Queensland Health
Office of the Chief Nursing Officer

Modelling Contemporary Nursing and Midwifery
a framework for shaping professional practice

Nurses interest based bargaining project
August 2008
Modelling Contemporary Nursing and Midwifery: a framework for shaping professional practice is a comprehensive resource designed to assist nurses and midwives assess, select, implement and evaluate models of contemporary nursing and midwifery practice that best meet patient and staff needs in their workplace.

August, 2008
Foreword

In a world of many career choices, nursing and midwifery continue to offer challenging roles in dynamic, evolving healthcare environments. However, the competitive workforce means that in order to first attract and then retain nurses and midwives, Queensland Health needs to ensure that our practices are contemporary, innovative and inclusive of work-life balance. It is also important to recognise that nurses and midwives are part of a broader healthcare team and it is timely that we consider and assess the best way to work with other healthcare providers to provide quality patient care now and into the future.

These factors were recognised when the Nurses (Queensland Health) Certified Agreement (EB6) 2006 was enacted. Five priority nursing and midwifery workforce issues underpinned the implementation of that agreement.

These priority areas were:

1. The development and implementation of a nursing and midwifery recruitment and retention strategy
2. The effective management of nursing and midwifery workloads and nursing and midwifery workforce planning
3. Adoption of a consistent approach to models of contemporary nursing and midwifery practice
4. The implementation of a nursing and midwifery education and development framework
5. The implementation of a work-life balance strategy for nurses and midwives

In order to address priority 3, ‘Adoption of a consistent approach to models of contemporary nursing and midwifery practice’, the Models of Contemporary Nursing Practice Committee (MoCNPC) was formed. The committee decided to develop a framework that would consider, but not be limited to:

- the advancement of expanded or new nursing roles (eg. extended practice-nurse roles, nurse practitioner)
- models of practice delivery used in midwifery and other nurse-practice areas
- practice change that promotes and supports a multidisciplinary team approach to patient care
- the appropriate use of Assistants in Nursing
- promotion of ‘evidence-based practice’
- endorsement/development of ‘continuity of patient care’.

The MoCNPC undertook an extensive literature review and consultation with senior nurses and healthcare staff. As a result, the Modelling Contemporary Nursing

and Midwifery: a framework for shaping professional practice (the Framework) was developed. The Framework is a step-by-step guide to help nurses and midwives analyse their current practice and use the findings to implement (where required), and evaluate a new, contemporary practice model. By giving nurses and midwives the opportunity to evolve a new model, it is hoped that job satisfaction, and therefore workforce retention, will be increased.

Queensland Health has a number of other planning documents that should be used in conjunction with the Framework. These include the Business planning framework, Rostering Framework, Code of Conduct, Staff Development Framework, Clinical Governance Policy and Change Management documents.

Nursing and midwifery are exciting and rewarding professions. Queensland Health is encouraging nurses and midwives to renew the delivery of services by challenging current practice, and implementing and evaluating a new method of practice delivery that will deliver quality healthcare to Queenslanders.

Pauline Ross
Chief Nursing Officer
Queensland Health
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Overview

Contemporary nursing and midwifery practice occurs in diverse settings ranging from tertiary level acute-care hospitals to remote community clinics. Professional nurses and midwives are required to provide the best possible patient care that is contemporaneous, timely, ethical, and resource (human, financial and material) efficient.

To ensure the provision of quality healthcare that is safe, accessible, responsive, efficient, effective, sustainable and appropriate, nurses and midwives need to regularly examine their practice, and where necessary, change it. These changes may also require other healthcare professionals to modify their practice.

The purpose of the *Modelling Contemporary Nursing and Midwifery: a framework for shaping professional practice* document (this framework) is to provide a structure that informs and guides nurses and midwives (at all professional levels) in a variety of practice settings.

While being required to provide individualised holistic care within the formal practice setting, each nurse and midwife is influenced by intrinsic factors such as her/his personal, cultural and professional experiences, and extrinsic factors related to organisations, society, and the physical environment. Each of these extrinsic factors has cultural, environmental, and political facets.

In 2002, the Queensland Government published *Smart State: Health 2020: a vision for the future – Directions statement* that identified a number of global trends currently affecting the management of health (wellbeing) and healthcare across the developed world, including Queensland, that are likely to influence future policies and decisions. These trends include:

- changing the focus from healthcare (services) to health (the wellbeing of populations)
- the growing and ageing population
- the shift of disease burden from acute conditions to chronic diseases
- the changing nature of healthcare delivery
- the changing healthcare workforce
- emerging medical technologies and increasing application of evidence-based healthcare
- growth in consumerism and community involvement in healthcare
- increasing costs of healthcare
- globalisation
- environmental change.

(Queensland Health, 2002, pp. 7-9)

The attitudes of patients, communities and society also change as social, financial and physical environments change. For example, the following factors require consideration by health professionals when they reflect upon their practice:

- demographic (an ageing population)
- fiscal (wages, employment, and the financing of healthcare)
- physical (natural disasters, climate change)
- political (policy initiatives such as health promotion, illness detection and prevention)
- civil conflict (riots, terrorism)
- lifestyle (reduced physical activity, obesity)
- new technology (procedures, pharmacology, gene therapies)
- increasing rates of illness and disease (chronic illness such as diabetes, heart disease, mental illness, dementia, insect-borne diseases).

If the impact of these factors on the maintenance of the health of the community is to be minimal, healthcare managers and health professionals will need to identify the best ways to deliver patient care effectively and efficiently. For example the *Queensland Health Strategic Plan 2007–12 (2007 p. 2)* has four strategic directions:

1. Improving (patient) access to safe and sustainable health services
2. Better meeting people’s needs across the health continuum
3. Enhancing organisational work processes and systems to support service delivery and business effectiveness
4. Developing our (staff) in a way that recognises and supports their role in the delivery of health services.

This framework addresses the first two strategic directions (patient safety and contemporary healthcare needs) through the Foundation Principles. It also includes a step-by-step plan that includes strategic questions and tools and techniques that can be used to resolve them, thereby facilitating the involvement of staff in the process of long-term and sustainable change. This approach addresses strategic directions 3 and 4, namely the critical enabling functions of planned practice-change development and implementation by valuing and empowering staff (through the provision of authority and autonomy by management) to make changes in their workplace.
To ensure that changes to a practice model are applied to the workplace, it is important to have a systematic organisational infrastructure that supports this method as a way of delivering care. Porter-O’Grady (2006, p. 15) notes that ‘from the information infrastructure to the interdisciplinary and organisational framework, new approaches to organising and delivering care are essential.’ Healthcare organisations need to consider specific issues related to their multidisciplinary workforce, management strategies including policies, authority and control, and the distribution of resources, power and influence, all of which may compete with the professional imperative of providing quality healthcare.

While much has been written about the need for health professionals to make autonomous decisions that benefit patients, the reality of the practice setting is that often extrinsic factors (eg. changes to government policy) influence their decisions, and that although the need for practice-change is frequently recognised, it is often poorly managed, implemented and/or evaluated. Reasons for this missed or mis-management include inadequate personal resources (knowledge, time, confidence), fear of change and retribution, a lack of opportunity, and insufficient organisational resources including human and financial assets, workforce skill-mix, and equipment. Organisations that have an over-reliance on authority and longevity (where expertise is derived from only experience rather than knowledge, critical thought, and/or evidence), and ritual and tradition often lack managerial skills that promote and support innovation, processes to facilitate change, support for staff undergoing change, and evaluation and/or auditing processes that assess the outcomes of practice change.

Therefore, it is essential for health professionals to regularly assess the quality of the care they provide in order to determine whether the practice model used to guide their practice is relevant for all stakeholders – patients, health professionals, and healthcare providers (both public and private) – while making best use of the available resources. In order to do this, health professionals need to assess their clinical practice, and if appropriate, select a ‘new’ practice model, successfully manage its implementation, and evaluate its effectiveness in achieving the core values of the practice setting.

Davidson, Halcomb, Hickman, Phillips, and Graham (2006, p. 48) state that ‘regardless of whether change in healthcare delivery is attempted on a micro basis (eg. ward level) or macro basis (eg. national or state system) in order to achieve sustainable, effective and efficient changes a well-planned, systematic process is essential.’

In keeping with current practice the terms nurse and midwife have been used throughout this framework. This term is inclusive of nurse practitioners (NPs), registered nurses (RNs), midwives, mental-health nurses (MHNs), enrolled nurses (ENs), and nurses in specific practice settings such as community nurses (CNs), rural nurses, and school nurses (SNs).

The term patient is intended to include clients, residents and healthcare consumers. It is also important to acknowledge the importance of the patient’s significant other(s) when considering the provision of patient care.

How to use this framework
During the preparation of this framework, the committee, with responsibility for its development was mindful of a number of issues:

- the intended audience ranged from beginning-level to experienced nurses and midwives and their different levels of knowledge and understanding
- the diverse workplaces in which they provide healthcare
- the ‘busy-ness’ of the workplace and associated time constraints
- the various roles and positions (eg. clinical, education, managerial) of nurses and midwives within the healthcare systems and levels of authority and influence within those roles and positions
- the need to produce a ‘model of care’ that while not aiming to be universally applicable, was relevant, purposeful and user-friendly enough for it to be useful to most nurses and midwives.

A nurse or midwife may choose to browse through the document as part of her/his reflective practice and professional development by paying attention to the foundations principles. A group of nurses or midwives may use it to guide a review of the clinical practice in their workplace. A manager might select the implementation strategy section to facilitate change in her/his practice area, while an audit committee might use the last section to monitor clinical practice outcomes.

It is hoped that the user will be able to select the section of this framework that best suits their needs and utilise it accordingly.
References


Queensland Health 2007, Strategic Plan 2007-12, Brisbane: Author.
Chapter 1: Introduction

1.1 Background

The negotiations about pay and conditions between Queensland Health, and nurses and midwives working in the public health sector in Queensland (represented by the Queensland Nurses Union), resulted in the acceptance of the sixth enterprise bargaining agreement (EB6) in 2006. A number of issues arose from the negotiation process, including the adoption of an Interest-based Bargaining (IBB) approach (developed by the Harvard Business School) to oversee the implementation of the agreement’s five priority areas:

1. Workforce recruitment and retention
2. Nursing and midwifery workloads management
3. Modelling contemporary nursing and midwifery
4. Education and staff development
5. Work life balance

The Nurses Interest Based Bargaining Implementation Group (NIBBIG) was formed to investigate these five areas and provide recommendations for their effective management.

The focus of NIBBIG was to include, but not be limited to:

- the advancement of expanded or new nursing roles (eg. extended practice-nurse roles, nurse practitioners)
- midwifery models of care used by or for midwifery
- multidisciplinary team models of care
- the appropriate use of Assistants in Nursing (AINs)
- the use of evidence to inform professional practice ensuring continuity of patient care.

Five subcommittees were established. The responsibility for ‘the adoption of a consistent approach to models of contemporary nursing midwifery practice’ (EB6 priority area 3) was undertaken by the Models of Contemporary Nursing Practice Committee (MoCNPC).

In order to achieve a consistent approach, the MoCNPC decided to develop a flexible user-friendly tool that recognised the diversity of settings in which nurses and midwives practice and gave them information and a structured approach to help them design, implement and evaluate a model of care using agreed foundation principles.

The five Foundation Principles (refer Chpt 2) are:

1. Patient-centred care
2. Best use of nursing and midwifery resources
3. Safe practices
4. Quality care – judicious use of evidence
5. Trends in contemporary healthcare

They were identified by the MoCNPC as the key elements of nursing and midwifery practice. From Nightingale onward, nurses and midwives have developed models and theories that examine the relationships between four key elements: Person, Nurse (and Midwife), Health, and Environment (Fitzpatrick & Whall, 1983; Pearson, Vaughan, & FitzGerald, 1996; Marriner Toney & Alligood, 1998). Within the overarching relationship with Health, the Foundation Principles (FPs) have been derived from the four key elements. For example:

- Person is associated with FP-1
- Nurse (and Midwife) is linked to FP-2
- Environment (physical, societal, legal and organisational aspects) are represented by FP-3 & 4

The Foundation Principles are also similar to those used in Queensland Health’s Business Planning Framework: Nursing Resources (2005), namely:

- The patient/client
- The nurse
- The organisation.

Other articles such as Transforming Care at the Bedside (Institute for Healthcare Improvement, 2007) list four ‘Key Design Themes’ for improving bedside care:

- Safe and reliable care
- Vitality and teamwork
- Patient-centered care
- Value-added care processes.

These are closely allied to the FPs.

The constantly changing nature of our world (the Environment) required the MoCNPC to develop a framework that was contemporaneous, therefore the document Modelling Contemporary Nursing and Midwifery: a framework for shaping professional practice and FP-5 reflect the need for nurses and midwives to ensure their practice models are capable of managing current and future healthcare.

1.2 Aim

Using a consistent and logical approach, the aim of the Modelling Contemporary Nursing and Midwifery: a framework for shaping professional practice document (this framework) is to challenge nurses and midwives to assess the effectiveness, efficiency and efficacy of their current practice model in meeting the Foundation Principles and, if required, to assist them to design, implement and evaluate a suitable contemporary practice model in their workplace.
1.3 Purpose

There are a number of models that influence the delivery of patient care in our healthcare system. These include nursing and midwifery practice models, the biomedical model used by doctors and some allied health professionals, and a managerial model that focuses on business planning and resource allocation. It is also necessary to consider societal expectations and patient beliefs that may be influenced by religious and cultural considerations. Nurses and midwives need to be aware of the unequal power of these models, therefore it is important for them to consider the control that each model exerts through key stakeholders, legislation and systems that affect the delivery of healthcare. Nurses and midwives need to focus on the pivotal coordinating role that their practice plays in this complex matrix.

This framework is a comprehensive guide and resource that provides nurses and midwives with a process that helps them identify and develop an understanding of the factors that should be considered in contemporary nursing and midwifery practice. It provides direction as to how a ‘new’ practice model may be implemented and how the effectiveness and outcomes of a practice model can be evaluated. It is an instrument that can also be used to support and promote the importance of nurses and midwives within the healthcare system.

1.4 Definitions

This section discusses the definitions used in this framework. There are several meanings related to ‘models of care’ and often terms are used interchangeably.

While ‘models of care’ inform practice about ‘what is being done’ (the approach to, and underlying beliefs about the care that is provided), ‘models of practise’ provide direction as to ‘how it is done’. The discussion below attempts to provide clarity by examining these interpretations in order to help the user make sense of the terminology.

Model

A practice model is ‘...a descriptive picture of practice which adequately represents the real thing’ (Pearson, Vaughan, and FitzGerald, 1996, p. 2). A model is formed when an idea is explained by using symbolic and physical visualisation. It can be used ‘to facilitate thinking about (abstract) concepts and the relationships between them (Bush, 1979, cited by Mariner-Tomey, 1998, p. 4).

This framework assists in the development and application of models that assist professional practice by linking the abstract concepts of the foundation principles to the reality of providing the best possible healthcare. It provides an ‘action’ map and resources that nurses and midwives can use to further develop their professional practice.

Model of care

A literature review undertaken by Queensland Health for the development of the Changing Models of Care Framework (2000, p. 4) found that there was no consistent definition of ‘model of care’ and determined that ‘a model of care is a multifaceted concept, which broadly defines the way health services are delivered.’ Tierney (1998, cited in Davidson et al. 2006, p. 48) noted that ‘ambiguity exists in the literature, with the terms model of care, nursing model, philosophy, paradigm, framework and theory often used interchangeably despite referring to diverse, yet parallel concepts.’ Davidson et al. (2006, p. 49) define a model of care as ‘...an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, EBP (Evidence-Based Practice) and defined standards. It consists of defined core elements and principles and has a framework that provides the structure for the implementation and subsequent evaluation of care.’ They suggest that it should be clearly articulated ‘...to ensure that all health professionals are all actually ‘viewing the same picture’, working towards a common set of goals, and are able to evaluate performance on an agreed basis’ (Davidson et al. 2006, p. 49).

