EP 1: How nurses adapt, develop, apply, evaluate, and modify, the Professional Practice Model.

In the current healthcare environment, economic and cultural conditions have created an optimal opportunity to envision a new direction for nursing as a profession. Nurses, who have always led with standards undergirded by excellence, must now set the new description of what the nursing profession can be as well as identifying contributions to the care delivery model for the future. Towards that end, nurses find themselves in the formative stages of charting a new direction of the profession, regardless of the care setting. The articulation of a professional practice model provides a framework for setting this new direction. In this source of evidence, information will be presented that describes the evolution of the Patient Care Services’ professional practice model at the Massachusetts General Hospital (MGH) and how the model continues to be applied, evaluated, adapted and modified.

Development and Modification of the Professional Practice Model (PPM)

When the Senior Vice President for Patient Care and Chief Nurse (CNO) assumed the helm in 1996, one of the initial components of her four-point plan was to develop a professional practice model (Attachment EP 1.a). The CNO collaborated with the PCS Executive Team to develop the Professional Practice Model (PPM) which was unveiled in the December 12, 1996, issue of Caring Headlines (Attachment OOD 11.a). The CNO stated,

“It is a privilege to introduce this issue of Caring Headlines, which is dedicated to describing key elements of our emerging professional practice model. Now, in the crucial, formative stages, it is important for all of us to understand exactly what this model is, and invest our interest and energy into making it a viable, working reality.

The past seven months have seen tremendous change, both organizationally and in the mindset of individuals helping to mold a new culture during this very turbulent time in health care. I have seen it at staff meetings, forums, luncheons, and committee meetings – there is renewed understanding around the importance of having a practice model and its intrinsic connection to the delivery of high-quality care.

Though the fruits of our efforts may not fully be evident until all aspects of the model are understood and embraced by clinicians and others in our community, the challenge now is to define the concepts in a way that brings significance to our daily practice. Each “piece” of the model represents components of practice. Since each component is inherently related to all of the others, we have chosen an “interlocking” puzzle to represent our model.

If the model is to work, each of us needs to understand, embrace, and master the skills involved; participate in the whole process; and be willing to learn – continuously learn – because the environment in which we work is rapidly changing. This is a journey we must take together.”

At MGH, the PPM is seen as a framework that allows nurses and other healthcare disciplines to clearly articulate contributions to practice within their profession. For Nursing, with a well-designed framework, nurses feel connected within the context of their relationships to the patient, to their own practice, to the roles of other providers in contributing to the plan, to other nurses, and to the institution. This framework and structure allows the nurses to better plan, manage and adapt to change. This framework and structure facilitates the identification of goals and strategies, in addition to roles. Articulation
of a model for the nursing professionals within an organization provides a critical mass of energy to support resources, strength, and visibility within an often-complex structure.

The importance of a PPM has been recognized since the initial Magnet Hospital Study in 1983, which articulated the salient elements of professional practice as autonomy, control over practice and collaborative relationships with physicians. The MGH PPM builds on that foundation and incorporates findings from current research on organizational behavior, descriptive theory models, teamwork, and importance of a narrative culture. Each of these elements is a component of the practice of nursing at the MGH across care settings.

**MGH Patient Care Services’ Initial Professional Practice Model, 1996: Components**

In 1996, the initial PPM at the MGH in Patient Care Services (PCS) (Attachment OOD 11.a and Attachment EP 1.b) was framed by a well-articulated patient- and family-focused vision (OOD 1). The unique contributions of each of the professional disciplines and support staff in collaboration with nursing bring special meaning to the relationships that always keep the patient at the forefront. The vision acknowledges that the primary focus of the model is the patient, however, also stresses that the importance of preserving the integrity of the relationship between the patient and clinician is a key element for success. The vision clearly demonstrates the need for action in creating a practice environment that did not have insurmountable barriers, was built on a spirit of inquiry, and reflected a culturally-competent workforce supportive of the patient- and family-centered values of the institution in practice outcomes.

Values

Supporting the PCS vision is a clearly-articulated set of values which anchor clinical decision-making and are expressed in policies, practices and norms of behavior. The values are: leadership, entrepreneurial teamwork, caring, innovation and scientific practice. In
addition, as described in the PCS vision statement (OOD 1), Nursing and Patient Care Services value accountability, responsibility, diversity, resource effectiveness and the core value of patient-centered care.

