureate	12	60
Masters	5	25

Findings

Findings of the study are organized around three identified groups of PPM users and six emergent themes. Participants adopted and used the practice model in one of three ways. 1) Intentional users, 2) Passive users, and 3) Non-adopters. Study participants described the PPM being used as a blueprint for the construction of nursing care. The model was depicted as a visual representation of the priorities and values of nursing within the organization that subsequently guided care provision. Participants explained the sphere of model influence on personal, professional, peer to peer, and nurse to patient relationships. The degree of model use was congruent with the sphere of influence the model had on daily nursing practice.

Intentional users described the sphere of influence of the model as facilitating change in nursing practice therefore improving patient care. For this group, the model facilitated changes to practice such as revision of communication forms, promotion of nurse driven problem solving skills, stimulation of professional development, and enhanced interdisciplinary collaboration. Intentional users employed the model to actively improve themselves professionally and promote collaboration by changing their behaviors and reactions to individuals and situations. A well-seasoned Associate Degree prepared nurse shared his experience.

> Sometimes the change is not on the other person, it is on you. How you relay or take a message. I think when you have a model like this it stresses the importance of why we are here overall. This model helps; it has been a personal challenge to me with an individual. I try to use this model every day the best I can. Every

> day, I take 10 seconds, little by little, I am learning to deal with it myself, it reminds me, and our patient mission is above all.

Intentional users described using the model as having significant impact on their personal identification as a nursing professional. A less experienced Baccalaureate prepared participant shared her model views.

> I can tell you I have not worked anywhere else with a model. The way we practice nursing here, at a place with a professional practice model engrained, will be with me forever as a nurse. This [model] will be engrained within me throughout my career. This is a multifaceted profession. This [model] is what you strive for by gaining your certifications, gaining knowledge, and working together as a team. It makes you who you are as a nurse and you will take that with you the rest of your life. You will take it with you to the next place. Yes, it sets your habit and your pace, to continue life-long learning.

Passive PPM users described an awareness of the PPM but stated they did not consciously think about it while delivering care. The model was present, and they felt they routinely used elements of the model on an everyday basis. However, there was not a conscious effort to apply the model or to examine aspects of the model that they did not routinely use, such as the professional growth and development component. Passive users identified the PPM as consistent with routine nursing practices and tended to describe model use as intuitive and part of basic nursing practice. A Baccalaureate prepared participant shared the following: "It is how we operate; you could literally take this away [model] and we would still do the same things every day. The model is not

what is controlling it". Passive users characterized model influence on practice as less dynamic and more episodic and nursing task oriented. A minimally experienced Baccalaureate prepared participant shared this example:

> If someone sees something, for example a break in sterile technique, we are going to communicate that to maintain quality and safety. We communicate to do this. Even positioning, speaking up and saying, hey, I don't think this looks right, so we can fix it by keeping our eye out for the patient and working together to communicate and preserve our quality of care. This is something that happens every day.

Passive users did not engage the model to promote professional development to the same degree of active users. Passive users employed the model within nursing to promote communication but did not describe model use as a catalyst to improve interdisciplinary collaboration or to change practice. A passive user described the model as exerting little influence on practice and as simply a reminder to do the things she was trained to do as a nurse. "We do this, every day without realizing we are doing it and that is the thing. It is a neat tool, but I think as our jobs are designed, we have to do these things".

Non-adopters are those nurses who self-identified as being unaware of the PPM and expressed surprise that it existed. In some instances, non-adopters would acknowledge that they had seen a copy of the model on their unit but indicated that it was not actively used. A Baccalaureate prepared participant with limited experience stated the following:

> If you would have asked me before today, what are the components of our PPM; I would have been like, our what? Then seeing this, I am like; oh, this is in my breakroom. Okay so, actually sitting here and looking at it, I can give you plenty of examples of how we are using it or not using it. I feel like it is a good tool to remind us what is really important because on a day-to-day basis, little petty things make us forget about what our mission is here. I don't think this model is stressed enough in a sense. I had no idea what this really was before.

After viewing the model, non-adopters consistently agreed that perhaps it might be a useful guide to nursing practice.

Both intentional users and passive users of the PPM described model adoption and use as differing from unit to unit and even shift to shift in the same units depending on unit culture, leadership reinforcement, and staff engagement. The nurses described their experiences with model adoption and use to be explicitly influenced by their direct leadership. This experience was shared by a non-adopter who was moderately experienced Baccalaureate prepared nurse.