Fowler, Hardy, and Howarth (2006, pp. 40–41) refer to a model of care as a ‘nursing practice model’ and define it as ‘...an operational model for redesigning nursing practice for the provision of patient care in an organisational setting, specifically at a clinical services unit level (ward)...it governs the manner in which nurses organise work groups, communicate with work group members and other disciplines, interact, make decisions, and create an environment within which nursing care is delivered among care providers, and specify communication and coordination patterns necessary to support (patient) care.’

These definitions are similar in that they relate the theory of the ‘model’ to the provision of patient care by nurses and midwives. The purpose of professional practice by nurses and midwives is patient-centred healthcare, and this framework, with its use of foundation principles and structure, guides them toward building a healthcare practice model that best meets the needs of their workplace.
Nursing model of care
The Nursing Model of Care – Toolkit for Nurses (Queensland Health, 2003, p. 1) defines a nursing model of care as the ‘organisation and delivery of nursing care’ within diverse work units and settings that range across the continuum from acute to community, in metropolitan, regional, rural and remote areas. Davidson et al. (2006, p. 49) defines a ‘nursing model’ as pertaining ‘solely to the practice domain of nursing’. The patient is central to the nursing model of care.

Midwifery model of care
The Queensland Nursing Council (no date) defines midwifery care as being woman centred care that ‘...occurs in an open and interactive environment in which the woman and midwife negotiate a partnership to achieve the best possible health outcomes.’ The International Confederation of Midwives (cited by Australian Nursing and Midwifery Council 2006, p. 1) notes that ‘a midwife may practice in any setting including the home, community, hospitals, clinics or health units.’

Despite the differences between nursing and midwifery ‘models of care’, there is enough flexibility within this framework for it to be useful in the development of a model of care that assists both nurses and midwives with their organisation and delivery of optimal patient care.

Models of nursing
Models of care should not be confused with ‘models of nursing’ or ‘nursing theories’ that comprise the beliefs and values that guide nursing practice. The four elements or concepts that comprise most (if not all) nursing theories are: the Person (patient, resident or client); Health (wellness–illness, physical, mental, spiritual); Environment (physical, social, cultural and political); and Nursing (nurses and midwives). Pearson et al. (1996) suggest that while beliefs and values are the foundations upon which the rest of the model of nursing is built, it is essential to have goals in order to provide a common or agreed purpose, and systems of care delivery that result in the delivery of the agreed service, namely healthcare.

Models of midwifery
Recent research by Kennedy, Rousseau and Low (2003) into the essence of midwifery care identified four elements that comprise ‘midwifery’: the woman as the central focus, the midwife as the provider or ‘instrument’ of ‘midwifery care’, the professional partnership or ‘alliance’ that forms between them, and the environment in which this occurs. These components are similar to the four features of nursing models: Patient, Nurse, Health and Environment.

Models of practise
These ‘models’ could be more accurately described as ‘systems of work’ as they relate more to care delivery processes and the organisation of nursing work than the explication of the ways that ‘models of care’ guide the practices of nurses and midwives toward providing the best possible patient care. Traditionally ‘nursing work’ was based on task allocation, however patient allocation, team nursing (and midwifery) and primary nursing (and midwifery) are other approaches to the contemporary organisation of healthcare delivery (Pearson et. al. 1996, pp. 23-4). They suggest that ‘practise models’ are an adjunct to care delivery (as was the nursing process) with models of care providing the underlying principles and goals that have guided nursing practice. Other care delivery strategies have focused on management practices such as key worker, case management, managed care, and nursing beds (Royal College of Nursing, 1992, p. 39).

Examples of nursing care delivery models defined by Fowler et al. (2006, p. 41) include patient-focused care; model of professional accountability; primary or total nursing care; individualised care; team or functional nursing care; Magnet Hospital environmental/shared governance; quality-caring model (acute care); and model for promoting process engagement (chronic illness).

This framework is founded on the key beliefs and values of the models of both nursing and midwifery (as its foundation principles) and uses the contributions of both models of care and models of practise to guide the practice of nurses and midwives so that they can provide the best possible healthcare in the most efficient and effective way.
Framework
A framework shapes and guides the implementation and evaluation phases of a model’s development, it is the ‘brace and girders that support the model’ (Davidson et al. 2006, p. 49). This framework provides guidance for assessing the quality of care that results from current service delivery, and a process whereby clinicians are guided through the steps whereby a ‘new’ practice model can be implemented. It contains resources that inform the different practice models that could be used in a variety of clinical and community settings.

The value of this framework extends beyond just guiding the implementation and evaluation phases of a model’s development; it delivers a strong foundation upon which the selected model can be assessed for its validity. The logical structure that guides the decision-making processes of clinicians provides justification for the modification of workplace practices. Furthermore, it provides guidance for assessing the quality of healthcare that results from current service delivery methods and a process whereby clinicians are guided toward setting goals and implementing a ‘new’ (or changed) practice model.

1.5 The purpose and benefits of a model of care

Because nursing models of care have been poorly defined, Fowler et al. (2006) suggest that they have been variously seen as a governance structure, a compensation scheme (where guidelines that direct practice are lacking) or a strategy for allocating patients to staff (or staff to patients). This has contributed to confusion about the meaning of the terminology. The lack of clarity about the purpose of nursing models of care has added to this uncertainty. Various reasons have been given for developing and introducing nursing models of care; they include increasing work satisfaction and staff retention, cost containment, service efficiencies, quality improvement, and improving patient outcomes (in terms of health status, number of attendances and duration of stay) (Fowler et al. 2006, p. 41).

Davidson et al. (2006, p. 49) argue for the need to define the term ‘model of care’ and propose that it ‘describes the delivery of health care within the broader context of a health system.’

Girard (1993) emphasised the practical application of models of care when she used the term ‘nursing care delivery models’ when referring to new practice models for delivering nursing care in the perioperative setting.

The Nursing Worklife Model of Manojlovich and Laschinger (2002) also identified the importance of a nursing model of care in informing and directing nursing practice. They suggest that it directly influences the organisational factor of staffing and resources, and the personal accomplishment of staff.

The benefits of using an agreed practice model include:

- consistency of patient care and continuity of care patterns and management (treatment)
- reduction in disagreements and conflict within the ‘patient-care team’
- understanding of the aims, goals and interventions of nursing by all stakeholders (nurses, patients and other health professionals)
- providing direction to nursing care by defining its ‘fit’ or place within the practice setting
- guiding decisions about practice and policy because the selected components of the model guide the interventions and outcome evaluation
- focus the criteria for team-member selection.

(Pearson et al. 1996, p. 4-5).

Having determined the advantages of using an agreed practice model as a conceptual tool that provides ‘a standard or example for imitation or comparison, combining concepts, belief and intent that are related in some way’ (Davidson and Elliott, 2001, p. 121) it is essential that the chosen practice model meets the required needs and standards. Several authors including Davidson and Elliott (2001, p. 123) and Girard (1993, p. 483) have suggested that the essential criteria for a practice model include:

- a basis in evidence that is clearly identified and documented and/or a grounding in theoretical propositions (a professional knowledge base)
- a foundation derived from assessment of patient and health-provider needs
- evaluation of health-related and intervention outcomes (for patients, nurses, other health professionals, and organisations)
- the identification of nursing competencies and defined nursing roles
- professional autonomy and accountability
- consideration of the safety and wellbeing of nurses
- respect for legal and ethical positions, including equity of access for all members of society and interventions that are culturally sensitive and appropriate
- consultation and collaboration between key stakeholders and, where applicable, involve a multidisciplinary approach
endorsement of self-determination and health promotion
optimal and equitable utilisation of health care resources including financial and budgetary impacts and quality-management factors
currency (they need to be contemporaneous), with flexible application, practicality, and ‘repeatability’.

In summary, practice models serve a number of functions. These include the provision of a ‘common’ language that supports communication between nurses and/or midwives, they permit others to ‘see what nurses and midwives see’ (and therefore gain an understanding of nursing and midwifery), enable review by other stakeholders (eg. patients, health professionals, managers, lawyers) so that their suitability and legality can be assessed, and allow for accountability because the ideas that have been selected can be tested (theoretically) before they are applied to the practice setting. They should be based on the best available evidence (tried and tested), support the delivery of quality patient care, and through their involvement in selecting, implementing and evaluating a practice model that best suits the specific needs of their workplace, increase nurses’ work satisfaction.

Summary
While the above terms and the components that they represent are similar and interrelated, it is hoped that this section has assisted you to make sense of the terminology surrounding models of care and practice models. This framework’s foundation principles guides practice and can be used to set goals, it also provides a structure that can be used to evaluate current clinical practices and they change if necessary through practice-change processes. It informs and guides the provision of healthcare in diverse workplaces and has a practical focus on the service-delivery aspects of patient care. It can therefore be used by nurses and midwives at the ‘local’ or ward level.

Due to the diverse range of practice settings in which nursing and midwifery care is provided it is important to acknowledge that (a) there are many different practice models and (b) that more than one practice model is likely to be suitable for a particular setting. It is therefore necessary for the nurses and midwives practising within each discrete workplace to reflect upon the model that currently guides their practice, determine its quality and, if appropriate, select and utilise a ‘new’ practice model.

1.6 The operation of this framework
Background
The influence of healthcare systems and organisations on nurses is well documented. The dominance of the biomedical model of care (cure) and its practitioners (doctors) continues to be supported as a social script politically, economically, and socially, despite the centrality of the nursing resource (Porter-O’Grady and Malloch, 2006). While the importance of nurses’ education (with entry level for Registered Nurses at the Baccalaureate level) and advances in clinical practice have been influential in improving patient care despite the increasing complexity of clinical services, the challenges of maintaining the status quo that limits the control and influence of nursing has hindered the provision of quality patient care.

Buerhaus and Needleman (2000, in Porter-O’Grady and Malloch, 2006, p. 184) suggest that ‘inadequate resource planning, limited inclusion of nurses in strategic and policy decisions, financial and economic decisions made without nursing consultation’ have all adversely affected nurses and midwives, and therefore the quality of care they provide. To overcome the predominance of the biomedical focus and the traditional organisational structures and management strategies that support it, innovative nursing and midwifery models and strategies including the nursing worklife model, practice development units, action research, and evidence-based practice have been developed to facilitate the delivery of patient care by nurses.

Purpose
This framework is a comprehensive guide that provides nurses and midwives with a process to identify and understand the factors that should be considered in contemporary nursing and midwifery practice. It is underpinned by the five foundation principles that should be integral to all healthcare delivery. They are fundamental values that should be considered when assessing and subsequently improving (if indicated) nursing and midwifery practice.

By posing sample questions, this framework guides nurses and midwives through areas that need to be considered when changing a practice model. Nursing and midwifery does not occur in a vacuum, it is anticipated that through the use of this framework nurses and midwives will be challenged to recognise that quality patient care requires consideration of a broad range of factors.
The process that guides nurses and midwives begins with a comprehensive analysis using evaluation and feedback of the current nursing care they deliver in their practice situation. The intent of this evaluation at the outset is to assist them to identify the limits to the care they currently provide. When these limits have been defined, the nursing or midwifery team can clearly recognise ‘gaps’ in their practice that inform the direction of future changes.

This framework directs how a ‘new’ practice model may be implemented. The identification and engagement of key stakeholders, together with the harnessing of resources is paramount if practice change is to be successful. Information about evaluating the effectiveness of the new practice model is also provided. A continuous, rigorous evaluation plan ensures that revisions to practice are dynamic and responsive to contemporary healthcare trends.

It is essential that when using this framework, the foundation principles that underpin it are used to guide the development of practice change. Of equal importance is the need for it to assist the user to identify achievable goals, implement practice-change processes and measure the outcomes.

Framework map

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*Framework principles*

- Patient-centred care
- Best use of nursing and midwifery resources
- Safe practice
- Quality care – judicious use of evidence
- Trends in contemporary healthcare practice

References


Chapter 2: Foundation principles

The purpose of this chapter is to discuss and describe the five foundation principles identified by the MoCNPC (a sub-committee of NIBB(G) as important, underlying assumptions upon which professional nursing and midwifery practice is based.

The five Foundation Principles addressed in this framework are:

1. Patient-centred care
2. Best use of nursing and midwifery resources
3. Safe practice
4. Quality care – judicious use of evidence
5. Trends in contemporary healthcare

2.1 Patient-centred care

There has always been an inextricable link between patients and nursing. Historically, patients were individuals who were sick or seeking food, shelter and comfort and their needs were met by religious orders. This then developed into patient care provided by nurses and midwives, and the need for specialised training, and later education, was recognised.

Today, an increasing number of healthcare professionals are involved in ‘health’ care. However, nurses remain the single largest group of healthcare professionals and are therefore pivotal in ensuring the provision of healthcare services that are ‘patient-centred’.

Seven primary dimensions of patient-centred care in the United States were documented by Gerteis, Edgman-Levitan, Daley, and Delbanco (1993):

1. Respect for patients’ values, preferences and expressed needs
2. Coordination and integration of care
3. Information, communication, and education
4. Physical comfort
5. Emotional support and alleviation of fear and anxiety
6. Involvement of family and friends
7. Transition and continuity.
These primary dimensions were further examined and key aspects of each identified.

1. Respect for patients’ values, preferences and expressed needs
   Patients often feel a sense of loneliness, loss of identity, and anonymity. To overcome this, nurses and midwives need to consider the effect on the patient of her/his illness/condition, treatment and health management, and hospitalisation and/or scheduling of care and/or treatment (including the time and expenses related to travelling and appointments, absence from work and loss of anonymity). Staff need to attend to the patient’s:
   - quality of life
   - involvement in decision-making
   - dignity
   - needs and autonomy.

2. Coordination and integration of care
   To overcome the patient’s feelings of powerlessness and vulnerability, staff need to inspire trust by ensuring the coordination and integration of:
   - clinical care
   - ancillary and support services
   - ‘front-line’ patient care.

3. Information, communication and education
   While not overwhelming patients with facts and routines, it is important to provide them with important and relevant information and where necessary, education:
   - regarding their clinical status, progress, and prognosis
   - about processes of care
   - to enable knowledge development that facilitates autonomy, self-care, and health promotion.

4. Physical comfort
   Because most health disturbance is accompanied by physical discomfort and disability, the physical care provided by nurses and midwives is of paramount importance in promoting comfort, and relieving discomfort/dis-ease. Staff need to:
   - attend to pain management
   - help with activities of daily living
   - ensure patient surroundings and the health facility environment are hospitable.

5. Emotional support and alleviation of fear and anxiety
   Of equal importance to physical comfort is the provision of psychosocial comfort. Staff need to alleviate the fears and reduce the anxieties of the patient which may be related to:
   - clinical status, treatment, and prognosis
   - the impact of health disturbance on self and family
   - the financial impact of the health problem.

6. Involvement of family and friends (as decided by patients)
   The importance of ‘significant others’ should never be underestimated because of the influence, both positive and negative, they can exert on the patient and professional carers. They can be an essential part of the team (comprising both health professionals and non-professionals) caring for the patient or a ‘thorn in the side’ that limit therapeutic opportunities and hinder recovery. Staff need to consider the extent to which they can:
   - accommodate family and friends (physically [a place to stay] and psychosocially [identify ‘significant’ individuals and their affect on the clinical course and subjective experience of the patient])
   - involve family in decision-making
   - support the family as associate caregivers
   - recognise the needs of the family.

7. Transition and continuity
   The fear of the unknown – will I return to my ‘normal’ state? How will I experience post-treatment and post-illness? – causes anxiety in patients. To minimise this, staff need to ensure that patients:
   - receive and understand all of the necessary information
   - access the required support
   - receive care and services that are planned and coordinated.