Philosophy
A philosophy statement is derived from the values, principles, and beliefs, which support the individualized contributions of each discipline. Within the PCS PPM, the philosophy statements are discipline-specific and articulate what each discipline believes in and what contributions the professionals wish to contribute to the whole. The MGH philosophy of nursing focuses on the patient care, education, research, and contributions of nurses to promote the quality and safety agenda (TL 1).

Standards of Practice
Standards are the practical application of values and philosophy. Standards of practice exist to ensure that the highest quality of care is maintained regardless of the professional providing the care or the experience level of those professionals. In a PPM, standards of practice support the “learner” or novice nurse as well as the experienced provider. For a provider lacking clinical mastery skills, standards of practice provide a structure on which to base and build practice and decision-making. Standards serve as teaching tools by providing guidance in situations in which the provider may not be experienced. By serving as a teaching tool, standards of practice establish a level of expectation about care delivery and patient safety within an organization. Understanding the unique clinical needs of each patient and situation and appreciating the principles of critical thinking in applying standards is imperative to providing individualized, high-quality care. The ability to integrate clinical knowledge and standards of practice within a professional practice model is a competency common to experienced professionals.

Collaborative Decision-Making
Collaborative decision-making is built on the premises of teamwork and team learning. The network of relationships between people who come together under a practice model structure can create strong bonds. Members of these teams describe a sense of “feeling like we’re making a difference.”

Professional Development
As the healthcare environment evolves and changes, professional development activities take on increasing importance in ensuring that nurses provide quality care as well as in providing a mechanism to attract and retain excellent clinicians. Professional development within a PPM supports the enhancement of leadership competencies as well as provides avenues for growth and career progression for nurses at all levels. Outcomes of professional development include: mentoring, teaching, generating publications, conducting research and scholarly activities, as well as exemplifying patient care and family support.

Patient Care Delivery Model
Design and definition of the care delivery model is another component of the PPM. The best care delivery model promotes the highest quality while being cost-effective and patient-centric. Nurses need to acknowledge that the healthcare world is changing but that their contributions will always be needed. The model for patient care delivery exemplifies the outcomes of the various components of the PPM because they are joined together in a way
that can be described and replicated. The patient care delivery model at MGH is interdisciplinary, patient- and family-centered care.

**Privileging, Credentialing and Peer Review**

Another part of the PPM, privileging and credentialing processes, ensures that patients and their families receive quality care from competent nurses in all settings. The public trusts that there is a mechanism in place, which ensures that all nurses have the appropriate credentials (OOD 17).

Peer review (EP 20) is an important component of privileging as well. This process supports autonomy and accountability for nursing practice within the organization. Through peer review, staff members have the opportunity as well as the responsibility to support each team member in improving both individual and organizational performance. An effective system of peer review and privileging within a PPM should ensure that the patient and their family members receive excellent care from competent providers.

**Research**

At the MGH, the PPM is based on knowledge, experience, tradition, intuition, and research. The implementation and support of evidence-based practice requires a setting that promotes the acquisition and application of knowledge, provides access to new scientific knowledge, and fosters the ability of clinicians to use knowledge to affect patient outcomes.

Research is the bridge that translates academic knowledge and theory into clinical practice. Research dictates that evidence and is a necessary prerequisite for the establishment of clinical practice, thus building the practice model. The goal of nurse researchers is to identify an issue of significant concern to the discipline of nursing and develop a substantial body of information related to that clinical phenomenon, which is scientifically vigorous and relevant. Research-based practice within a practice model creates a spirit of inquiry that consistently challenges critical thinking of nurses at all levels. Translating the questions generated at the bedside into formal scientific hypotheses is a part of the continuum of professional development.

**Theory-Based Practice**

The challenges of the practice environment represent an opportunity to reflect on practice and to articulate the “whys” of what we do. Understanding the philosophic, structural, and theoretical foundation of practice is an important component of professional development and the overall change processes that need to be taken to ensure that the practice environment is effective. As nurses develop into individual practitioners and collaborative colleagues, they find it exciting to share, explore and challenge the theoretical perspectives used in the delivery of patient care.

**Revised Professional Practice Model, 2006: Components**

Ten years after the articulation and implementation of PCS’ initial professional practice model at MGH, nurse leaders critically reviewed the model of professional practice and identified that updates were indicated to meet the new demands of the healthcare delivery system (Attachment OOD 11.b and Attachment EP 1.c). Again, a special issue of *Caring Headlines* was used to present the revised version of the PPM. The CNO wrote:
“A little more than ten years ago, we published a special issue of Caring Headlines. Significant contributions have been made to patient, families, our hospital, the communities we serve, and our respective professions because of an interdisciplinary practice that is supported by a our strong vision, values, and guiding principles.