> The model is a great thing to have, a great tool but it almost useless to us because we don't practice it. I think most of it is because for the longest, the unit pretty much ran itself for 8-9 months. So, no one really enforced it. The prior person there tried but it wasn't backed up. You take it and if you follow it, you follow it, and if you don't, you just don't. There is no actual person consistently enforcing it and making sure all of this is going.

One clear finding is that the model must be consciously maintained and reinforced in order to facilitate consistent use. The environmental context of the organization, unit, and shift must be conducive to PPM adoption and use. Leadership must attend to nurse familiarity with the PPM and how it is used to modify nursing care.

Six themes emerged regarding model use emerged; 1) Provides a foundation of care, 2) Supports professional knowledge, 3) Enhances reflective practice, 4) Promotes collegiality, 5) Cohesiveness of model components, and 6) Used Inconsistently. These themes incorporated the aspects of model use, outcomes, and opportunities for improvement.

Provides a Foundation of Care

Both intentional and passive users likened the PPM to the foundation of consistent and standardized patient care. Intentional users described model use and awareness promoting alignment of professional and institutional values to enhance the delivery of nursing care. Passive users equated the model components to the fundamentals of nursing practice and did not actively think about and engage the model to enhance professional development or care delivery.

Intentional users stated the model provided a visual representation of standards of care as well as guided professional development. Subsequently, this group assimilated a broader view of nursing as a dynamic profession congruent with the ideals of nursing within the organization. A Baccalaureate prepared participant with limited experience stated:

> I think this practice model helps guide us in growing professionally and focus[es] all of these other aspects [model components] to provide the care through the hospital that is standardized. It is a visual representation of all those expectations and how we give better care.

Passive users uniformly described PPM components as being intuitive to basic nursing practice and as being engrained in care delivery. Another Baccalaureate prepared participant shared her model experience.

> I just feel like it is our foundation. We don't actually have to think about it because it is something engrained in what we do. So, I feel like this may be why everyone just thinks this is pretty [model] because it is something we have learned to do since the time we decided to be a nurse.

The PPM was uniformly and consistently described by all users as a visual guide and reminder to promote patient and family centered care. Intentional users verbalized recognition of the model as a tool to direct nursing practice change daily. An experienced Baccalaureate prepared intentional user provided the example of model use as a tool for training new nurses regarding institutional provision of care.

> I think before this model these were all things that I just innately knew needed to be done but what this tool helps me with is teaching new people. This [model] gives me a picture, titles, and how they all tie together; you need to have these in order to give proper care to your patient. Before, it was more like an intuition thing. This lays it out; it is good for a visual, a tool for teaching and for communication.

Passive users identified with the model as a visual reminder to intuitively direct care without active mental engagement with the model. "I feel like it is a foundation of what we use every day, it is a visual representation. I'm not sure we actively think about it because we do it automatically every day".

Supports Professional Knowledge

Both intentional and passive users expressed use of the model to expand personal knowledge and subsequently sharing of this knowledge to educate their nursing peers. Intentional users actively engaged the model to promote inner change through professional development to improve themselves as nurses and promote evidence-based practice. Passive users did not describe the same degree of intentional model influence on their professional development nor did they describe evidence-based practice mentoring of younger nurses based on the model

Intentional users described mentoring and sharing their professional knowledge with peers to advance professional nursing. An Associate prepared participant with five years of nursing experience shared her model experience.

> I try and get younger nurses involved in taking part in unit based shared governance council or just in activities that are going to improve the group. Just by motivating them, it seems they come to me and ask me questions and develop a relationship. If you are trying to get something maybe like in the unit-based council, that we are trying to work on maybe like staffing or something. I tell them to look up research articles. You know how to investigate these things because we have to have proof in order to move forward with things…...I am

> using this tool. I tell them the reason you are doing this, trying to make changes is to provide some benefit to the patient, family, or community. You use this model to kind of guide you. Growth is mentioned here. I tell them exactly what the model says you know whether it is research or advancement.

Passive users described sharing their knowledge to help peers with nursing or unit specific tasks. An experienced Baccalaureate prepared participant shared her model experience.

> I got my certification. I am able to help other nurses with their questions. For example, I can answer more medication questions, I can help them identify rhythm strips and anticipate orders. That goes into communication, teamwork, and helping them [peers] grow to another level. It [model components] kind of all fits together.