A later study in the United States by Godkin and Godkin (2004) identified six caring behaviours:

1. Uniqueness
2. Connecting with the patient’s experience
3. Sensing
4. Going beyond the scientific data
5. Knowing what will work and when to act
6. Being with the patient.

The behaviours that demonstrated nurses and midwives presence or ‘being with’ the patient were communication, respect, aid, comfort, empathy, visibility, informing, attitude, and reliability. These behaviours have also been summarised as providing nursing CARE (communication, assistance, respect and empathy).
In the United Kingdom in 2000, the National Health Service (NHS) developed a plan that considered ‘what patients want’. It determined that there were eight ‘benchmarks’ of fundamental nursing care:

- nutrition
- tissue viability – pressure ulcers
- hygiene and mouth care
- record keeping
- continence
- privacy and dignity
- principles of self care
- safety of patients with mental health needs. (Mullally, 2001, p. 337).

Lumby and England (2000) observed that Australian patients valued nurses who demonstrated the ability to perform the promised service (treatment or procedure) dependably and accurately and who were willing to promptly help them. Another important factor that contributed to patient wellbeing, identified in a study by Middleton and Lumby (1999), was the reassurance of the continuous nursing presence that was responsive and attentive to their needs. The importance of nurses demonstrating their respect for patients (through attentiveness and timely responses) and maintenance of the patient’s integrity (to reduce their feelings of vulnerability as ‘a patient’) was noted by Irurita (1999). These Australian findings are similar to those identified in overseas studies.

This framework requires you to analyse your practice setting using the foundation principles to determine the impact that your current model of care and practise has on the quality of the healthcare that you provide. For example, what are the patient satisfaction levels in your workplace? The above research findings can be used to develop focussed questions that assess specific issues related to patient satisfaction (ie. the quality of the staff’s response and its timeliness). Patient responses can be analysed to determine if their individual needs are being met. Examples of these types of questions are provided in Chapter 3. ‘Analysis of your practice setting’.

2.2 Best use of nursing and midwifery resources

This section considers the staff (human resources) involved in the provision of patient care. The composition of the workforce, for example insufficient numbers, an unsuitable skill-mix or lack of experience, can affect the quality of patient care. In order to effectively use human resources it is necessary to understand their roles and determine how they can best contribute to ensure optimal patient care.

What is nursing and midwifery?

‘Care’ is a term that is used universally, while ‘nurse’ and ‘carer’ have different meanings depending upon whether they are used by a health professional or a member of the public. ‘Midwife’ is rarely used other than by registered midwives, however some allied health professionals assert that they can provide midwifery care by ‘being with the mother’. Below are definitions of nursing and midwifery and the different staff that provide patient care. It explains their healthcare roles and describes the context in which they practice.

The International Council of Nurses (2002 cited by the QNC 2005, p. 15) definition of nursing:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.

The International Confederation of Midwives (2005 cited by the QNC 2005, p. 15) definition of midwifery:

The midwife is recognised as a responsive and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and childcare.
The Queensland Nursing Council (2005) defines nursing and midwifery practice as:

The application of knowledge, skills and attitudes towards alleviating, supporting or enhancing actual or potential responses of individuals or groups to health issues.

Nurses’ and midwives’ spheres of practice may include:
- giving direct care, including assessing, planning and evaluating care
- coordinating care and supervising others
- leading, managing
- teaching, education, health promotion and counselling
- undertaking research
- developing health, nursing and midwifery policy.

Nursing is undertaken by nurses. There are a number of different levels of nurses and midwives as defined by the Queensland Nursing Council (QNC) (2005, pp. 9-11). The categories of nurses, midwives and healthcare personnel are identified below.

Registered nurse (RN)
An RN is a person with appropriate educational preparation and competence for practice, who is licensed under the Nursing Act 1992 to practise nursing in Queensland.

Midwife
A midwife is a person with appropriate educational preparation and competence for practice, who is licensed under the Nursing Act 1992 to practise midwifery in Queensland.

Enrolled nurse (EN)
An EN is a person with appropriate educational preparation and competence for practice, who is enrolled and licensed under the Nursing Act 1992. As an associate of the RN, an EN must practise with the support and professional supervision of an RN or midwife.

Nurse practitioner (NP)
An NP is educated to function autonomously and collaboratively in an advanced and expanded clinical nursing role. The role includes assessment and management of clients and may also include:

- the direct referral of clients to other healthcare professionals
- prescribing medications; and
- ordering diagnostic investigations.

Unlicensed healthcare workers (HCWs)
There are a number of unlicensed workers within the healthcare system that work in conjunction with licensed practitioners.

Unlicensed HCWs are paid employees whose roles include carrying out non-complex personal care tasks. HCWs include Assistants in Nursing (AINs), Personal Care Assistants (PCAs), orderlies, and ward attendants. As valued members of the healthcare team, their role relationship with licensed nurses and midwives will vary according to their employment contract. HCWs may have a care-worker qualification or no formal education for their role. They are not professionally regulated and therefore are not bound by standards set by a central licensing authority. They must work with the support and supervision of an RN or midwife when carrying out tasks delegated to them in accordance with a documented patient care plan.

Aboriginal health workers and Torres Strait Islander healthcare workers
Aboriginal and Torres Strait Islander healthcare workers are unlicensed healthcare workers who hold competency-based qualifications in Aboriginal and Torres Strait Islander Primary Health Care (Queensland Health, 2007). Broad diversity exists within the role, which includes the possession of generalist or specialist skills’ sets. These are integral skills and practices required at the interface between the primary healthcare setting and Indigenous peoples and communities (OATSIH, 2006). Responsibilities may extend to the supervision and management of other healthcare workers (or other members of the healthcare team) (Queensland Health, 2007).

Within the provisions of a primary healthcare team, the healthcare worker role is not only vital to promoting cross-cultural understanding and respect (RCNA, 2003; CATSIN, 1999), but also for facilitating better health outcomes and access to healthcare services for Aboriginal and Torres Strait Islander peoples (Queensland Health, 2007). Aboriginal and Torres Strait Islander healthcare workers principally working within mainstream or Indigenous Community Controlled healthcare services, integrate primary healthcare practices with the unique cultural values of the Aboriginal and Torres Strait Islander community which they represent (Queensland Health, 2005).
The working relationship between Aboriginal and Torres Strait Islander healthcare workers, and that of RNs and midwives will differ in keeping with the practice context, and the needs of the employing organisation. In some contexts, the healthcare worker may function independently or in collaborative partnership with an RN or the multidisciplinary team. Conversely, the Aboriginal and Torres Strait Islander healthcare worker may be accountable to an RN or midwife (or other member of the healthcare team) for activities that are delegated to them, for example, actions arising from a case-management or nursing care plan (Queensland Health, 2005).

Levels of registered nurses and midwives

There is also a range of levels of registered nurses and midwives as defined by Queensland Health. Grade I RN is the entry level for novice RNs. A more experienced nurse or midwife may be employed as a Clinical Nurse and has more experience and/or further education qualifications. Experienced RNs who have further specialist skills, qualification and knowledge include Nurse Unit Managers (NUMs), Nurse Educators (NEs) and Clinical Nurse Consultants (CNCs). Senior Nurse Managers include Assistant Directors of Nursing (ADONs) and Executive Director Nursing Services (EDNS).

Scope of nursing practice

The QNC (2005) determined that the scope of nursing and midwifery practice is that which nurses and midwives are educated, competent and authorised to perform.

The actual scope of an individual nurse or midwife’s practice is influenced by:

- level of competence, education and qualifications of the individual nurse or midwife
- context in which they practice
- service provider’s policies
- client’s health needs.

Beginning and experienced nurses and midwives have differing levels of skills and abilities. Benner’s (1984) application to nursing of the Dreyfus model of skill acquisition proposed that the acquisition and development of nursing skills involved a continuum of five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. These different levels reflect transformation in four aspects of skilled performance:

- less reliance on rule-based activity to acceptance of intuition as a valid form of knowledge
- an increasing awareness of the complete (whole) picture rather than a perception of disconnected parts
- a changing role from detached observer to increasing engagement with the activity of nursing.

Other factors to consider when assessing the quality of nursing and midwifery staff are their knowledge levels derived from postgraduate studies, continuing professional development, the quality of their experiences (including their ability to undertake reflective practice and think critically) and their capacity for adaptability and teamwork.

Their performance is also affected by workplace rostering (refer Best Practice Rostering Framework), numbers, and levels of skill and experience and the workplace culture (is it supportive, collegial between nurses and midwives and other health professionals, and allowing for autonomous practice). Teamwork is particularly important for staff well-being and patient outcomes. It is important to assess workplace satisfaction, as it can provide information about the impact of the organisation on staff and the value of the support that the organisation provides to meet their needs, physical, and emotional (psychosocial).

Nurses and midwives workplaces are many and varied; they range from rural and remote areas where they may be the only health professional in the community to large tertiary-level acute care hospitals in major cities. They may be independent practitioners, community nurses and midwives, or work within out-patient clinics, aged care facilities, correctional facilities (prisons), or mental health facilities.

An effective model should ensure that the expertise of the most experienced nurse is utilised to maximum benefit. It should ensure that the process of providing nursing care to hospitalised patients is efficient and equitable and promotes a positive working, learning and healing environment. The system of allocating nursing staff is the invisible ingredient that supports a purposeful structure. Staffing levels, skill mix, clinical supervision, professional development, physical resources and equipment, patient acuity and the availability of medical, allied health and support personnel are examples of the complexity of factors that are sculptured to form an effective structure for the delivery of nursing care.

(Greenhill and Henderson, 2000, p. 41)
2.3 Safe practice

Nurses and midwives comprise the majority of healthcare professionals and have the most patient/client contact (through their on-call or 24 hour presence). They are pivotal to the maintenance of safety for patients and other healthcare professionals because they are in a key position to monitor the immediate physical environment and the outcomes of treatment. Federal and State legislation covers a diverse range of factors including building codes and facility management, patient safety, occupational health and safety (OHS), and registration of health professionals. The range of legislation includes:

- the physical environment (building code, fire safety, evacuation procedures)
- chemicals used in the workplace (for cleaning, sterilising, and medications)
- biological hazards, including infection control
- ergonomic (no-lifting policies)
- code of conduct, psychosocial (anti-discrimination, sexual harassment, and bullying)
- staffing levels, duration and frequency of shifts
- competency assessment and professional development.

Relevant legislation includes the *Health Services Act, 1991; Industrial Relations Act, 1999; Nursing Act, 1992; Workplace Health and Safety Act, 1995; and the Health (Drugs and Poisons) Regulation, 1996.*

As previously mentioned, the licensing organisation for nurses and midwives in Queensland is the Queensland Nursing Council (QNC) ([www.qnc.qld.gov.au](http://www.qnc.qld.gov.au)). The Australian Nursing and Midwifery Council (ANMC) ([www.anmc.org.au](http://www.anmc.org.au)) also promotes safe practice through the publication of the following professional standards for nurses and midwives:

- Principles for the Assessment of National Competency Standards (2002)
- National Competency Standards for the Midwife (2006)

Safe practice can be measured by the PRIME incident data, which collects information on but not limited to:

- aggressive incidents
- drug administration errors
- incidents of pressure ulcers

Safe practice is also guided by facility policy and procedure manuals. These should be regularly reviewed and their content informed through the best practice literature.

Clinical Governance (CG) is a framework that is used to promote safe patient care. It was defined by Scally and Donaldson (1998, p. 61) as ‘A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’ This accountability for safe practice is transferred to nurses and midwives through not only their responsibility to their employing organisation but, more importantly, their professional values. At the organisational level it involves:

- patient, public and carer involvement
- strategic capacity and capability
- risk management
- staff management and performance
- education, training and continuous professional development
- clinical effectiveness
- information management
- communication
- leadership
- team working.

(NHS Clinical Governance Support Team, 2007).

Gray (2005, p. 254) summarised CG as ‘doing the right thing, at the right time, by the right person – the application of the best evidence to a patient’s problem, in the way the patient wishes, by an appropriately trained and resourced individual or team.’ For CG to be effective this involvement needs to occur across the organisation and involve operational staff including porters, cleaners, and food service staff, and administrative staff including ‘practice’ or reception staff. Queensland Health has a similar approach to CG; information can be accessed at: [qheps.health.qld.gov.au/nahs/clinical/cl_governance.htm](http://qheps.health.qld.gov.au/nahs/clinical/cl_governance.htm)

Another online resource for healthcare workers/managers interested in developing a culture of safety is: [www.saferhealthcare.org.uk/IH1/](http://www.saferhealthcare.org.uk/IH1/)
2.4 Quality care – judicious use of evidence

Traditionally patient care has relied upon experienced and ‘expert’ practitioners who logically applied their knowledge of anatomy and physiology to provide ‘common sense’ approaches to treatment and the management of patient care. This led to the provision of healthcare that was based on ritual and tradition and accordingly was resistant to new ways of seeing patients and new treatments. The evidence-based practice movement requires healthcare practitioners to test the reality of effectiveness and efficiency of those treatments because patients and their bodies do not always respond in a ‘logical’ way. For example, it took over 20 years for the use of corticosteroid treatment in threatened premature labour to become standard practice, and a number of years before a cause of gastric ulcers was identified as Helicobacter pylori and the management with antibiotics instead of surgery or anti-ulcerant medications (H2-receptor antagonists) became the accepted treatment.

It is therefore essential that healthcare providers regularly and routinely evaluate the effectiveness and efficiency of their practices (and treatments) so that they can ensure that they provide optimum healthcare. This is best done by regularly reviewing their practices and comparing them with the most recent reviews of research findings.

Evidence-based practice (EBP) focuses on the quality of the healthcare management interventions that patients receive. Originally developed by Cochrane in 1972, when he noted that there was a collective ignorance about the effects of new medical treatments on patient wellbeing, EBP focuses on the formal review of research findings and the publication of summaries so that ‘best practice’ can be available to all clinicians. The Cochrane Collaboration which systematically reviews healthcare research, available at: www.cochrane.org was duly established to undertake these tasks. The Joanna Briggs Institute of Evidence Based Nursing and Midwifery (JBIEBNM or more recently, the JBI), was created to facilitate the use of evidence-based healthcare practice globally for nurses and midwives. Like the Cochrane Collaboration it is a leading international organisation for the translation, transfer and utilisation of evidence of the feasibility, appropriateness, meaningfulness and effectiveness of healthcare practices. Information on JBI can be accessed at: www.joannabriggs.edu.au

Both organisations publish ‘best practice’ guidelines that are available to nurse and midwifery practitioners through QH’s intranet site by accessing the Clinicians Knowledge Network (CKN). Other useful sources include the Australian Centre for Evidence Based Clinical Practice available at: www.acebcp.org.au

An initiative that draws on findings from best practice includes SBAR, a framework that can be used to communicate about patients’ conditions systematically by describing the current situation (S), their background or history (B), assessment of change in their condition (A), and recommendation (R) for ongoing management (Institute of Healthcare Initiatives [IHI], 2004, p. 8). This is a variation on the use of the SOAP format to communicate about patients’ conditions – subjective and objective data about the patient, assessment of their (changed) condition, and a plan for managing her/his ongoing care.

Clinical Governance is also used to ensure that patient healthcare is consistent and of the highest quality. This can be achieved through the use of Clinical Practice Guidelines (CPGs) and Essence of Care benchmarks to ensure Clinical Effectiveness (CE) and Healthcare Standards. These recent initiatives are part of the ‘quality of care’ push by healthcare providers in a number of countries to ensure that they meet their duty of quality care obligations. The National Health Service (NHS) in the United Kingdom, the Institute for Healthcare Improvement (IHI) in the United States of America, and QH and New South Wales Health (NSW Health) in Australia all provide resources, often as on-line documents, that can be used to ensure that the highest possible standard of patient care, informed by the best available evidence, is provided to their constituents.