Health care has changed dramatically in the past ten years, and with it, our professional practice environment. Advances in research and technology, new knowledge and understanding of disease processes, increasingly diverse patient population, and fluctuating political climates, have all contributed to a dynamic healthcare arena. Without a strong and durable PPM, it would be impossible to thrive during times of great change. But a strong and durable practice model is exactly what we have.

This issue of Caring Headlines documents the progress we’ve made and benchmarks our leadership in the development of a blueprint for the delivery of exceptional, patient-centered care.

A few new components were introduced into this version of the PPM which are described below.

**Narrative Culture**

The creation of a narrative culture has been transformational at the MGH. Over time, clinical narratives have become part of the fabric of professional life in the organization. Narratives are part of the application process for the clinical advancement program, awards, and annual performance review.

Putting pen to paper allows clinicians to see their practice in a different light and it is also a springboard for dialogue with colleagues and clinical experts. Through the very important process of dialogue, and thus communication, clinicians are asking questions that prompt them to delve deeper into their thinking and motivation. Clinicians might ask themselves the following questions: What were my concerns about this patient in this situation? How was this situation similar to situations I have experienced in the past? How was it different? What did I learn? These questions allow clinicians to enter into the clinical situation from a different perspective, see it in a different way, and, perhaps, identify different interventions and strategies.
Clinical narratives can be difficult to read when they do not describe what is considered to be “perfect practice.” At the MGH, it has been found that those are the narratives one needs to write and talk about because they describe the realities of practice and the environment in which care is being provided. The practice model has evolved to be open to all stories and the dialogue that follows, thus creating and sustaining the highest quality of care.

**Clinical Recognition and Advancement**

Clinical recognition and advancement have been found to be effective retention tools at MGH. The Clinical Recognition Program at MGH emerged and developed as clinicians reviewed narratives written by clinicians and identified themes and criteria which applied to the six disciplines of Nursing, Physical Therapy, Occupational Therapy, Respiratory Care, Speech-Language Pathology, and Social Work. Themes including the clinician-patient relationship, effective patterns of clinical decision making, and teamwork and collaboration emerged. Analysis of these themes helped establish a set of professional behaviors and attributes that act as developmental milestones, which have now been implemented as a component of the PPM.

The theoretical foundation of the Clinical Recognition Program is the Dreyfus Model of Skill Acquisition. Developed by Dreyfus and Dreyfus, this model described how, in the acquisition and development of a particular skill, individuals pass through the five stages of novice, advanced beginner, competent, proficient and expert. The word “stage” is crucial as it relates to the recognition program at the MGH because it reinforces the idea that clinicians must master each stage or level of development before progressing to the next.

Central to the Clinical Recognition Program is the reflective process, which allows individuals to incorporate theory with practice, shaping clinical practice over time. This process helps individuals understand their experience and integrate information in a meaningful way. Reflective practitioners committed to lifelong learning have enabled us to advance and sustaining excellence in patient care.

**Innovation and Entrepreneurial Teamwork**

Innovation and entrepreneurial teamwork are critical to the creation of a PPM that embraces change. Nurses and other health care clinicians need to innovate and make certain that the delivery of patient care and structures that support it change to meet the changing populations they serve. Several key assumptions guide the work at the MGH with regard to innovation:

- Our employees are our biggest assets.
- Innovation takes great leaders.
- Imagination is necessary and fun for innovation to occur.
- Collaborative decision-making is a core value.
- A professional practice environment is the foundation on which we will build our future.
- Patient-centered care is the key.

Together, questions about beliefs, values, and traditions and how these will affect innovation, are addressed. These clinicians must also address the designing of the ideal environment for innovation, the changes that need to occur for the success in regard to this ideal environment, and the best way to capture insights from clinicians at the bedside.
Patient-Centeredness

Patient-centeredness is the most critical piece of the revised PPM and is strategically placed in the center, touching all other components. The ability to efficiently and effectively care for patients and families requires the support of an array of resources, programs, and processes. At the MGH, The Institute of Medicine’s six pillars of quality and safety (2001), which includes the pillar of patient-centeredness, are used as touchpoints:

- Patient-centeredness: All care will honor the individual patient and the respective patients’ choices, culture, social context, and specific needs.
- Safety: We will work to ensure no needless death, injury, or suffering of patients and staff.
- Effectiveness: Our care will be based on the best science, informed by patient values and preferences.
- Timeliness: We will waste no one’s time and will create systems to eliminate unnecessary waiting.
- Efficiency: We will remove all unnecessary processes or steps in a process and streamline all activities.
- Equity: Our work will ensure equal access to all.