Enhances Reflective Practice

Intentional users indicated the model prompted reflective practice and reflective thinking to actively promote change in practice and improve patient care. Intentional users employed the model to process overarching opportunities for practice improvement and personal development. Passive users described the model as a catalyst for situational reflection.

Intentional users displayed vigilant self-awareness resulting in an attitude conducive to positive practice change and professional growth. A highly seasoned Master prepared participant shared the following model use experience:

> Is there something I missed today? Something different I could have communicated to my patient to help them understand. To be able to come back and say, oh yeah, I should have, tomorrow I am going to work on that. It helps to grow as a new nurse. It is a great model for professional growth.

Passive users also described model use as a catalyst for reflective thinking regarding specific episodes of practice. A less experienced Baccalaureate prepared participant shared her experience.

> I don't know about you guys but after a code, maybe a few days later, someone is always asking what ways we could improve on code blues and stuff like that. I think with this model, without one [component], you know it is like you need all 4 [components] to safely care for a patient.

Promotes Collegiality

Collegiality emerged as a theme for both passive and intentional users. For users of the PPM, collegiality was facilitated. Intentional users verbalized self-awareness of model use to improve collegial relationships with the overall goal of improving patient care delivery. Passive users described using the model to coach one another on the correct execution of skilled nursing tasks and for basic communication with other disciplines.

Intentional users promoted interdisciplinary collegiality by sharing the practice model with other disciplines to brainstorm ideas and coordinate care delivery. A Baccalaureate prepared participant with limited experience shared this example.

On my unit, we work really close with the therapist. We have started sharing the model with them because we work together side by side to get patients home safely. So now, we are coming up with all kinds of new ideas, brainstorming ideas, and now we are meeting weekly to see what else we can do to bridge this huge disconnect. I feel like using this model shows we are all trying to do the same thing and I feel it is really helping our relationships

Passive users described being more unit staff focused and did not appear to actively engage the model to promote interdisciplinary collaboration beyond basic communications.

A way that it [model] is used and it comes together is our MDDR [multidisciplinary daily rounds]. Mostly, I can at least say it works. Teamwork because we communicate with the entire hospital; doctor on call, case manager, social worker or other nurses to make sure we have all the orders we need, like therapy orders for SNF. We are communicating with everyone.

Cohesiveness of Model Components

Intentional users, passive users, and non-adopters all acknowledged the synergy of the model noting the whole PPM to be greater than the sum of the individual components of the model. Participants noted each model component should be equally emphasized and implemented for successful model use. A minimally experienced Baccalaureate prepared participant shared the following:

For me, not any one facet of this model is necessarily like standing out but rather how they all work together and how it just brings about the importance of every

single one of these aspects [model components], teamwork, communication, growth, quality/safety and how that all points to the patient, the family, and the community. So, it is kind of a reminder that you need all of those aspects in order to provide great care and to meet the goals we have here.

A moderately experienced Master prepared nurse ruminated:

> If you look at just one aspect, you are not really looking at the model. You are not going to utilize the model as you are supposed to. You have to actually see how everything relates. It is important to look at it as a whole.

Used Inconsistently

Inconsistency refers to fragmented model use among staff. Three groups, intentional users, passive users, and non-adopters, described different levels of engagement and use of the model. Intentional users identified differences in the adoption of specific model components such as professional growth as well as inconsistencies between shifts and amongst units with leadership reinforcement of PPM and staff PPM use accountability. A new Baccalaureate prepared nurse describer her experience.

> I feel like with this model, that it is big part that some people may not have on their unit. There may be a difference in culture from day shift to night shift. I will say one thing we need to work on is growth, my unit we kind of lack advancing, in our education, I don't feel like the motivation is really there

Passive users articulated the need for specific direction to adequately execute model components. A highly seasoned Master prepared participant shared these thoughts.

> I think sometimes as far as getting to communication and teamwork, it is talked about, but to get more tangible things, is more difficult. Break it down and help us to interact better. How can we learn how to do this better? How do we get to better communication? How can we learn? I think it is inherent in all of us as far as wanting to be here and take care of the patient, but how do we get there?

Those voicing concerns about inconsistency also articulated the need for additional reinforcement of model use. Another experienced Master prepared participant shared this experience.