CPGs are ‘…systematically developed statements of recommended best practice in a specific clinical area, designed to provide direction to practitioners in their practice’ (Registered Nurse Association of Ontario, 2002, p. 5). They should be used to:

- deliver effective care based on current evidence
- resolve a problem in the clinical setting (eg. poor management of pain)
- achieve excellence in care delivery by meeting or exceeding quality assurance standards
- introduce an innovation (eg. a new effective test or treatment).

(RNAO, 2002, p. 5)
CE is ‘doing the right thing in the right way and at the right time for the right patient’ (Royal College of Nursing, 1996). Clinically effective practice is similar to CPGs in that it provides a model to enable nurses and midwives to do ’the right things right for patients’ (NHS Executive, 1998a, p. 3). The three main areas are inform (about best evidence of clinical and cost effectiveness), change (audit review current practice and where appropriate modify), and monitor (evaluate whether the changes have resulted in real improvement) (NHS Executive, 1998, p. 4).

2.5 Trends in contemporary healthcare practice

Change is an unceasing and inevitable part of our lives. In relation to healthcare, it is paramount that we regularly monitor our practices and change them (when necessary) to ensure that we provide the best possible patient healthcare. We also need to plan for future changes that may affect healthcare so that we can be proactive (rather than reactive) to them. There are several important areas that health professionals need to consider: the funding and provision of healthcare, workplace changes, changes to population demographics (size and ageing), patterns of illness, and advances in technology. This section lists some of the areas that require consideration.

Political/legal/economic factors

Political factors and the state of the international and national economy will influence funding policies and expenditure patterns.

a) Commonwealth direction/policies/funding

Current Commonwealth direction and policies usually include the setting of National Health Priorities. These are often areas of healthcare that will receive additional funding.

b) State government direction/policies/funding

One of the whole-of-government priorities is ‘Better quality of life’ and this gives effect to QHs mission statement.

c) QH direction/policies/initiatives

The current Queensland Health Strategic Plan. Examples of Government responses include:

- in 2007, a Federal Government initiative regarding the health of Aboriginal children in the Northern Territory was implemented
- in 2006 training for all QH nurses for mandatory reporting of child abuse was introduced.

Incidence and prevalence of disease

Chronic conditions

The Australian Institute of Health and Welfare (AIHW 2000) determined that chronic health problems such as ischaemic heart disease, stroke, depression, cancer, dementia, chronic obstructive airways disease, diabetes mellitus, asthma and osteoarthritis are and will remain the dominant focus of the health system for the foreseeable future. These chronic health problems are frequently complex to manage requiring close linkages between home, primary health services, hospital and nursing home care.

Emerging health areas of concern

- obesity
- post traumatic stress disorder
- ageing population
- increasing use of illicit drugs such as ‘Ice’ (Methamphetamine) and ‘Ecstasy’ (Methylenedioxyamphetamine), as well as more traditional drugs such as heroin, cocaine and cannabis (also known as marijuana, ganja and hashish) that are linked to illness associated with overdose, and mental illness
- increasing rates of depression and mental health problems related to hardship created by drought in rural and remote areas.

Workforce trends

- casualisation of the workforce
- scarcity of the workforce – lack of availability and/or loss of healthcare workers in rural and remote areas
- nurse practitioners
- specialisation of nursing and midwifery.

Advances in technology

- increased complexity in service delivery
- increased specialisation and potential for fragmentation in service delivery
- telehealth
- increasing capability in the provision of care, (eg. organ transplantation, joint replacements, infertility management, cosmetic (image altering) surgery).
Consumer expectations and involvement

- increased patient involvement – internet access to information of varying quality
- patient autonomy
- patient involvement in decision-making
- increased need for accountability
- clinical governance (as discussed in previous section)
- audits and feedback mechanisms
- legal issues regarding professional indemnity, patients seeking financial reimbursement for injury.
References


Royal College of Nursing (RCNA) 2003, ‘Position Statement: Health services for Aboriginal and Torres Strait Islander Peoples’. Deakin West, ACT: Author.

Chapter 3: Analyse your practice setting

Do you have an understanding of the healthcare requirements of the community you serve and how you deliver the health services to them?

The purpose of this chapter is to help you assess the quality of your current practice model drawing on the foundation principles discussed in the previous chapter (Chpt 2) so that you can identify areas where change is required.

Framework map

| stakeholders | evaluate your success | resources |
| stakeholders | implement your strategies | resources |
| stakeholders | assess your environmental readiness | resources |
| stakeholders | decide on your goals | resources |

| stakeholders | analyse your practice setting | resources |

It is important to consider the compatibility between the services that are required by specific client groups and those that are currently provided. Consideration of the resources (human, social, organisational and physical) needed to deliver this service is paramount. This includes the nursing and midwifery knowledge, skills and abilities, and experience of the staff delivering the service (human capital).

3.1 Assess the healthcare requirements

A useful resource to determine the healthcare needs of a community is the Australian Institute of Health and Welfare (www.aihw.gov.au), a national agency for the collection of health and welfare statistics. Comparison with similar areas or regions may provide some insight into the needs of communities, while local councils and state health authorities should keep data and statistics relating to health concerns in their areas. Within major cities, specialised agencies collect and collate data relating to healthcare matters, and in acute-care facilities there are specialised sections within departments (communication between departments may not be well coordinated) that collect and analyse data. These resources may be helpful in gaining an understanding of the ‘bigger picture’ of the healthcare needs of communities and regions.

When you are examining your current practice model it may be useful to ask: What are the characteristics (ages, gender, and healthcare needs including diagnoses and co-morbidities) of the client group(s) for whom care is being provided? You need to obtain these details in order to be able to identify their needs. The Internal Factor: Performance in the Service Profile (refer QH Business planning framework, consult QHEPS) outlines Patient/client complexity/acytity as a key area for consideration. It discusses the collection of data relating to the occasions of service and complexity of care required, and refers to ‘casemix’ and Diagnosis Related Groups (DRGs) that may be linked to a Patient Dependency System.

3.2 Describe the current healthcare services

The service profile of the organisation defines its aims and objectives, and analyses its internal and external environment for strengths, weaknesses, opportunities and threats (SWOT analysis). It includes the collection of data relating to patient/client activity including admissions, occupancy and separations (discharges), numbers of operations, emergency department presentations, outpatient ‘occasions of service’, and home visits. You may have undertaken this form of analysis when developing a service profile of your workplace (refer QH Business planning framework, consult QHEPS).
After completing the service profile, you should be able to ascertain the type and number of services provided and use that information to explore if there is any discrepancy between the requirements and what is delivered.

3.3 Identify any gaps (if present)

The next component of the analysis is the comparison of the required service with the provided service. Hopefully there will not be discrepancies. However, if there are any discrepancies, then they need to be managed. It is beyond the scope of this framework to provide advice on mechanisms that could be used to facilitate this process if there is a major mismatch because of external planning and resourcing.

However, if these discrepancies exist they should be elevated at the local, district and where appropriate area level through discussion and negotiation with key stakeholders (community and healthcare service providers).

At the local level (within a local community, clinic or hospital) the next step is to determine whether the current practice model is suitable (see the following sample questions for direction). When determining the effectiveness of the practice model you need to identify where current practice is successful and unsuccessful in meeting safe and quality care as per the Foundation Principles. The Foundation Principles (as described Chpt 2) are useful in establishing a comprehensive base for broad evaluation.

Assessment question: Does the practice model identify patients as individuals?

Foundation Principle 1.

- Have nursing and midwifery clinical protocols been developed that seek patients’ perceptions about their understanding and expectations of their health?
- Are patients provided with information about who will be providing different aspects of this care, and the expected timeframes?

Patients are dissatisfied when their expectations are not realised. It is important when collecting information about patient satisfaction to clarify their expectations and the reality of the available services at the first suitable opportunity eg. the first occasion of service, and regularly re-visit it to assess and maintain their satisfaction with the service.

- Have staff been taught not to assume that they know what patients need and want?
- Have staff been provided with learning opportunities in facilitated sessions where they can practice interacting with patients to learn about patients’ needs and how to provide them?

Information/data sets that can provide feedback about patient centred care currently delivered include:

- patient satisfaction surveys
  More information can be obtained from qheps.health.qld.gov.au/drac/html/qmsu_homepage
- patient quality of care surveys
- number of patient education programs
- number of ‘hits’ on information sites.

When nurses can deliver the care that they feel patients desire nurses experience less moral conflict and possibly are more likely to stay within the profession (Schluter et al. 2008).

3.4 Define the most appropriate and safe practice model

Assessment question: How can you ensure that the practice model addresses safe practice issues?

Foundation Principle 3.

- What are the skills required for the provision of patients’ physical and emotional needs?
- Are staff able to legally perform the required skills?
- Are there effective monitoring/checking systems that increase the likelihood of identifying errors before they occur?
- What is the profile of nursing and midwifery staff needed to provide care that is safe (ie. within their scope of practice)?

Problems can arise when nurses and midwives are required to:

- perform or supervise activities outside their experience or scope of practice
- undertake tasks for which they have not been adequately trained or educated
- work in an environment to which they have not been oriented or readied.

An information/data set that can provide information about the safety of nursing and midwifery practices is:

- PRIME clinical incident data – patient falls, needlestick injury, medication incidents, pressure areas.

Consult the patient safety officer in your district for clinical incidents information in your practice area.
Assessment question: Can the use of evidence in practice improve patient care and also reduce difficulties for nursing staff?

**Foundation Principle 4.**
- Are there ineffective practices that are based on traditional and ritual?
- Has a literature search or systematic review been undertaken to explore these issues?
- Have clinical experts met to explore how the evidence in the literature be contextualised to nursing practice?

A project introducing nurses to evidence about caring for dementia patients identified that when the evidence was translated into simple nursing acts that it assisted the nurses to provide better care and manage these patients in the acute care environment (Henderson et al. 2006). When evidence can be contextualised into the practice environment it is more likely to be adopted and incorporated into nursing behaviours (Winch et al. 2005).

Assessment question: Can you identify the contemporary trends that are or will influence nursing and midwifery practice?

**Foundation Principle 5.**
- What initiatives are occurring within contemporary health practice that could improve the practice in your workplace?
- What information needs to be sought to ‘value add’ to your service? ie. What problems is your service facing?

Evidence from external sources, rather than internal feedback, can assist you in addressing contemporary issues.
- Explore the published literature to learn what other similar areas are doing. Ask your librarian to assist you with key words and data sources.
- A careful search includes keeping detailed documentation of the search strategy used. Search terms need to be identified by the clinicians most familiar with the area.
- Once you have located the literature organise ‘expert groups’ or an interest group (such as a journal club) to explore how this literature could ‘value add’ to the practices in your workplace.
- Another Australian text that you may find useful in exploring practice is ‘Solution Focused Nursing: Rethinking Practice’ written by Margaret McAllister.

**References**


**Checklist**

By now you should have analysed and mapped your clinical setting according to the Foundation Principles, identifying areas your practice change needs to address. You can use the table below to assist you to review this process.

<table>
<thead>
<tr>
<th>What your model needs to consider ...</th>
<th>Examples of data sets for information</th>
<th>Problems that arise if inadequately addressed</th>
</tr>
</thead>
</table>
| **Patient-centred care** | Are staff taught to identify and provide for patients needs? (refer page 19) | • patient satisfaction  
• patient quality of life surveys | • patient dissatisfaction |
| **Best use of nursing and midwifery resources** | Do you have the appropriate levels and numbers of staff to provide appropriate care? (refer page 21) | • staff turnover  
• staff absenteeism  
• BPF - NR | • increased staff turnover  
• absenteeism |
| **Safe practice** | Is care provided safe, that is, sufficient resources and adequate monitoring and supervision (refer page 24) | • PRIME incident data | • increased sentinel events |
| **Quality care – use of evidence** | Are best practice guidelines incorporated into practice? (refer page 25) | • benchmark L.O.S.  
• re-admission | • inefficient use of health service resources |
| **Trends in contemporary healthcare practice** | What are the issues affecting care delivery to your client group? (refer page 26) | • professional literature/media reports | • inefficient use of health service resources |

This information (+ data) informs the modifications that are needed in any practice change. You now know the areas your new changed practice needs to address. These areas will inform the goals that you will establish.
### Framework map

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Evaluate your success</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders</td>
<td>Implement your strategies</td>
<td>Resources</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Assess your environmental readiness</td>
<td>Resources</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Decide on your goals</td>
<td>Resources</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Analyse your practice setting</td>
<td>Resources</td>
</tr>
</tbody>
</table>

### Foundation principles

- Patient-centred care
- Best use of nursing and midwifery resources
- Safe practice
- Quality care — judicious use of evidence
- Trends in contemporary healthcare practice

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**Chapter 4: Decide on your goals**

Do you know what goals are needed to address gaps in service delivery?

The purpose of this chapter is to help you decide on the goals that will demonstrate that you have achieved your desired practice standard. It also helps you determine the resource requirements based on the gaps identified in the previous chapter (Chpt 3).

### 4.1 Clarify what you want to achieve

It is important that you decide on the goals that you aim to achieve; they may relate to better patient-centred care, safer practice, more efficient use of resources, the application of ‘best practice’, or the implementation of an innovative treatment. They must be realistic, achievable and measurable so that they clearly guide the changes that need to be undertaken. Once the practice-changes required to achieve the goals have been planned you need to determine the resources that are required to facilitate the change processes. Of particular importance is consideration of staffing requirements because when changing a model of care your human resources (social capital) are your greatest asset in achieving your desired aim.

### 4.2 Determine the nursing and midwifery requirements

In order to determine the staffing requirements for the safe provision of nursing and midwifery care that is needed to achieve your goals, it is necessary to consider competency of staff mentors, the organisation of their work, and their degree/levels of satisfaction.

**Assessment question:** How do you assess the quality of the workforce and guide its subsequent development?  
**Foundation Principle 2.**

- Are nursing and midwifery staff educated and competent to deliver the service required by the patient group(s)?
- Are there systems and processes in place that ensure all staff are orientated to the physical, organisational, cultural and social aspects of the workplace? (An outline of appropriate processes are specified in QH Nursing and Midwifery Staff Development Framework) (refer pages 34-35).

Continuing education support and career development have a positive impact on staff retention in the workplace.

---

**When embarking on making changes to practice it is essential to:**

1. Decide on your goals
2. Describe the changed practices required to achieve your goals
3. Determine the qualities of the nursing and midwifery staff needed to deliver the required services.
Assessment question: Is care organised so that nurses can optimally deliver?

Foundation Principle 4.

- What are the issues that currently hinder practice that could be improved?

A study into the complexity of nursing has identified that the major problems for a group of medical/surgical nurses were:
- missing equipment or supplies
- repetitive travel (supplies were located in a central store away from the patient areas where they were needed)
- interruptions by other allied health workers and/or families
- geography of assignment, that is, the patients the nurses were assigned to were not always co-located in close proximity
- waiting for systems or processes, for example, hospital discharge
- difficulty accessing resources to continue or complete care, for example, locating the correct personnel for assistance or information; inconsistencies in care communication from multiple healthcare providers.

(Ebright, Patterson, Chalko, and Render, 2003).

Other issues may be related to the provision of non-treatment care such as meals, finding linen or vases for flowers, patient transport, answering telephone calls or making telephone enquiries, a lack of portable (cordless) telephones, answering enquiries (in person or via telephone) for other patients or health professionals or finding healthcare records.

These problems need to be addressed through exploring the organisation of work and ward-based model of care delivery. This usually involves key stakeholders, obtaining evidence, providing further education/training to improve the required skills of staff, and ensuring an environment receptive to change.

Information/data sets that can provide information about whether the best use of nursing and midwifery resources is being attained include:
- staff satisfaction
- staff turnover (vacancy rates/terminations and transfers)
- staff absenteeism
- staff quality of life/perceived health status.

Contact your Human Resource Department for information about staff movements.