Patient-Centeredness is an integral component of the Patient Care Delivery Model described in OOD 11.

Application of the PPM

As the CNO noted in 1996, “the operational challenge in articulating a PPM is in defining concepts in such a way that brings significance to daily practice. Each component is critical to practice and care delivery. If the model is to work, each clinician needs to understand, embrace and master the skills involved and be willing to learn — continuously learn — because the environment in which care is delivered is rapidly changing. This is a journey that the healthcare team takes together.”

Each component of the PPM is hardwired into the infrastructure and ultimately into practice. Examples are presented in detail throughout the MGH Magnet evidence submission as noted in the table below:

<table>
<thead>
<tr>
<th>Professional Practice Model Component (2006)</th>
<th>Applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centeredness</td>
<td>Professional Practice Model (OOD 11, EP 1)</td>
</tr>
<tr>
<td></td>
<td>Patient Care Delivery Model (OOD 11, EP 1)</td>
</tr>
<tr>
<td></td>
<td>Innovation Units (TL 4EO)</td>
</tr>
<tr>
<td>Vision &amp; Values</td>
<td>Vision &amp; Values Statement (OOD 1)</td>
</tr>
<tr>
<td>Standards of Practice</td>
<td>Save Our Skin Program (SE 1EO, NK 6, NK 7)</td>
</tr>
<tr>
<td></td>
<td>LEAF Falls-Reduction Program (SE 1EO, NK 6, NK 7)</td>
</tr>
<tr>
<td><strong>Pain Management (NK 6, NK 7)</strong></td>
<td>Care of the Geriatric Patient (NK 7)</td>
</tr>
<tr>
<td>----------------------------------</td>
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</tr>
<tr>
<td><strong>Narrative Culture</strong></td>
<td>Clinical Recognition Program (TL 7)</td>
</tr>
<tr>
<td></td>
<td>Annual Performance Reviews (EP 20)</td>
</tr>
<tr>
<td></td>
<td>Awards &amp; Recognition portfolios (TL 7)</td>
</tr>
<tr>
<td><strong>Professional Development</strong></td>
<td>Norman Knight Nursing Center for Clinical &amp; Professional Development (SE 5)</td>
</tr>
<tr>
<td></td>
<td>Knight Simulation Program (SE 5, SE 11)</td>
</tr>
<tr>
<td></td>
<td>Roles of Clinical Nurse Specialists (OOD 9, TL 2, SE 5, NK 7)</td>
</tr>
<tr>
<td></td>
<td>Role of Professional Development Specialists (SE 5, TL 4EO)</td>
</tr>
<tr>
<td><strong>Clinical Recognition &amp; Advancement</strong></td>
<td>Clinical Recognition Program (TL 7, EP 20)</td>
</tr>
<tr>
<td></td>
<td>Attending Registered Nurses (TL 4EO, SE 1)</td>
</tr>
<tr>
<td></td>
<td>Nurse Scientist Advancement Model (NK 4)</td>
</tr>
<tr>
<td><strong>Collaborative Decision-making</strong></td>
<td>Collaborative Governance (SE 1)</td>
</tr>
<tr>
<td></td>
<td>Collaborative Governance Champions (SE 1)</td>
</tr>
<tr>
<td></td>
<td>Interdisciplinary Rounds (TL 4EO, EP 16)</td>
</tr>
<tr>
<td></td>
<td>Interdisciplinary Committee participation (OOD 15, SE 1, EP 23)</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>Yvonne L. Munn Center for Nursing Research (NK 4)</td>
</tr>
<tr>
<td></td>
<td>Munn Research Awards (NK 4)</td>
</tr>
<tr>
<td></td>
<td>Nursing Research Expo (NK 4)</td>
</tr>
<tr>
<td></td>
<td>Retooling for Evidence-Based Practice (NK 4)</td>
</tr>
<tr>
<td><strong>Innovation &amp; Entrepreneurial Teamwork</strong></td>
<td>Center for Innovations in Care Delivery (TL 7, NK 8)</td>
</tr>
<tr>
<td></td>
<td>CMS Advisor Program (TL 7, NK 8)</td>
</tr>
<tr>
<td></td>
<td>Innovation in Practice Program (NK 8)</td>
</tr>
<tr>
<td></td>
<td>Innovation Units (TL 4EO)</td>
</tr>
</tbody>
</table>
Evaluation of the PPM