> I think it is a good visual reminder, when I am reminded to look at it. I have been here two years and I can honestly say this is the only time I have looked at it and contemplated this model, although it is posted in the breakroom, but it just becomes part of the wallpaper or a part of the scenery you know. So, the only time I have really thought about this model is in instances like this where somebody is really drawing attention to it.

Summary of the Findings

The major findings are summarized as follows: Three distinctive groups of PPM users emerged based on their descriptions of lived experiences of working within a professional practice model. The groups were labeled as intentional users, passive users, and non-adopters. All three groups described some limitations with different components of model adoption and use based on degree of leadership support and model reinforcement. Six themes of model use, outcomes, and opportunities were identified: 1) provides a foundation of care, 2) supports professional knowledge, 3) enhances reflective

practice, 4) promotes collegiality, 5) cohesiveness of model components, and 6) inconsistent use. Years of experience, age, and educational preparation did not influence whether nurses were intentional, passive, or non-adopters.

CHAPTER V

SUMMARY OF THE STUDY

A PPM improves nursing power and control, improves nursing care, and affects patient care outcomes. The purpose of this descriptive phenomenological research was to explore the collective and individual lived experiences of experiences of inpatient, direct care nurses practicing in a community-based hospital within the framework of a nursing PPM. Husserl's transcendental philosophical underpinnings guided this study (Streubert & Carpenter, 2011). This chapter summarizes the study and presents a discussion of the findings as they compare to the research literature. Proposed practice interventions and recommendations for further research will be presented.

Summary

The purposive sample consisted of 20 participants who were registered nurses working at least twenty hours per week in the identified facility and employed for a minimum of six months prior to participation in the study. Three semi-structured focus groups were used to gather data regarding nurses' experiences using a professional practice model. Of nurses participating in the focus groups, most participants were female, Caucasian, Baccalaureate prepared and worked the day shift.

Participants described adopting and using the PPM in one of three ways: 1) intentionally, 2) passively, or 3) not at all. Intentional users described the model as a catalyst to create change to nursing practice as well as employed the model to actively change their behaviors and reactions to individuals and situations. Passive users described model use as intuitive and part of basic nursing practice and characterized

model influence on practice as less dynamic and more episodic and task oriented. Non-adopters are those who self-identified as being unaware of the PPM and expressed surprise to know it existed.

Six themes emerged from the data as follows. 1) Provides a foundation of care; both intentional and passive users described the PPM as the foundation of consistent and standardized patient care. Intentional users described the PPM as promoting alignment of professional and institutional values. Passive users equated model components to the fundamentals of nursing practice. 2) Supports professional knowledge; both intentional and passive users used the model to expand and share personal knowledge. Intentional users actively engaged the model to promote inner change while passive users did not describe the same degree of model influence. 3) Enhances reflective practice; intentional users indicated the model prompted reflective practice and reflective thinking that actively promoted change in practice and improve patient care. Passive users described the model as a catalyst for reflective thinking that did not necessarily result in practice change. 4) Promotes collegiality emerged as a theme for both passive and intentional users. For users of the PPM, collegiality was facilitated. 5) Cohesiveness of model components; Intentional users, passive users, and non-adopters all acknowledged the synergy of the model noting the whole PPM to be greater than the sum of the individual components of the model. 6) Used inconsistently refers to fragmented model use among staff noted by intentional users, passive users, and non-adopters. Differences in the adoption of specific model components, variations between shifts and amongst units were noted. These differences encompassed leadership reinforcement of the PPM and staff

PPM use accountability. The need for additional reinforcement of model use was highlighted. These themes incorporated the aspect of model use, outcomes, and opportunities for improvement.

Discussion of the Findings

A review of the literature, quantitative and qualitative, did not demonstrate research that fully described the lived experiences of inpatient, direct care nurses practicing in a community-based hospital within the framework of a nursing PPM. A limitation of the review included scarcity in the literature regarding high-level research to describe direct care nurse's experiences of utilizing a PPM and exploration of barriers and facilitators of successful implementation of a nursing PPM. Themes emerging from the analysis of literature included elements of professional practice and PPMs, strategies for successful PPM implementation, and outcomes of model use. Literature regarding components of PPMs and strategies for successful PPM implementation were primarily derived from expert opinion evidence regarding nursing professional practice and PPMs.