Upon considering your answers to the preceding questions use the table below to ascertain the staffing that will best meet your specific goals:

<table>
<thead>
<tr>
<th>Nature of work</th>
<th>Nurse or midwife</th>
<th>Non-nurse</th>
<th>Time</th>
<th>When</th>
<th>Where</th>
<th>Level of skill/knowledge required</th>
</tr>
</thead>
<tbody>
<tr>
<td>You need to describe the nature of the work that needs to be performed to reach your desired goals.</td>
<td>Does the work need to be performed by a nurse, midwife or non-nurse – refer Foundation Principle 2 ‘Best use of nursing and midwifery resources’ in particular scope of practice framework for nurses and midwives (2005) (Refer <a href="http://www.qnc.qld.gov.au">www.qnc.qld.gov.au</a>)</td>
<td>When considering these factors it may be useful to give consideration to a suitable practice model (eg. case management, team nursing, patient allocation) that can provide the requisite service at an appropriate time and place. For an overview and references for further reading about delivery of nursing and midwifery practice – refer to the appendix.</td>
<td>The processes and structures for planning and supporting the relevant education needs can be sourced from qheps.health.qld.gov.au/ocno/docs/qhnmsdf.pdf Explained next page.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
*For further guidance about structures and processes to develop staff, refer to the Queensland Health Nursing and Midwifery Staff Development Framework at: qheps.health.qld.gov.au/ocno/docs/qhnmsdf.pdf
When the composition of staff is determined and the necessary skill set is identified, you need to establish how you will develop and maintain this level of competence/expertise.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency/Date</th>
<th>What needs to happen?</th>
<th>By whom (designated responsibility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory skills eg. Manual handling</td>
<td>annually February</td>
<td>The specific content of the training and upskilling will be informed from the previous mapping exercise where the knowledge, skills and abilities to provide the designated service were identified.</td>
<td></td>
</tr>
<tr>
<td>Basic life support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training/upskilling eg. Use of CPAP mask</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration cytotoxic agents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge planning protocols</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support/Clinical supervision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Succession Planning</td>
<td></td>
<td>The forms of supervision or support that you provide will need to fit with the practice model eg. patient allocation, case management. It is imperative that consideration is given to forms of support simultaneously with the organisation of care in your area/facility.</td>
<td></td>
</tr>
<tr>
<td>What does the staff complement need to look like in the future? Have you undertaken succession planning to provide for these needs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership Behaviours eg. Decision-making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical thinking</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References

Ebright, E, Patterson, E, Chalko, B & Render, M 2003, ‘Understanding the complexity of Registered Nurse Work in Acute Care Settings’, *Journal of Nursing Administration*, vol. 33, no. 12, pp. 630-638.


Checklist

By now you should have:

1. Clearly articulated goals that address the gaps in service provision.
2. Identified staffing requirements (including knowledge, skills and abilities) required of staff and a plan that outline the specific education and staff development activities required by staff to reach this.

If you have completed this checklist, you will have decided on your goals and planned your setting requirements to attain these goals.
Chapter 5: Assess your environmental readiness

The purpose of this chapter is to assess environmental readiness for the goals that you have decided (Chpt 4). This includes undertaking stakeholder and resource analysis to compare the required resources – human, organisational (managerial and cultural), physical and financial with the available resources. This assessment identifies the possible discrepancy between the required and available resources and informs the content, structure and process of the implementation plan.

Framework map

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Activity</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement your strategies</td>
<td>Implement your strategies</td>
<td>Resources</td>
</tr>
<tr>
<td>Assess your environmental readiness</td>
<td>Assess your environmental readiness</td>
<td>Resources</td>
</tr>
<tr>
<td>Decide on your goals</td>
<td>Decide on your goals</td>
<td>Resources</td>
</tr>
<tr>
<td>Analyse your practice setting</td>
<td>Analyse your practice setting</td>
<td>Resources</td>
</tr>
</tbody>
</table>

**Foundation principles**

A number of important environmental factors that strongly influence the likely success of practice change need to be considered when developing your implementation plan:

1. Recognition of the importance of the context (workplace culture)
2. Identification of enablers and barriers that influence practice change
3. Assessment, collection and mobilisation of the required resources
4. A comprehensive communication strategy that clearly expresses the ideas and activities required to achieve change
5. Identification of risk factors (to be formulated into a risk management plan).

5.1 The importance of context

‘Culture eats strategy for breakfast’ (Elwyn, 2006)

This quote emphasises the reality that strategies and processes, irrespective of their quality, will not be adopted if they are not accepted by staff, individually or collectively, in the practice setting. If the workplace culture is resistant to change then it is unlikely that change will occur and/or endure, therefore it is imperative that consensus and agreement is achieved prior to implementation.

Most of the nursing literature relating to change management emphasizes the importance of leadership. Greenhalgh, Robert, MacFarlane, Bate and Kyriakidou (2004), Rycroft-Malone (2004), Osbourne and Gardner (2005), and Henderson and Winch (2007) espouse the value of a visionary, transformational ‘hands-on’ leadership approach, role clarity, effective organisational structures and teamwork, democratic-inclusive decision-making processes, devolution of decision-making to frontline teams, and an enabling/empowering approach to teaching, learning and managing.

Strategies to develop ‘change friendly’ workplace cultures were developed in the United Kingdom (Nursing, Clinical and Practice Development Units/Programs) and the United States of America (the Magnet Recognition Program) and have been utilised in other countries including Australia. They all highlight the need to establish a culture that promotes and supports inquiry and practice change through the provision of autonomy and authority to staff in the practice setting. Changing a culture requires examination of the history of that culture so that the enablers and barriers that affect practice change can be identified, contextualised and constructively managed. This is crucial if the ‘new’ practice model is to be successfully implemented. It permits the core change-management team to enlist the cooperation of local champions and those with authority to supply resources and positive leadership.

Management tools, including PEST (assessment of the political, economic, social and technological factors that affect an organisation) and SWOT (analysis of the internal strengths and weaknesses of the organisation [workplace], and the external opportunities and threats to the organisation) can be used to identify enablers and barriers.
5.2 Identification of enablers and barriers

Enablers
These are people who facilitate progress by providing others with the resources, authority, or opportunity to make possible a change in the service model that guides nursing and midwifery practice. They are not the people who directly undertake the change activities – that is the necessary function of the staff in the workplace.

Identifying enablers: conduct a stakeholder analysis
Stakeholders are individuals, groups and/or organisations with a vested interest in your decision to change your practice model. They may be influential in the practice change process and/or directly or indirectly affected by the outcome. It is essential that you engage with them in the most appropriate way so that they support the proposed change.

Stakeholder analysis involves three steps:
- identify individuals and groups that are directly and/or indirectly associated with the practice change
- categorise and prioritise their interest in, and influence on, the practice change process
- develop an understanding of their likely feelings and reactions (eg. their level of cooperation or resistance).

The power/interest grid below allows you to prioritise your stakeholders and develop strategies that secures their assistance (or minimises their impact if they aren’t cooperative).

Making the most of the enablers: engaging stakeholders
Identification of your stakeholders allows you to develop a strategy to engage them in the change process, communicate with them, and gain their support.

Leaders
Leaders within the organisation need to be involved to support and reinforce the proposed changes. When seeking support from the leadership team, it is worthwhile clarifying what you would like from them, eg. do you want them to talk with the staff group, or distribute notices/emails from their office so that their commitment is known to the organisation?

Champions (opinion leaders)
The involvement of opinion leaders is crucial; they need to be identified and their role clearly explained. They are often most effective if they are recognised within the organisation as internal leaders, although external specialists may be required to assist them or to fill the role if they are not present or available. Opinion leaders can be influential in communicating the value and relative advantage of adopting the practice changes that have been clearly identified. However, they need to be carefully selected (ie. be well regarded by most staff) so that they do in fact make a difference. They should provide feedback about staff attitudes and opinions – what is working and what is not, and how staff are feeling about the outcomes of the change process.

An advantage of local champions is that they are often known to most of the stakeholders, have knowledge of readily available resources and networks, and have organisational authority (which may relate to their managerial, educational or professional role). Where possible, it is important to utilise local facilitators from the workplace. However, if they are not achieving the necessary changes (eg. they are too busy, lack effectiveness, or are inexperienced) then it is necessary to engage the services of additional (possibly external) facilitators. They may be recruited from other areas within the organisation, other related organisations, the education sector, or as consultants with recognised expertise and experience.
Staff
Staff support is more likely if they understand the reasoning behind the decision to change the nursing and midwifery practice. This can be achieved by involving them in the change process as early as possible, perhaps in the analysis stage where the Foundation Principles are discussed, because this forms the basis of the practice change plan. All staff are responsible for implementing the change, therefore it is essential that you encourage their participation, for example by talking with them about the need for change and inviting them to explore ‘what the changes mean for them.’

Patients
Communities and patients are the focus in the healthcare system, therefore it is essential that they are actively involved in their healthcare and the healthcare system. Engagement with patients can occur in a number of ways, for example, patient satisfaction surveys, newsletters that provide information, or focus groups and consultative forums that solicit their interest and obtain feedback.

Barriers
There are a number of impediments that can hinder or prevent practice change. They may be internal (within the workplace or organisation) or external (a lack of support from other health professionals), physical (inadequate space or equipment), cultural (resistance to change), legal or political (outside the current scope of practice), or related to human resources (insufficient staff or unskilled staff).

5.3 Resources
A lack of resources through inadequate planning or insufficient ‘buy-in’ from the key stakeholders is recognised as a major barrier to the implementation of change. Consideration needs to be given to the following resources that are needed to reduce the impact of potential barriers:

- Time is required for staff to engage in the processes necessary for shifting attitudes and gaining agreement about the change process. This may be in the form of workshops, de-briefing sessions, staff relief, or reduced workloads
- Information is needed if staff are going to engage in the change process, that is, become motivated to contribute to the team effort.

Note: When planning resources it is useful to prepare a business case outlining your needs. It is important to commence these processes early in the planning phase. (Consider preparing a business case as soon as possible).

Assessment question: Do you have sufficient enablers to motivate the staff in the workplace to successfully implement change? (Refer to the list below.)

Enablers
- Supportive management
- Local opinion leaders
- Project management skills
- Facilitators
- Change agent skills
- Knowledgeable staff members

Barriers
- Inefficient management processes
- Lack of local resources, especially local champions
- Lack of time
- Lack of motivation
- Too many other projects/ imperatives

Too many barriers and not enough enablers mean that you are unlikely to succeed implementing your planned changes.

5.4 Communication systems
Once you have determined your goals, understood your context, including recognition of your enablers and barriers, and also resources, it is timely to communicate what it is you are seeking to achieve.

All stakeholders (staff and patients) need to be informed about the proposed practice change, and their involvement encouraged by requests for ‘feedback’ and attendance at meetings. Within a large organisation such as a hospital, an internal communication strategy needs to be developed, implemented and monitored to inform and involve all stakeholders.

The use of a combination of communication strategies is most likely to be successful. Initially these could include notices (posters, newsletters, screen-savers) and information sessions either in routine meetings or as special events to introduce the practice changes to staff and other stakeholders. This could be followed up by interactive meetings to further explain the ideas, seek
support and input from interested stakeholders. This needs to be done with consideration of environmental readiness factors, such as the busyness of the workplace, the experience, knowledge, interest and available time of the staff and other stakeholders, and the degree of support from managers and health professionals.

Effective communication can overcome difficulties such as limited time, a diverse group and/or a large number of stakeholders, and multiple practice sites and/or large areas. Of equal importance is the quality of the information being provided. It should be concise and simple, and tailored to take into account the knowledge level, time constraints, and the information technology (IT) equipment and technical skills of the intended recipients. Inadequacies in these areas often result in stakeholders losing interest and may lead to the failure of the practice change process due to lack of motivation.

Developing the communication plan involves:
- selecting the important information and key messages that need to be communicated
- identifying the availability of existing communication and marketing units such as a media liaison unit
- locating all possible methods and systems for dissemination of information (eg. internal newsletters, QH electronic bulletin boards, volunteer staff to distribute letters, and at ward meetings, grand rounds, in-service education sessions, orientation sessions)
- using the most appropriate communication tool for the particular desired result, for example, bulletin boards are best for information dissemination while ward meetings that can be interactive are best to elicit opinions.

**Checklist for effective communication**
- The message is clear and consistent
- Identify relevant groups/individuals
- Utilise existing channels of communication
- Communicate in a timely manner
- Escalate from information boards to more interactive style of communication
- Consider the environmental context eg. busy periods in the day
- Publicise successes.

**Sample communication plan**

<table>
<thead>
<tr>
<th>Target group</th>
<th>Method of consultation</th>
<th>Means of feedback</th>
<th>Actioned by</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public/visitors Risk Rating – High</td>
<td>Display in lift foyer of orange and blue</td>
<td>Suggestion box with pre-prepared questionnaires</td>
<td>Marketing and Communication Unit Planning and development admin officer</td>
<td>June</td>
</tr>
<tr>
<td>Ward staff Risk Rating – Low Will be grateful for involvement</td>
<td>Poster in ward directing staff to provide feedback Reminder at handover or bed management meeting to provide feedback</td>
<td>Online email function directed to Rita’s support officer</td>
<td>Marketing and Communication Unit Planning and development compilation of email</td>
<td>June</td>
</tr>
<tr>
<td>Support staff Risk rating – Low Likely low involvement</td>
<td>Display in staff dining area</td>
<td>Suggestion box with pre-prepared questionnaires</td>
<td>Marketing and Communication Unit</td>
<td>June</td>
</tr>
</tbody>
</table>
5.5 Risk Management

When considering the factors that determine the environmental readiness of the workplace it may be helpful to develop a risk management plan.

Risk management is a process that involves the recognition of risk factors that could affect an organisation or outcome, an assessment of their likely incidence and the severity of their effect, the development of strategies to manage them, and planning to mitigate the risk using managerial resources. (Refer to the QH Managing Organisational Change – ‘How To’ Guide, 2002, for further information).

Risk factors for implementing change can be internal or external. They include:

- changes to the enablers and barriers
- changes to the workplace such as increased numbers of patients or patient acuity
- staff movement or shortages
- changes to the practice change management team
- organisational changes such as loss of a major sponsor
- cultural changes such as increased resistance
- delays in achieving consensus and team building
- political changes
- communication failures.

Risk Management Plan: These identified risks are often derived from your barriers

<table>
<thead>
<tr>
<th>Activity</th>
<th>Level of risk</th>
<th>Likelihood of risk</th>
<th>Mitigation strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Checklist

By now you should have:

1. Identified the culture of your workplace
2. Listed enablers and barriers relevant to your practice situation
3. Determined and organised resources necessary for the implementation of change
4. Developed a communication plan (ideally with dates)
5. Compiled a risk management plan.

If you have completed this checklist, your environment should be ready for the implementation of change.
Chapter 6: Implement your strategies

Do you know the most effective strategies to bring about changes in practice?

The purpose of this chapter is to guide you through the processes as to how the changes can be achieved. Addressing the education and staff development needs of your workforce (as determined in Chpt 4) can constitute a major component of the implementation process. Consideration of the enablers and barriers and availability of resources (identified Chpt 5) will shape how staff development and other accompanying activities are conducted.

Framework map

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Evaluate your success</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders</td>
<td>Implement your strategies</td>
<td>Resources</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Assess your environmental readiness</td>
<td>Resources</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Decide on your goals</td>
<td>Resources</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Analyse your practice setting</td>
<td>Resources</td>
</tr>
</tbody>
</table>

Four components of the implementation process are discussed:

1. Gain consensus
2. Enact enablers and overcome barriers (identified in Chpt 5)
3. Action strategies (based on goals identified in Chpt 4)
4. Maintain momentum

6.1 Gain consensus

The capacity of an organisation to effectively and efficiently achieve change is predicated upon its ability to reach an agreement as to its purpose, goals and direction. The purpose of an organisation’s mission statement is to publicise its goal(s) and provide a reference for its stakeholders. The building of consensus between the stakeholders involves the development of a mutual understanding so that they share an agreed goal, a common language and terminology, a joint strategy to achieve change, and a predetermined timeframe.