Evaluation of the PPM is integrated into the fabric of Patient Care Services’ practice environment. Two methodologies are used: one internal (Staff Perceptions of the Professional Practice Environment) and one external (Magnet Recognition).

Internal Evaluation of PPM

Internally, the MGH-developed Staff Perceptions of the Professional Practice Environment Survey (referred to as the SPPPE survey or RPPE scale) has been administered to nurses and clinicians across Patient Care Services every 12 to 18 months since 1997. This tool:

- Provides an assessment of eight organizational characteristics determined to be important to clinician satisfaction including: autonomy; clinician-physician relations; control over practice; communication; teamwork/leadership; conflict management/handling disagreements; internal work motivation and cultural sensitivity (Attachment SE 1.d).
- Allows clinicians the opportunity to participate in setting the strategic direction for Patient Care Services
- Trends key information
- Provides feedback on strategic goals
- Identifies frequency, preparation, and access to resources in managing common patient problems
- Identifies opportunities to improve the environment for clinical practice.

TL 10 provides details about the psychometrics and global reach of this tool.

Key Findings from the 2011 SPPPE Survey

The overall response rate for the 2011 SPPPE survey (N=1,957) is 49%, which is 1% lower than the 2010 (N=1,664) response rate (50%) and 10% less than the 2008 (N=1,941) response rate (59%). The 2011 response rate continues the decline begun in the 2010 SPPPE response rate. Except for Occupational Therapy, which experienced a 3% increase to 63% over 2010, all PCS disciplines demonstrated decreases in response rates in 2011 ranging from 1% in Nursing to 13% in Speech/Language Pathology. In 2011, Ambulatory Care (n=217) and Child Life Specialists (n=10) groups were included in the SPPPE. Just as the 2010 response rate (50%) from the 2008 rate (59%), the slight decrease in the 2011 response rate (49%) may have been influenced by the continuing unprecedented local, national, and global economic changes as well as the current and future fiscal challenges across Partners HealthCare.

<table>
<thead>
<tr>
<th>Department</th>
<th>Population Size</th>
<th>Surveys Completed</th>
<th>Overall Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care</td>
<td>476</td>
<td>217</td>
<td>46%</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>18</td>
<td>12</td>
<td>67%</td>
</tr>
<tr>
<td>Child Life Specialists</td>
<td>10</td>
<td>7</td>
<td>70%</td>
</tr>
<tr>
<td>Nursing</td>
<td>3052</td>
<td>1481</td>
<td>49%</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>35</td>
<td>22</td>
<td>63%</td>
</tr>
</tbody>
</table>
The next table presents the results of Overall Work Satisfaction with the Practice Environment. Work satisfaction was measured by a single-item indicator asking clinicians to rate on a 4-point scale how satisfied they were working on their primary unit (Nursing) or in their department (other PCS disciplines). Overall, 86% of 2011 respondents reported they were satisfied or very satisfied working at MGH, which is a decrease of 1% from 2010 (87%) but still an increase of 1% over 2008 (85%). Respiratory Therapy and Social Services showed an increase in work satisfaction scores from 2010 to 2011 whereas the Chaplaincy, Nursing, Occupational Therapy, Physical Therapy, Respiratory Therapy and Speech/Language Pathology decreased during this time period. The biggest decreases in work satisfaction scores were seen in Occupational Therapy (14%) and the Chaplaincy (12%). The Ambulatory Care group work satisfaction scores (85%) were similar to Nursing scores (84%) and the Child Life Specialists’ work satisfaction scores (100%) were the highest of all PCS groups.