Quantitative studies explored the outcomes of PPM implementation such as nursing job satisfaction, nursing autonomy, and nursing retention. The few qualitative studies present in the literature explored experiences of nurse practitioners, renal unit nurses, and nurse leaders. It should be noted findings from these three studies were applicable and consistent with the present study findings (Elliot, et al., 2017; Harwood et al., 2007a, 2007b; Storey et al., 2008). The following documents the present study's findings as related to previous research.

One finding of this study was nursing staff in an acute care community-based hospital can actively in engage in PPM use. Participants who actively used the PPM described PPM use as the foundation of consistent and standardized patient care. This finding was similar to the findings of Harwood et al. (2007a, 2007b), who examined nurse perceptions of quality of care post PPM implementation in an acute care renal unit of a university-based teaching hospital. Participants in the qualitative portion of the Harwood et al. study (2007b) described active PPM use as promoting consistent care delivery. Subsequently, this led to nurse perceptions of enhanced quality of care and beneficial patient outcomes. The Harwood et al. study (2007b) differed from the present study in that it was conducted with only renal unit nurses and specifically regarding post PPM implementation perceptions of quality of care; however, the finding that acute care nurses can actively engage a PPM to promote consistent care corresponds with findings of the present study.

The present study found professional growth is congruent with goals of using a PPM in some nurses within this population. PPM use made a difference in practice and nurses used the model to increase awareness of advancing professional practice and intra-disciplinary communication. This finding is similar to the findings from a study by Elliot et al. (2017), who found that PPM use positively influenced role development and professional development in nurse practitioners. The Elliot et al. study differed from the present study in that it was conducted with nurse practitioners; however, the finding that a professional growth is congruent with goals of using a PPM and that the PPM

influenced advancement of professional practice was consistent with findings of the present study.

This study concluded that the environmental context of an organization must be conducive to PPM use and attended to nurse familiarity with the PPM and how use modifies nursing care. Environmental context made a difference in this study. Nurses working on units actively promoting the model used it in practice. Without this active support, nurses were not using the model to guide patient care. This finding of nurses actively using the model is similar to the findings of Storey et al. (2008), who examined successful PPM implementation by interviewing hospital-based nursing directors. The Storey et al. study concluded a PPM could be successfully implemented through promotion of interdisciplinary practice, modeling leadership behaviors to embrace change, integrating the model into practice by increasing visibility, and a shift in mindset. The Storey et al. study differed from the present study in that it was conducted with nurse leaders specifically regarding successful PPM implementation; however, the findings that a PPM is successfully implemented through appropriate environmental context and nurse familiarity parallel findings of the present study. The Harwood et al. (2007a, 2007b), study also demonstrated that a unit with support did actively practice using the PPM.

The present research study resulted in a comprehensive description of how inpatient direct care registered nurses use a professional practice model in daily practice. Limitations of this study included the small sample size and single study setting**.** The sample in the present investigation differed from samples in previous phenomenological research conducted with nurse practitioners, nursing leaders, and renal unit nurses. The

present investigation included nurses from varied inpatient units across an acute care facility. Studies conducted with different populations appear to have congruent findings regarding professional development, promotion of consistent patient care, and strategies for successful PPM implementation.

Conclusions

Based on the findings of this study, the following conclusions were derived:

1. Nursing staff in an acute care community-based hospital can actively in engage in PPM use.
2. Professional growth is congruent with goals of using a PPM in some nurses within this population.
3. Active PPM use made a difference in practice as some nurses used the model to increase awareness of advancing professional practice and intra-disciplinary communication.
4. The environmental context of an organization, unit, and shift must be conducive to PPM use.
5. Organizations must attend to nurse familiarity with the PPM and how the organization uses it to modify nursing care.

Implications

The implications of this study, based on findings and conclusions drawn include:

1. If institutions want to implement and actively use a PPM, active promotion beyond a simple orientation is required. The PPM must be highly visible, consistently reinforced, and use continuously evaluated.

2. Administration, managers, and nursing staff need a congruent expectation and understanding of model use and adoption.
3. Managers should evaluate model use as part of the performance review process.
4. Nurses should familiarize themselves with the institutional PPM, actively engage the PPM, and hold one another accountable for PPM use.

Recommendations for Further Studies

Recommendations for further research include:

1. Examine interventions to promote better use of the professional practice model.
2. Replicate the investigation in other environments to determine if findings are specific to the organization.
3. Quantitatively examine PPM influence on professional practice and intra-disciplinary communication.
4. Examine interventions to improve model adoption and use in the study facility to include: 1) active model promotion, 2) consistent reinforcement, 3) regularly scheduled dialogue between leadership and staff about model use, and 4) model use as part of the performance review process.