Before continuing further it is necessary to add a note of caution. A lot has been written about change-management and how it can best be accomplished. Indeed, there are a plethora of books and articles that claim to have ‘the answer’. It is important to note that when exploring the best motivators of change in nursing and midwifery practice, the most useful assistance can be found by examining the nursing literature rather than exploring general business literature or even medical literature. Therefore incentives (either internal or external) must be relevant to, and also desired by, nurses and midwives.
In order to achieve the desired outcomes, it is necessary to build consensus through discussions between opinion leaders and the stakeholders where agreed outcomes are determined after consideration of all of the relevant factors (including human and financial resources).

There is greater acceptance in the workplace when stakeholders are involved in the planning and implementation of a ‘new’ practice model that will affect how they deliver care. Because the intended outcome of the change process is a ‘new’ way of practicing for all staff in the workplace, their participation during each of the stages of the change management process is essential to reach consensus. When they have direct influence over the changes that are being made to their practice, they can become part of the ‘change management team’ and have ownership of the process. It is therefore important to plan interactive sessions where the roles of all participants are identified. These roles then need to be communicated throughout the workplace and regularly reinforced at appropriate forums such as ward meetings.

### Develop a schedule for achieving consensus

#### Consultation Plan

<table>
<thead>
<tr>
<th>Activity/method</th>
<th>Members</th>
<th>Frequency</th>
<th>Responsible person/group</th>
</tr>
</thead>
<tbody>
<tr>
<td>leadership team meetings</td>
<td>hospital/nursing midwifery executive</td>
<td>fortnightly then monthly</td>
<td>DON</td>
</tr>
<tr>
<td>staff forum</td>
<td>all staff groups</td>
<td>monthly</td>
<td>project officer</td>
</tr>
<tr>
<td>unit based meetings/interactive education sessions</td>
<td>local teams</td>
<td>weekly</td>
<td>Nursing Unit Manager/Nurse Educator/Clinical Facilitator</td>
</tr>
</tbody>
</table>

### 6.2 Enact enablers and overcome barriers

As part of the process of gaining consensus or ‘buy-in’ it is essential that you are aware of and manage the enablers and barriers. Intervention strategies need to be tailored to maximise the use of enablers and overcome the identified barriers (as discussed in Chpt 5). If the potential barriers have been examined, then specific interventions that address them will be more likely to succeed. Multi-faceted interventions that address specific barriers are more effective than single or ‘non specific’ interventions.

### 6.3 Action strategies

You will have previously decided your goals and identified education needs (Chpt 4), recognised enablers and barriers (Chpt 5), targeted resources and possibly commenced communicating your intended changes. It is time to develop a specific implementation plan. You will need to provide detail so that everyone who is involved can clearly see ‘who is doing what and when’. You need to think carefully about how the change will be achieved, and how these achievements will be measured.

#### Tips for starting

Tailor strategies to take advantage of available resources and support. Start with a small aspect of the change that can be readily achieved so as to maximise the chance of success. This also allows you to undertake a ‘dummy’ run so that you can test your implementation strategy. It is essential that this ‘test’ is closely monitored so that any necessary adjustments can be made to better adapt it to the local workplace.

#### Strategies

- Meetings
- Behaviour change strategies
- Feedback loop

#### Meetings

Meetings are an important aspect of the implementation process.

Meetings are an important way for two or more people to come together to discuss the implementation of practice-change. Regular planned meetings with all the key stakeholders should be conducted during the implementation phase. Informal and ad hoc meetings are also appropriate because they allow for consultation and resolution of unexpected problems. The value of meetings is maximised if the messages that are being communicated are clear and if the
appropriate audience is present. They should include an agreed time and suitable venue, agenda, effective chairperson, formalised procedures, minute recording and task lists (recording who is taking what action and by when).

Schedule regular Formal meetings (at least weekly) during implementation to obtain feedback and discuss issues arising from the ‘new’ practice model. They provide the opportunity to evaluate the success of the implementation and identify issues, situations and people that are creating barriers to the change process. The meetings should focus on situations where change is not forthcoming despite the provision of more resources such as personnel and education. Often targeted responses such as ‘new’ (changed) work practices such as patient (versus task) allocation, the rescheduling of shifts (start times or length), different skill mix of staff, or educational strategies that provide learning experiences in local situations with prompt and personalised feedback are more effective than providing more (staff, training or equipment). Also, provide ongoing support during the trial period to help users along the learning ‘curve’.

Facilitation is an important component of the success of these meetings. Establishing, leading, and guiding meetings such as these can be difficult. Nurses and midwives need to develop skills in facilitation if they are going to guide change in their organisation. The Queensland Health Change Management – Tools and Processes for Implementing Organisational Change – How To... Guide (QH, 2002) discusses several ‘quality tools’ that can be used for managing meetings, collecting ideas, analysing processes and collecting information. Tools for managing meetings and collecting ideas include brainstorming and affinity diagrams (a paper or ‘hard’ version of brainstorming for when groups may not be democratic and/or there is unequal power distribution) (QH, 2002b).

Meetings provide immediate feedback on changed activity. Prompt feedback that is relevant and swiftly acted upon reassures stakeholders and encourages participation in the implementation process.

Behaviour change strategies
Facilitators are beneficial because they act as leaders, educators, motivators, managers and ‘supporters’. The nature of support they provide in their role is guided through the needs of the staff (especially if they are internal to the organisation). Their role may include (through conversation that garner support) assessing the mood of the workplace, the opinions of staff, and the levels of understanding of the stakeholders (whether more or further education is required). They can provide informal education sessions and counselling when necessary that allows for a prompt response to an actual or looming problem. Their presence can reassure other staff that they are ‘one of us (the workers)’ and they can role-model the desired activities such as the ‘new’ practices associated with the changed practice model.

Education sessions
Implementing change invariably includes staff needing a new set of skills/practices. Therefore continuous education sessions are an essential part of the change process. Depending on whether the change requires a new skill set or knowledge acquisition will determine the format and conduct of such sessions.

Role model function
The role-model function is especially important if staff are having difficulty integrating the changes into their practice. While it is intended that the implementation plan accommodates the application of the ‘new’ practice to the local setting, how staff are able to perform this function in the workplace is less predictable, and therefore ongoing evaluation (albeit by the ‘local’ facilitators) needs to assess this effect. Local facilitators can use their knowledge and experience to demonstrate desired practices commensurate with the changes being implemented (Eaton et al. 2007).

6.4 Maintain momentum
Analysis of research findings in the Registered Nurses Association of Ontario Toolkit (2002, p. 50) found that educational outreach visits, reminders, interactive educational meetings, and multi-faceted interventions including audit and feedback, and marketing were all effective in sustaining momentum in implementing change. Where only one or two of these interventions were used or when they were patient mediated they were only occasionally effective. Multiple dissemination was most effective.

Educational interventions that require participation by health professionals and other stakeholders are the most effective methods to bring about a change in behaviour necessary for implementing changes in practice.
Educational outreach visits: These are pre-organised sessions where ‘modelling of care’ opinion leaders meet with discrete groups (stakeholders) within the targeted workplace to provide information and direction that assists the stakeholders to further engage with the implementation.

Reminders: These can be personal (if time permits) or more general, ranging from personal visits, telephone calls, emails, screen savers, posters and flyers to advertisements in existing media. They should be brief and provide both details and a request for a stakeholder response (i.e. to perform a particular activity such as submit information, attend a meeting to assist with continued motivation of the changes) that ensures activity during the implementation process is sustained.

Interactive educational meetings: These are pre-organised meetings that seek to address issues arising through the implementation through discussion and negotiated agreement. As with any formal meeting, there needs to be a chairperson and/or a facilitator. A written agenda should be distributed prior to the meeting highlighting the topics for discussion and the schedule and a written record of the proceedings should be compiled. By the conclusion of the meeting, what is to be done, by whom, and by when should be agreed and noted to assist with ultimate resolution of the issues arising.

Planning map for resources needed for education/staff development sessions

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Cost</th>
<th>Implementation/who</th>
</tr>
</thead>
<tbody>
<tr>
<td>staff attendance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>backfill costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*refer to Business planning framework for further tools

Resources – non-labour (teaching and IT support)

<table>
<thead>
<tr>
<th>Item</th>
<th>Number</th>
<th>Cost</th>
<th>Implementation/who</th>
</tr>
</thead>
<tbody>
<tr>
<td>teaching materials/equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>room bookings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>computer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>phones</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>office equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>monitoring of processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>data/record management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>filing archiving space</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Multi-faceted interventions – audit and feedback, reminders, and marketing: These include the use of a combination of strategies including the collection, analysis, and consideration of prescribed data (audit and feedback), reminders (see above), local consensus (see above), and marketing to monitor implementation of change, and maintain ‘ownership’ by stakeholders.

Feedback loop

Your plan needs to include an ongoing monitoring process so that you can assess the effectiveness of each component of your implementation strategy (the change process), its effect (both desired and unexpected) on the workplace, and outcome measures (ideally these will be the same that you used in the initial analysis so that a direct comparison can be undertaken).

To assist with the collection and analysis of information a number of aids can be used. These include ‘run charts’ to track changes over time (using a graph format) and, ‘control charts’ (that are similar to ‘run charts’ but with limit lines – upper and lower). Aids may also include check lists that collect specific (quantitative) data (the item or behaviour is either present or absent), flow charts using a ‘universal’ language/meanings of symbols (a method of process analysis – modelling the process so that it’s more
‘concrete’), and Pareto charts that involves the identification and prioritisation of the five main issues relating to the issue being investigated and quantification of impact of each issue (QH, 2002b). The Pareto principle or 80/20 rule states that 20% of the factors causes 80% of the problem, and therefore 20% of the management effort can fix 80% of the problem.

References


Checklist

By now you should have:

1. Devised a schedule for achieving consensus
2. Developed strategies that
   • address the needs of your workplace
   • overcome barriers and draw on enablers
   • utilise effective behaviour change strategies.
3. Implemented a comprehensive monitoring and feedback loop

If you have completed this checklist, your environment should be ready for the implementation of change.
Chapter 7: Evaluate your success

Is the ‘new’ model successful in addressing the issues that led to its introduction? 
Are there any unexpected consequences arising from the model?

The purpose of this chapter is to introduce you to a range of evaluation strategies. Evaluation is essential to monitor the quality of care provided to patients. This data can inform the team about the success of the changes.

Framework map

<table>
<thead>
<tr>
<th>stakeholders</th>
<th>evaluate your success</th>
<th>resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>stakeholders</td>
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<tr>
<td>stakeholders</td>
<td>assess your environmental readiness</td>
<td>resources</td>
</tr>
<tr>
<td>stakeholders</td>
<td>decide on your goals</td>
<td>resources</td>
</tr>
<tr>
<td>stakeholders</td>
<td>analyse your practice setting</td>
<td>resources</td>
</tr>
</tbody>
</table>

Foundation principles

Baseline data is needed to ‘set the scene’. Before commencing practice change it is necessary to seek the answers to a number of questions including: ‘Where are we, and where do we want to go? (refer Chpt 3). Once change has been initiated then it is important to assess whether the change strategies have been effective (ie. whether practices have been modified, thereby ensuring that the model has been successfully implemented). It is important to ask the questions: How is the process going? ‘Are we doing the right thing, for the right people, at the right time?’

The evaluation process should be initiated early in the practice change process and occur concurrently with the implementation of this framework. There should be a number of different types of evaluation depending on the stage of implementation. At each stage (eg. analysis of practice setting, deciding on goals, assessment of staff and where appropriate patients should be undertaken prior to moving to the next stage. It is not absolutely essential that each stage is evaluated formally, at times, informal feedback can suffice (refer Action Strategies, Chpt 6.3).

The evaluation plan should be as simple as possible and should include structure, process and outcome indicators. The use of existing resources such as data and tools and the experience and advice of others (and the expertise of recognised consultants) simplifies the evaluation process, reduces the anxiety that can be associated with the development of a ‘new’ evaluation tool, and can save time and possibly money. For the formal evaluation of outcomes, it is important to use existing measurement tools that are credible, reliable and have been validated.

Its focus will vary according to the stage of this framework to which the ward/work unit has proceeded (ie. analysis of the practice setting, assessment of environmental readiness, the effectiveness of implementation strategies or staff and patient outcomes). It is helpful if evaluation can be managed as a discrete component of this framework by a staff member(s) with primary responsibility for evaluation.

There are a number of steps in evaluation which include:

1. Clarifying the purpose of the evaluation
2. Selecting the tools to be used in the evaluation
3. Developing the evaluation plan
4. Putting the evaluation plan into action
5. Disseminating your findings

7.1 Clarifying the purpose of the evaluation

The purpose of undergoing a change in the practice model is to positively affect the outcomes of care for patients and/or nurses and midwives. It is important to evaluate the impact of that change using evaluation processes that your healthcare organisation employs (if they are relevant and appropriate). Porteous, Sheldrik, and Stewart (1997, in RNAO, 2002, p. 58) describe evaluation as a process that ‘systematically gathers, analyses, and reports data about a program to assist in decision-making.’ Assessment determines the effectiveness of the implementation strategy, and the outcome evaluation demonstrates whether the expected changes have been achieved, and if so, if the benefits were worth the costs?

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Manias (2005, p. 169) notes the importance of clearly explaining the terms used to define the parameters of the program evaluation. They include the goal, outcome, strategy and objectives, and performance indicators and measures. There are several ways of interpreting these terms and it is therefore important to reach a consensus as to their meaning and clearly define those meanings (see the table below). Using the work of Owens and Rogers (1999, in Manias, 2005, p. 169), Manias identifies five forms of evaluation that provide information relating to the purpose, focus and timing of data collection: proactive (synthesis of what is known about the ‘old’ model), clarificative (provides an explanation as to why the ‘old’ model was used), interactive (focusing on how the ‘new’ model could improve outcomes), monitoring (justification and refinement of the ‘new’ model), and impact (justification and accountability of the ‘new’ model for the latest outcomes).

**Definitions of evaluation terms**

<table>
<thead>
<tr>
<th>Goal</th>
<th>The aim that the initiative seeks to achieve in general</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>The changes in attitude, behaviour, health condition or status that the initiative seeks to achieve. It also concerns the learning outcomes in relation to process, knowledge and skills</td>
</tr>
<tr>
<td>Strategy</td>
<td>The plan used to achieve the desired outcomes</td>
</tr>
<tr>
<td>Objective</td>
<td>The specific targets that need to be accomplished in an effort to achieve the outcomes</td>
</tr>
<tr>
<td>Performance indicator</td>
<td>The responses or measured changes in attitude, behaviour, health condition or status that indicate progress towards objectives and outcomes</td>
</tr>
<tr>
<td>Performance measure</td>
<td>The way in which changes in attitude, behaviour, health condition or status will be measured</td>
</tr>
</tbody>
</table>

(Manias, 2005, p. 169)

### 7.2 Selecting the data collection tools to be used in the evaluation

#### Retrospective data

Retrospective information can be collected to provide information about the existing model. This can be through an examination of patients’ old notes/healthcare records or through existing databases.

#### Audit

The Government of the United Kingdom, in the White Paper ‘Working for Patients’ defines audit as:

‘The systematic critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of the resources and the resulting outcome and quality of life for the patient.’

It is concerned with current practice, that is, the care given, the resources used and the benefit or outcome.

Nursing Audit has been defined as:

‘A system which allows the review of performance, the recognition of good practice and identification of deficiencies so that improvement in the care process can be made.’

Dawes (2005) notes that while it is easy to collect data, it is difficult to set the standards or criteria for the measures within the evaluation.

#### Balanced Scorecard

The Hospital Reporting System developed by Queensland Health (1999) involves the collection of a large amount of data relating to activity, staffing and performance that could be used as part of the evaluation process. The Business Planning Framework: Nursing Resources – Resource Manual (Queensland Health, 2008 refer website) contains a section relating to the evaluation of performance. Module 5: Evaluate Performance includes a range of indicators that are used to measure organisational performance in relation to the patient/client, the staff, and the organisation (both financial and process) (Queensland Health, 2008 refer website). It discusses the need for a ‘Balanced Scorecard’ that comprises both financial and non-financial performance, and while this may be of limited assistance to you, the Balanced Scorecard – Nursing that evaluates organisational aspects relating to access, activity, efficiency, financial, innovation, quality and staff should be more relevant to the evaluation criteria of the model-change process.
Examples of scorecard indicators for medical/surgical wards including the following:

The Client
- Complaints
- Satisfaction
- Incidents (includes falls, medication errors)
- Re-admission rates
- Infection rates
- Complications.

The Staff
- Absenteeism (including sick leave, worker’s compensation)
- Incidents
- Re-deployment
- Turnover
- Education hours
- Satisfaction.

The Organisation – Financial
- Budget integrity
- Annual leave
- Workforce data
- Overtime ($) 
- Worker’s Compensation ($) 
- Cost per HPPD.

The Organisation – Process
- Activity
- The extent to which service objectives have been achieved
- Hours per unit of activity
- The extent to which planned skill mix levels have been reached
- Level of non-clinical support
- Types of audit processes that are in place
- The levels of achievement of performance planning and review.

Descriptive information
When an explanation is desired rather than purely numbers the following methods can be useful:
- Interviews – face-to-face or telephone
- Focus groups
- Short answer/open-ended questionnaires.

Surveys
Surveys are a popular tool as they are relatively easy to distribute and can provide specific feedback about staff or patient situations. When the reliability and validity of tools have been established for your context, they can provide meaningful data to inform future directions.

Examples of tools that could be useful for feedback about the Foundation Principles include:

Patient-centred care:
QualPACS Survey (Wandelt and Ager, 1974) measures the quality of patient care provided by nursing staff. This comprised 38 questions grouped into four categories: physical care, general care, communication issues, and professional implications.

Princess Alexandra Hospital Patient Satisfaction Survey (Greenhill and Henderson, 1997). There are four general questions, 45 questions grouped into four categories – communication and education, nurses skills, behaviours and attitudes (of nurses), discharge planning, patient’s perceptions and feelings – and then 11 other general questions (a total of 56 questions).

Single symptoms:
- Pain – Visual analogue scale, Verbal descriptor scale, Numeric rating scale, Brief Pain Inventory (Cleeland and Ryan, 1994), Short Form McGill Pain Questionnaire (Melzack, 1987).

Generic instruments that pertain to Quality of Life (QOL) (specifically Health Related QOL):
- Sickness Impact Profile (SIP) (Bergner, et al. 1976).
- McMaster Health Index Questionnaire (MHIQ) (Chambers, et al. 1976).
- Medical Outcomes Study Short Form 36 (SF-36) (Ware, et al. 1993).

Condition (disease) specific instruments:
- Quality of Life Index – Cardiac Version III (QLI) (Ferrans and Powers, 1984).

Symptom specific instruments:
- Seattle Angina Questionnaire (SAQ) (Spertus, et al. 1995).

Individual aspects of HRQOL instruments:
Best use of nursing and midwifery resources: RN Job Satisfaction (Stamps and Piedmonte, 1986). Thirty-eight questions grouped into five categories: autonomy, task requirements, organisational policies, interaction, and professional status.

Ward Organisational Features Scale (WOFS) Survey (Adams, Bond, and Arber, 1995). This survey allows nurses to assess the organisational qualities of their workplace. It comprises seven general questions followed by 14 sections, each featuring at least four questions. The 14 sections are:
1. Staff organisation
2. Ward leadership
3. Job satisfaction
4. Professional relationships – nurses and medical staff
5. Professional relationships – nurses and other healthcare professionals
6. Professional relationships – nurses and other nurses
7. Influence – timing of ward and patient events
8. Influence – human and financial resources
9. Influence – ward management
10. Ward layout – influence on work (how easy is it to achieve each of the following)
11. Ward facilities – influence on work (what influence do the following have on your work?)
12. Quality of ward services – influence on work (what influence do the following have on your work?)
13. Professional practice (how often do each of the following happen?)
14. Hierarchical practice (how often do each of the following happen?)

Practice Environment Scale (PES) of the Nursing Work Index (NWI) (Lake, 2002) and later the Nursing Worklife Model (NWM) (Leiter and Laschinger, 2006). The five practice domains of the PES and NWM are:
- nurse participation in hospital affairs
- nursing foundations for quality of care
- nurse manager ability, leadership, and support of nurses
- staffing and resource adequacy
- collegial nurse-physician relationships.

### 7.3 Developing the evaluation plan

The evaluation plan is crucial because the collection of information as part of the analysis of the practice setting and throughout the practice change process allows the determination of baseline data, assessment of the effectiveness of the implementation strategies and the overall outcome of the changed practice model. Decisions about the evaluation criteria should be made in consultation with all of the stakeholders, especially those concerned with the implementation of the ‘new’ practice model (Dawes, 2005).

#### Sample evaluation plan to identify measures (and estimated time period)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Patient-centred care</th>
<th>Best use of nursing and midwifery resources</th>
<th>Safe Practice</th>
<th>Quality Practice</th>
<th>Contemporary trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to changed practice (baseline)</td>
<td>QualPACS</td>
<td>Staff satisfaction; Nursing worklife model</td>
<td>Numbers in workforce turnover; qualifications; Incident data</td>
<td>Nursing and midwifery worklife balance; Improved patient outcomes</td>
<td>Number of effectiveness clinical guidelines integrated into practice</td>
</tr>
<tr>
<td>During process</td>
<td>Patient satisfaction; patient complaints data</td>
<td>Staff satisfaction</td>
<td>Assessment of information received (through surveys)</td>
<td>Focus groups</td>
<td></td>
</tr>
<tr>
<td>At completion of implementation</td>
<td>QualPACS</td>
<td>Staff satisfaction; Nursing worklife model</td>
<td>Numbers in workforce turnover; qualifications; Incident data</td>
<td>Nursing and midwifery worklife balance; Improved patient outcomes</td>
<td>Number of effectiveness clinical guidelines integrated into practice</td>
</tr>
<tr>
<td>One year after changed process complemented</td>
<td>QualPACS</td>
<td>Staff satisfaction; Nursing worklife model</td>
<td>Numbers in workforce turnover; qualifications; Incident data</td>
<td>Nursing and midwifery worklife balance; Improved patient outcomes</td>
<td>Number of effectiveness clinical guidelines integrated into practice</td>
</tr>
</tbody>
</table>

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While it is important to limit the number of outcomes that are to be measured, it is necessary to consider a range of evaluation criteria that capture the model-change process. Oversimplification of the evaluation process can result in the loss of important data and render it meaningless. The categories of patient-centred care, safe practices, best use of nursing and midwifery resources, quality care, contemporary healthcare trends and financial costs can be useful for organising evaluation of outcomes (see below).

7.4 Putting the plan into action

- Identify resource – seek the assistance of human resources including those with experience in evaluation (ie. quality assurance/risk management staff, knowledgeable nursing and midwifery staff, researchers and epidemiologists, university faculty)
- Prepare plan – that outlines the goal, target group, structure, process and outcome objectives, measurement criteria, and the resources required (see previous sections)
- Develop a timeframe that accommodates the collection, analysis and reporting of the evaluative data
- Inform and where appropriate seek approval for the evaluation process from the relevant stakeholders, who may include patient forum or consumer groups, professional bodies (including industrial organisations such as unions and federations), ethics boards, and the executive of the healthcare organisation (which may include governing bodies)
- Prepare budget – including actual or possible sources of funds and detailed accounting of anticipated costs and expenses (including the purchase of consultants, staff time, equipment and written materials etc).

The collected data needs to be processed, evaluated, and reported in a timely manner to the relevant stakeholders. Responsibility should be allocated to a staff member and a reporting schedule specifying responsibilities, should be prepared and adhered to. It is essential that deadlines are met to ensure the timely communication of data that can be used to inform decisions about the progress and direction of the change process. This justifies the collection of the data as an integral component of the process. The information can take a number of forms; written reports, verbal presentations, and it can be actively or passively disseminated (eg. at a formal meeting or available on a website or as a document available on request).


7.5 Disseminating the findings

There are a myriad of ways and places to disseminate your findings:

- unit-based education meetings
- grand rounds (discipline specific or interdisciplinary)
- poster presentations at conferences
- panel or roundtable presentations
- conference papers
- research reports
- published abstracts
- journal articles
- newspapers – media releases and feature articles.
  (Winch, 2008)

Checklist

By now you should have:

1. Developed an evaluation plan (see sample) that details:
   - the specific incident parameters that you want to measure
   - the tools that you will use to measure it
   - the time period/s you will collect the information
2. Identified a person responsible for evaluation
3. Access required resources.

If you have completed this checklist, your evaluation process should be prepared and ready to commence.
References


Leiter, MP & Laschinger, HK 2006, ‘Relationships of work and practice environment to professional burnout: testing a causal model’, *Nursing Research*, vol. 55, no. 2, pp. 137-146.


Chapter 8: Where to from here?

By this stage you should have a clearer understanding of what needs to be accomplished and a plan to support your endeavour. You may have even commenced the process of meeting with key stakeholders and assembling your practice change team and started collecting data on the changes. Any change process is difficult so it is important that you do not give up. Often it is a matter of ‘keeping up the talk’ to try and secure resources and also energy with others to assist you in the process. Whether you are at the beginning, in the middle or near the end of the change process, it is important to keep talking, and in particular, ‘talk up’ and celebrate your successes and achievements. Remember that good mentors and critical friends can assist you in your endeavours.

If cultural change is necessary, the time frame required to achieve this change in large organisations is years, not weeks or months, and so you should aim to bring about change at the local level of your workplace rather than at the organisational or district level. The RNAO Toolkit (2006, p. 7) notes that ‘...you are advised to carefully consider the fit between your organisation and the recommendations and directions provided in this (framework)’. Accordingly you should: prepare a business plan, use motivators who are likely to ‘resonate’ with your key stakeholders, use the experience of others, talk to colleagues (within your organisation and outside it), and use the education and business sectors when appropriate.

This framework is not the answer, but it does provide direction and assistance that you can use to develop your own answers that fit the context of your workplace. When seeking support and resources for your ‘new’ practice model, it is necessary to be able to clearly describe what it is, how it works, and why it is necessary. By doing so, you can argue for support, resources, and to maintain the sphere of influence of nursing and midwifery within the organisation to enable the best possible healthcare to patients.

Remember that other healthcare professionals may have competing interests that you have to consider: they will often be important stakeholders that you need to effectively manage if your management strategies are to succeed. Be prepared to postpone stages until conditions are more suitable, remember to frequently evaluate and consider the findings and change your plan based on the outcomes of implementation strategies. Use resources wisely, but recognise, reward and celebrate progress with the people that ‘make it happen’. Use morning/afternoon teas, attendance at workshops, seminars, workshops, education sessions etc., conference attendance, favourable shifts, ‘light duty/workload’ days, flexible shift times (delayed arrival or early departure), food, movie tickets, massage etc., holiday/leave applications. Remember publicise and advertise your successes.

A note of caution

The limitations of this framework relate to the difficulty in changing the culture of the workplace. The old saying that ‘Culture eats strategy for breakfast, process for lunch and people for tea’ (Elwyn, 2006) has been used in relation to a number of business management situations, ranging from the ‘war room’ in the management department of the Ford Motor Company in North America in 2006 as it attempts to restructure the company (Phillips, 2006), to the Clinical Editor of the online site saferhealthcare, Glyn Elwyn, as he discusses the very difficult process and resultant slow progress of the NHS in the United Kingdom to increase patient safety in that healthcare service through organisational change. Both these examples relate to very sophisticated organisations, and despite their vast resources the ‘enormity and complexity of the task’ of changing the culture of an organisation has severely restricted the outcomes that have been achieved. If the practice change is to have beneficial outcomes that are sustainable it is essential that they are supported by the workplace culture.
References


Appendix

The following is extracted from: Greenhill, J. and Henderson, M. (2000) Models of Managing Nursing Care Project, Brisbane; Princess Alexandra Hospital (Queensland Health) and Queensland University of Technology.

Models upon which allocation of staff can be based

<table>
<thead>
<tr>
<th>Model</th>
<th>Focus</th>
<th>Clinical decision making</th>
<th>Work allocation</th>
<th>Time span of allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patient care</td>
<td>Total patient care</td>
<td>Nurse at bedside, charge nurse makes some decisions</td>
<td>Assigning patients</td>
<td>One shift</td>
</tr>
<tr>
<td>Functional</td>
<td>Individual tasks</td>
<td>Charge nurse makes most decisions</td>
<td>Assigning tasks</td>
<td>One shift</td>
</tr>
<tr>
<td>Team</td>
<td>Group tasks</td>
<td>Team leader makes most decisions</td>
<td>Assigning tasks</td>
<td>One shift</td>
</tr>
<tr>
<td>Primary</td>
<td>Total patient care</td>
<td>Nurse at bedside</td>
<td>Assigning patients</td>
<td>24 hrs/d, 7 d/wk for duration of hospitalisation</td>
</tr>
</tbody>
</table>

Table 1. Comparison of Traditional Models of Care Delivery from: Tiedeman (June 2004), J Nurs Adm, 34(6), 291-297

Summary of findings from published Models of Care research

1. Plethora of research studies that are largely descriptive, or if experimental, have not controlled for all of the variables necessary.
2. Leadership trumps model of care (PAH Models Project).
3. Effective change management leads to improvement despite the model (PAH Models Project).
4. Primary nursing is very much seen as the most desirable professional model. ‘Team nursing fits very well with a mass production model which unfortunately is anathema to professional nursing’ (Manthey:2006) and there is evidence that it can deliver higher quality nursing care. However, while it may just be sustainable now in certain practice fields it won’t be in the future with predicted RN shortages.
5. When team nursing is compared to primary nursing, primary nursing wins in staff satisfaction and patient satisfaction. However these studies have generally been poorly conducted.
6. Nurse extenders/partners in the care of patients’ models common in US summary of the literature’s findings noted:
   - a repeated concern at extender absenteeism
   - the expressed need for education in change management, delegation and effective use of partners.

It has the major benefits in the following:
   - better use of RN time
   - decreased cost of care
   - alleviation of RN shortage
   - increased satisfaction of RN’s and staff.

7. Partners in Care Practice Model (PICP) (Lengacher et al. 1993) reported a significant effect on job satisfaction, particularly in the areas of interaction, task requirements and autonomy.
8. Modular Nursing (version of PICP) but clustered around patient diagnoses for best effect. Improvements: fiscal savings, perceptions of improved quality of patient care, significant decrease in RN stress and positive collaboration between nursing and ancillary departments.

The literature does not clearly identify one model over the other in terms of quality, measurable outcomes. From a professional perspective, primary nursing is preferred but this has not been validated comprehensively.

Primary nursing care model/relationship based nursing

Popularised by Manthey in the USA, primary nursing is currently and generally regarded as the most effective form of nursing delivery. In the past three decades, it has emerged as the major delivery system; it is characterised by:
   - a high priority placed on the individual nature of care
   - the allocation and acceptance of individual responsibility for decision-making and care of allocated patients
• its promotion of the professional issues
  of autonomy, accountability and the values which
  underpin nursing (Rafferty, 1992).

Primary nursing may include the use of associate
nurses to work in partnership with the primary nurse
(Scott et al. 1999), which is an important consideration
as skill mixes change.

Inconsistent conclusions for primary nursing care have
been found, ranging from higher patient satisfaction
with primary nursing to no significant difference (the
majority of studies), to less satisfaction when compared
to other models (Thomas and Bond 1991).