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APPENDIX A

IRB Approval

Committee for the Protection of Human Subjects

6410 Fannin Street, Suite 1100
Houston, Texas 77030

Rhonda Kitchen
Memorial Hermann

July 27, 2015

HSC-MH-15-0585 - *Experiences of Direct Patient Care Registered Nurses Utilizing A Professional Practice Model*

The above named project is determined to qualify for exempt status according to 45 CFR 46.101(b)

CATEGORY #2 *: Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:*

a. information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND ,

b. any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

(NOTE: The exemption under Category 2 DOES NOT APPLY to research involving survey or interview procedures or observation of public behavior when individuals under the age of 18 are subjects of the activity except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.)

Health Insurance Portability and Accountability Act:
Exempt from HIPAA

CHANGES: Should you choose to make any changes to the protocol that would involve the inclusion of human subjects or identified data from humans, please submit the change via iRIS to the Committee for the Protection of Human Subjects for review.

STUDY CLOSURES: Upon completion of your project, submission of a study closure report is required. The study closure report should be submitted once all data has been collected and analyzed.

Should you have any questions, please contact the Office of Research Support Committees at 713-500-7943.

September 28, 2015

MEMORIAL HERMANN HEALTHCARE SYSTEM APPROVAL FOR MEMORIAL HERMANN - NORTHWEST

Thank you for choosing Memorial Hermann as your service provider for this research study.

IRB ID: HSC-MS-15-0585 **PRINCIPAL INVESTIGATOR: Rhonda Kitchen, RN, MSN, CPHQ**

STUDY TITLE: Experiences of Direct Patient Care Registered Nurses Utilizing A Professional Practice Model

NUMBER OF SUBJECTS: 30

Approval is hereby granted by Memorial Hermann Healthcare System to initiate this research study at the Memorial Hermann – Northwest location. This approval is subject to the Principal Investigator's acceptance of the following stipulations:

STUDY-SPECIFIC STIPULATIONS:

Research Informed Consent:

1. The Joint Commission requires that a copy of the signed consent form for hospital-based studies be in research records. In addition, the MHHS Authorization for Disclosure of Protected Health Information for Research (with IRB approval stamp) must be placed in the research records.

2. The Principal Investigator and study team will please note that they must have the Study Participants complete the "Memorial Hermann Healthcare System, Memorial Hermann Hospital System, Photographic Or Recording Consent, Release And Waiver" form. The completed forms must be scanned and sent to Gisela Carrillo (Gisela.Carrillo@memorialhermann.org) with Memorial Hermann Hospital-Texas Medical Center's Office of Creative Services.

Other Stipulations:

3. The Principal Investigator may utilize the study flyer as approved by the IRB. We ask that the flyer be brought by the MH Clinical Innovation & Research Institute to receive a Memorial Hermann approval stamp on the flyer(s) prior to posting. Please bring to Citrine Elatrash, Research Assistant, Robertson Pavilion, room 364. She can be contacted via email at citrine.elatrash@memorialhermann.org

4. Please remember to acknowledge the Memorial Hermann – Northwest in any publications resulting from this study, and provide a copy of the publication to the Vice President, Research for Memorial Hermann Clinical Innovation & Research Institute (Cheryl.Chanaud@memorialhermann.org). The methods of acknowledgement may include:
   a. Memorial Hermann – Texas Medical Center as an author's affiliation;
   b. mention in an "acknowledgement" section; or
   c. as a footnote.

Please sign and return a copy of this letter to the Memorial Hermann Clinical Innovation & Research Institute to the attention of vicky.woodruff@memorialhermann.org to indicate your acceptance of our terms and policies (guidelines attached).

This study may not be initiated until the letter is signed and returned to the Memorial Hermann Clinical Innovation & Research Institute.

If you have questions or need additional information, please contact the Memorial Hermann Clinical Innovation & Research Institute at (713) 704-5655.