Increases in job satisfaction were reported by Blair
et al. 1982; Blenkarn et al. 1988; Sellick et al. 1983;
Roberts (1980); Brock and O’Sullivan (1988). No
significant difference was found by Wilson and
Dawson (1989) and Alexander et al. (1981), while
Giovannetti (1980) and Betz (1981), reported decreased
job satisfaction. Chavigny and Lewis (1984), found
that 73% of staff in their study opposed the adoption
of primary nursing, finding it stressful and difficult.
The UK studies (Reed, 1988; Bond et al. 1990; Manley,
1989) similarly yielded no definitive findings.

Australian literature is scant. A small study comparing
one medical ward that implemented primary
nursing against another medical ward that used
functional nursing found that job satisfaction and
patient satisfaction improved (Sellick, K, Russell, S
& Beckmann J, 1983). There were no studies that
compared other modalities of nursing care. A summary
of the major models of nursing care in Australia by
James (In: Clinton, M & Schiewe, D, 1995) outlined
the advantages and disadvantages of primary nursing,
patient allocation, modular and team nursing. James
suggested that case management is an expedient and
efficient model that suits departments with rapid
expands upon the advantages and disadvantages of
case management and critical pathways and argues
that not only is this model more efficient from a
management perspective, patients and the entire
multidisciplinary team are more actively involved in
planning and treatment. Also from a management
perspective, the development of a workplace
culture with increased autonomy and professional
development can be achieved through shared
governance (Leary, Legg, and Riley 1998).

Quality of practice studies
Although there are far fewer studies of the process
aspects of primary nursing, Nissen et al’s (1997)
summary of these studies reports their high degree
of congruence. Apart from Giovannetti’s (1980)
findings which showed that nursing modalities did
not significantly influence quality of care, studies by
Felton (1975); Eichhorn and Frevert (1979); Shukla
(1981); Martin and Stewart (1983); Culpepper et al.
(1986); Reed (1988); Gardner (1991); Bekkers et al. (1990),
all demonstrated a significantly higher quality of care.

Professional considerations
In recognition of the equivocal outcomes and
methodological weaknesses of primary nursing
research studies, Leach (1993) notes the lack of
systematic investigation of the ‘basic tenets, beliefs and
values of primary nursing’. He undertook a qualitative
study of two primary nurses’ perceptions of their role
in order to begin to generate a grounded theory of
primary nursing practice. In a similar philosophical
and conceptual vein, Johns (1990) highlights the
importance of primary nurses’ understanding of the
concepts of ‘authority’ and ‘autonomy’, and of issues
of role definition, accountability and collaboration in
the primary nursing context. Bowers (1989), Salvage
(1985), Bartels et al. (1977), Roberts (1980) and Ward
(1986) have argued the merits, shortcomings and
complications arising from these issues and concepts in
‘a very complex occupational environment, in which a
multitude of professional groups work’ (Bowers,
1989, p. 17). Tingle (1992) further explores the legal
implications of these aspects of the delivery system.
These issues are also inextricably bound up with the
broader question of nursing and professionalism.

Team nursing
Team nursing involves groups of people working
together to complete the necessary work through the
organised division of labour. In Kron’s (1981) concept of
team nursing, patients were allocated to specific
teams which were collaboratively responsible for their
care. In other (USA) variations, however, patient care
is delivered by task allocation; this has lead to the
criticism of lack of continuity of care (Peterson,

Unfortunately, there are few studies of team nursing
alone, most studies being devoted to a comparative
analysis of team and primary nursing. These studies
generally favour the primary mode. This is not to
deny, however, that some studies found more positive
individual outcomes for team than for primary
systems; for example:
• greater confidence in nursing skills (Reed, 1988)
• equality of status and promotion of democratic
  attitudes (Ciske, 1983)
• increased job satisfaction (Betz, 1981; O’Connor,
  1994)
• fewer sick days (Chavigny, 1984)
• increased nurse-patient contact (Chavigny, 1984).
An evaluation of the implementation of team nursing across four distinctive wards led O'Connor (1993, 1994) to conclude that the system demonstrably increased the quality of patient care. On a cautionary note, however, Sherman (1990) stresses the clinical, leadership and management demands of the team leader and the importance of clear and open communication between all team members. Most significantly, Rafferty (1992) reminds us that team nursing, like any other method of delivery, is influenced by nurses’ beliefs and values (particularly their individual attitude to issues of autonomy and accountability), and the complex, multi-factorial nature of the specific setting and culture within which they operate.

**Partnership/extender models**

Several nursing practice models use nurse extenders/partners in the care of patients. In a review of the literature from 1988 to 1992, Lengacher et al. 1993 reported the use of various partners or extenders ranging from licensed vocational nurses to technical assistants or aides. Their summary of the literature’s findings noted:

- a repeated concern at extender absenteeism
- the expressed need for education in change management, delegation and effective use of partners
- the major benefits of:
  - better use of RN time
  - decreased cost of care
  - alleviation of RN shortage
  - increased satisfaction of RN’s and staff.

Lengacher et al.’s own (1993) study of their PIPC (Partners in Care Practice Model) reported a significant effect on job satisfaction, particularly in the areas of:

- interaction
- task requirements
- autonomy
- pay.

Three years later, Heinemann et al. 1996 reported a higher level of patient satisfaction on all items (courtesy of nursing staff; nurses’ treatment of family and friends; timely attention; professionalism; satisfaction with care) in a unit piloting the PIPC model than in a traditionally served nursing unit.

**Professional practice/shared governance**

A professional practice or shared governance model (PPM) is ‘a unit-based governance system that empowers nurses by providing them with increased opportunities for autonomy, accountability, and control over the environment in which they deliver care’ (Zelaustas and Howes, 1992), and ‘allows innovation, promotes collegial relationships and emphasizes personal responsibility’ (Pierce et al. 1996).

Similar to other nursing models, there is no consistent evidence of improved outcomes resulting from implementation of shared governance. With regard to job satisfaction, for example, both improvement (Jones et al. 1993; Pierce et al. 1996) and no change (Minors, 1993 & Pinkerton, 1988) have been reported.

Other studies of professional practice/shared governance models report:

- positive financial outcomes (De Baca et al. 1993; Nardone et al. 1995)
- feelings of autonomy and empowerment (De Baca, 1993)
- improvement in delivery of care (Nardone et al. 1995)
- personal and professional growth for staff (Prince, 1997; Leary, 1998)
- positive process and procedural outcomes (Leary, 1998).

Perhaps the most significant and generalisable outcomes of the literature in this area, however, are Minnen et al’s (1993) illustration of how such models can provide the structure and support for organisational change and development, and the Hasting and Waltz (1995) reminder that ‘implementation of the model is a unit-based phenomenon, highly dependent on manager skill in leading the change and on staff role clarity, role skills, and perceptions of support from administration’ (p. 42).
Case management model

Nursing case management, a delivery innovation of the 1990’s is considered ‘a second generation of the primary care delivery model’ (Girard, 1994, p. 403). It has been defined as a multidisciplinary ‘system of health assessment, planning, service procurement/delivery/coordination, and monitoring to meet the multiple needs of clients’ (Girard, 1992, p. 404). Many variations of the system (dictated by the needs and nature of various institutions) have been implemented. While being identified as a professional practice model (as it is designed to increase nursing involvement in standards of practice), it also conjures important fiscal considerations:

Given ..., the need to balance the ‘cost/quality equation’, case management will become increasingly important and has the potential to become the predominant care delivery system of the 1990s (Ritter et al. 1992, p. 126).

Hoffman (1995) found that 88% of studies evaluating case management delivery reported improved fiscal outcomes. Improvement in patient satisfaction has also been demonstrated by:

- Edelstein and Cesta (1991)
- Hoyle et al. (1994)
- Sherman and Johnson (1991)
- Ritter et al. (1992)
- Trella (1993)
- Abbott et al. (1994).

Nurse satisfaction has been found as a positive outcome by Ritter et al. (1992) and Lanero and Gerber (1995). Positive professional outcomes (autonomy and collaborative practice) were emphasized by Adams and Rentfro (1991) and Abbott et al. (1994).

Given the relative youth of the case management model, the volume of literature devoted to its analysis is limited compared to that available for other models. Already, however, there is (as for other models) criticism of the scope and methodology of the available studies (Lynn and Kelley, 1997).

Miscellaneous models

In addition to the various model categories outlined above, the literature is peppered with idiosyncratic models designed to meet the needs of particular providers and their delivery contexts. These include:

- ProACT for critical care (Ritter and Longes, 1991)
- Culture Specific Nurse Caring Practice Model (MacDonald and Miller-Grolla, 1995)
- Human Needs Model (Minshall et al. 1986)
- Attending Nurse Model (Moreau et al.)
- Tredgold Model (Dennis, 1998)
- Nursing Model of Care (Kohler, 1990)
- Patient-Centred Framework (Robinson, 1991)
- Patient-Focused Care Delivery Model (Routh and Stafford, 1996)
- Coordinated Care Classification System (O’Neal et al. 1998).

Given that the process of nursing itself is confounded by these (and, no doubt, other) extraneous variables, there is, as Thomas and Bond (1991) point out, no clear cause and effect delineation between specific nursing processes or procedures and nursing outcomes. Albeit under the label of ‘primary nursing’, nursing processes (or the operationalization of models) are major variables. Indeed, they contend, a large number of studies make no attempt to describe or otherwise compare processes of care in the settings studied (p. 309).

Finally, Sella and MacLeod (1991) note the absence of studies which address the actual process of changing from one model of care to another. The residual effects of the management (or mismanagement) of this process would also need to be considered as a further (albeit transitional) subset of extraneous variables.

Research constraints – study variables

The comparability, validity and reliability of these studies are, for the most part, also compromised by a plethora of conceptual, contextual and methodological variables. For example, differences in:

- the instruments used to measure outcomes
- patient type and/or group (for example, ICU, general medical)
- sample size
- use of comparison or control groups
- definition or lack of definition of key concepts and terms (for example, ‘job satisfaction’ or ‘primary nursing’)
- conceptual dimensions of scale items used (for example, ‘autonomy’, ‘satisfaction’)
- method of nurse/patient allocation to various organisational modalities
- attention to issues and details of context-specific reliability, validity or consistency (which, in fact, are rarely addressed)
- timing of the studies (for example, proximity of the study to the introduction of the system)
- contextual (or other) appropriateness of instruments used
- cause-effect relationship
- mitigating external factors
• research design and method (for example, ex post facto, quasi-experimental and empirical)
• quality of care indicators
• complexity of the relationship between structure, process and outcomes.

Patient satisfaction and nursing care delivery models

Nursing care is the most significant factor in high-quality care in terms of patient satisfaction. The role of the nurse is crucial in promoting the quality of care, and that is affected by the methods of organising nursing care delivery.

The majority of studies were focused on primary nursing and team nursing in USA and the findings are inconsistent. Daeffler (1975) found that patient satisfaction was higher with primary nursing than team nursing, and patients perceived more omissions in care with team nursing than with primary nursing. However, she states that ‘the quality of care depends on the individual nurses, whether team or primary nursing is practiced’ (p. 22). Similarly, Sellick, Russell and Beckmann (1983) undertook an experimental study to compare functional nursing to primary nursing on two medical wards in Australia. They found patients nursed under the primary nursing mode reported higher satisfaction than those measured under the functional nursing model.

In contrast, Giovannetti (1980) found that the patients on the team unit appearing slightly more satisfied overall with their care than those on the primary unit, particularly in terms of the nurse’s response to pain, discomfort, and provision of information self-care after discharge (Giovannetti, 1980). The majority of studies, however, found no significant difference in patient satisfaction between patients on primary nursing wards compared with those nursed under different organisational regime.

Other than primary and team nursing, there is a more limited body of research-oriented literature on other nursing care models especially in Australia. An exception to this is a study by Berry and Metcalf (1986). They conducted a quasi-experimental study to measure the effects of changing task allocation (functional nursing) to patient allocation in one maternity hospital in UK. Patient satisfaction with care was examined. They divided the study into three phases: pre-change, change and post-change. The data were collected in pre and post-change phases. The findings indicated that patient allocation made little difference to the patients’ expressed satisfaction with care. They assert that the findings may have been more favourable if the instrument had been more sensitive, however, they did not provide the patient satisfaction instrument in their report. Thus, this indicates that further study is needed to explore the association between patient satisfaction and other nursing care models.

Several factors need to be taken into account while interpreting these diverse findings from measuring patient satisfaction. Firstly, there is no consensus regarding what the concept of patient satisfaction encompasses, which is reflected in the diversity of instruments used to measure patient satisfaction. None of the researchers used the same instruments, and issues of reliability and validity are seldom addressed (Thomas and Bond, 1991). Only Ventura et al. (1982) established the internal consistency of the Risser Patient Satisfaction Scale.

Furthermore, while the majority of studies use comparisons between two groups of patients, few demonstrate comparability of patients (Kerouac and Turchon, 1992; Thomas and Bond, 1991). For instance, the majority of studies are undertaken in various nursing units. Exceptions to this are studies by, Giovannetti (1980), Sellick et al. (1983), and Ventura et al. (1982). These authors demonstrate similarity between experimental and comparison groups with regard to the homogeneity of patients.

Finally, studies of patient satisfaction in terms of nursing care models have recorded very high levels of satisfaction (Giovannetti, 1980; Ventura et al. 1982). Ventura et al. (1982) point out that recording high level patient satisfaction may suggest varying levels of positive attitudes, rather than truly negative sentiment. A number of possible reasons may cause this phenomenon. They are insufficiently sensitive instruments (Macdonald, 1988), patient vulnerability (Sellick et al. 1983), desire for social approval, fear of appearing ungrateful, and excluding dissatisfied patients who might be not willing to participate by completing a questionnaire (Ventura et al. 1982). It may also be that patients are truly well pleased with the nursing care they received (Ventura et al. 1982).
Job satisfaction and models of care

It is frequently argued that primary nursing increases autonomy resulting in improved job satisfaction. On closer examination of the literature however, there is little empirical evidence that demonstrates a relationship between primary nursing and job satisfaction. Job satisfaction due to increased autonomy was evident in a study conducted by Athlin, Furaker, Jansson and Norberg (1993). The authors used Colaizzi’s phenomenological method to study primary nursing within a team setting. This nursing model fosters autonomy and creativity (Cornell and Ferguson, 1995; Villaire, 1993). This research was conducted mainly to obtain a deeper understanding of hospice care for dying cancer patients. The researchers discovered that under this model nurses could use their knowledge, expertise and creativity, and take part in decision-making for patient care. The project had a positive effect on quality of nursing care, interaction between the different professions, professional development, and job satisfaction. When continuity of patient care was interrupted, all nurses became very dissatisfied. These findings may be important but cannot be generalised to an acute care setting.

The effectiveness of practice partnerships was tested by Lengacher, Kent, Mabe, Heinemann, VanCott and Bowling (1994). In practice partnerships, the partners work the same shifts, and the more experienced registered nurse is responsible for training or supervising his/her partner (Lengacher et al. 1994; Strasen, 1989). The quantitative study consisted of an experimental unit and a control unit. It involved a pre and post-test of the model which was in practice for six months. The sample included registered nurses, licensed practical nurses (LPNs are equivalent to enrolled nurses in Australia) and technicians. Nursing administrators supervised the model so as to prevent cross contamination between units. The analytical tool used was the Index of Work Satisfaction (IWS) developed by Stamps and Piedmonte. An unexpected finding was that ‘the effects of the model decreased the perception of autonomy on the experimental unit compared to the control unit’ (Lengacher et al. 1994:6). However, this decrease in autonomy did not affect total job satisfaction for the experimental group. As other nursing levels, (besides registered nurses), were included in the study it is arguable just how applicable the results of this study are to registered nurses.

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Modelling Contemporary Nursing and Midwifery: a framework for shaping professional practice

Nurses interest based bargaining project
August 2008