APPROVED:

9/28/15

Cheryl M. Chanaud, PhD, CCRP — Date
Vice President, Research
Clinical Innovation and Research Institute
Memorial Hermann Healthcare System

ACCEPTANCE:

9/29/2015

Rhonda Kitchen, RN, MSN, CPHQ — Date
Principal Investigator

cc:
Melody Dickerson: VP and CNO Memorial Hermann NW
Sachin Bhandari: MH Associate General Counsel

Attachments:
Memorial Hermann Clinical Innovation and Research Institute Guidelines
Memorial Hermann Hospital System, Photographic or Recording Consent, Release and Waiver form

Institutional Review Board
Office of Research
6700 Fannin, Houston, TX 77030
713-794-2480
irb-houston@twu.edu
http://www.twu.edu/irb.html

DATE: October 1, 2015

TO: Ms. Rhonda Kitchen
Nursing - Houston

FROM: Institutional Review Board - Houston

Re: Exemption for Experiences of Direct Patient Care Registered Nurses Utilizing A Professional Practice Model. (Protocol #: 18523)

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and was determined to be exempt from further review.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. Because a signed consent form is not required for exempt studies, the filing of signatures of participants with the TWU IRB is not necessary.

Although your protocol has been exempted from further IRB review and your protocol file has been closed, any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Brenda Binder, Nursing - Houston
Dr. Elizabeth Anne Young, Nursing - Houston
Graduate School

APPENDIX B

Interview Schedules

Registered Nurses Experiences Utilizing a Professional Practice Model

Experiences of Direct Care Registered Nurses Utilizing a Professional Practice Model

Consent: I would like to discuss the consent form, the research procedures, use of results, and address any questions you may have. (Execute consent signatures).

I. Opening

A. Welcome and introductions

B. I would like to ask you all some questions about your experiences utilizing a professional practice model.

C. I hope to use this information to help describe how a professional practice model impacts nursing care delivery, professional relationships, and views of the profession.

D. This group discussion should take no longer than 1 hour.

E. I will be audio recording this group discussion and taking notes. I may ask questions to clarify your words or thoughts during the group discussion. I will transcribe the recordings and may contact you to clarify words and comments.

II. Interview Questions

1.) What stands out for you in terms of using a professional practice model?

2.) How has working within a professional practice model changed the way you care for inpatients in an acute care setting?

   a. Give me an example of using the model to care for an acute care patient. What worked? What did not work?

   b. Were there other times you used the model and had a different experience? Tell me about that?

3.) Give me an example of how model implementation influenced your relationship with a peer?

4.) How have these experiences influenced your view of nursing as a profession?

Give me an example.

5.) What would you tell other nurses about working within a professional practice model?

III. Closing

A. Thank you for your time and participation in this research.

B. I will be contacting you to schedule a group discussion to review and validate the study findings after the analysis has been completed

C. I look forward to sharing the research findings with you.

Validation Meeting Interview Schedule

A. Welcome and introductions

B. Review purpose of validation meeting. I would like to review the research findings and confirm if these finding are accurate and true to your experiences. Please feel free to offer additional insight.

C. This group discussion should take no longer than 1 hour.

D. I will be audio recording this group discussion and taking notes. I may ask questions to clarify your words or thoughts during the group discussion. I will transcribe the recordings and may contact you to clarify words and comments.

E. Review of Findings (Major and Minor Themes)

F. Discussion to perform member checking – confirmation of credibility and accuracy.

   1) How do these findings match what you understand about using a professional practice model?

   2) What elements of the professional practice model related to your experiences are present in these findings?

   3) Is there anything about your experiences utilizing a professional practice model that you feel is not represented in these findings?

Summary and Closing Comments. Thank you for participating in this research. The findings will be shared with you via your preferred method of either mail or email. I am happy to answer any questions you may have at this time.

APPENDIX C

Demographic Data Form

Experiences of Direct Care Registered Nurses Utilizing a Professional Practice Model

Demographic Information

Age: (Write in age) ______

Years of RN Experience: (Write in number of years or months if less than one year) _____

Gender (circle one): 1. Male 2. Female

Race (circle one): 1. White 2. Black

3. Hispanic 4. Asian

5. American Indian 6. Pacific Islander

7. Other ______________

Work Status (circle one): 1. 40 hours per week 2. 20 hours per week

Shift Worked (circle one): 1. Day/Evening 2. Evening/Night

Highest Education Level (circle one):

1. Associate Degree Nursing 2. Bachelor's Degree Nursing

3. Master's Degree Nursing 4. Masters (Other)

5. PhD Nursing 6. DNP Nursing

7. Doctorate (Other)