### Work Satisfaction for Overall PCS & by Discipline

<table>
<thead>
<tr>
<th>Discipline</th>
<th>2008</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care Services</strong></td>
<td>1934</td>
<td>1638</td>
<td>1919</td>
</tr>
<tr>
<td><strong>Ambulatory Care</strong></td>
<td>214</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td><strong>Chaplaincy</strong></td>
<td>13</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td><strong>Child Life Specialists</strong></td>
<td>7</td>
<td>14</td>
<td>44</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>1675</td>
<td>1383</td>
<td>1454</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>26</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>83</td>
<td>85</td>
<td>70</td>
</tr>
<tr>
<td><strong>Respiratory Therapy</strong></td>
<td>58</td>
<td>54</td>
<td>44</td>
</tr>
<tr>
<td><strong>Social Services</strong></td>
<td>59</td>
<td>59</td>
<td>80</td>
</tr>
<tr>
<td><strong>Speech/Language Pathology</strong></td>
<td>20</td>
<td>22</td>
<td>16</td>
</tr>
</tbody>
</table>

* N has changed due to missing data  
** Satisfied and Very Satisfied Combined

In the tables that follow, Patient Care Services clinicians continue to report high agreement with the professional practice environment characteristics of autonomy, control over practice, clinician-MD relations, communication about patients, teamwork, conflict management, internal work motivation and cultural sensitivity, which have been determined to be important elements within the MGH practice environment. Compared to 2010 scores, 2011 PCS staff reported: an increase in Clinician/MC Relations, Control over Practice, Teamwork and Conflict Management scores; remained the same in Communication about Patients, Internal Work Motivation and Cultural Sensitivity scores; and decreased slightly in Autonomy scores. Of note, changes were not found to be statistically significant.
## PCS Overall -- Practice Environment Characteristics & Mean Scores

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2008 Mean Scores</th>
<th>2010 Mean Scores</th>
<th>2011 Mean Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 1,941</td>
<td>N = 1,664</td>
<td>N = 1,957</td>
</tr>
<tr>
<td>Autonomy /Leadership</td>
<td>3.0</td>
<td>3.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Clinician/MD Relations</td>
<td>3.0</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>Control Over Practice</td>
<td>2.9</td>
<td>2.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Communication</td>
<td>3.1</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Teamwork</td>
<td>2.9</td>
<td>2.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Conflict Management</td>
<td>2.7</td>
<td>2.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Internal Work Motivation</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>3.2</td>
<td>3.2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

## Nursing -- Practice Environment Characteristics & Mean Scores

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2008 Mean Scores</th>
<th>2010 Mean Scores</th>
<th>2011 Mean Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=1,682</td>
<td>n=1,404</td>
<td>n=1,481</td>
</tr>
<tr>
<td>Autonomy /Leadership</td>
<td>3.0</td>
<td>2.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Clinician/MD Relations</td>
<td>3.0</td>
<td>2.9</td>
<td>3.0</td>
</tr>
<tr>
<td>Control Over Practice</td>
<td>2.9</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Communication</td>
<td>3.1</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Teamwork</td>
<td>2.8</td>
<td>2.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Conflict Management</td>
<td>2.6</td>
<td>2.7</td>
<td>2.7</td>
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<tr>
<td>Internal Work Motivation</td>
<td>3.4</td>
<td>3.5</td>
<td>3.4</td>
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<tr>
<td>Cultural Sensitivity</td>
<td>3.2</td>
<td>3.2</td>
<td>3.2</td>
</tr>
</tbody>
</table>

## Ambulatory Care -- Practice Environment Characteristics & Mean Scores

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>2008 Mean Scores</th>
<th>2010 Mean Scores</th>
<th>2011 Mean Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=217</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy /Leadership</td>
<td></td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>Clinician/MD Relations</td>
<td></td>
<td>3.2</td>
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<tr>
<td>Control Over Practice</td>
<td></td>
<td>2.9</td>
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<tr>
<td>Communication</td>
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<td>3.0</td>
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<tr>
<td>Teamwork</td>
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<td>3.0</td>
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<tr>
<td>Conflict Management</td>
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<td>2.7</td>
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<tr>
<td>Internal Work Motivation</td>
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<td>3.3</td>
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<tr>
<td>Cultural Sensitivity</td>
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<td>3.2</td>
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</table>

In 2011, the mean scores for the organizational characteristics for PCS ranged from 2.7 (Conflict Management) to 3.4 (Internal Work Motivation). Within each PCS discipline, there is variability in the overall ratings of these characteristics. These data, taken together with other elements of the report, may offer insights into strengths and areas for potential improvement within the MGH professional practice environment.
Almost 29% (n=565) of PCS clinicians who responded (n=1,957) to the 2011 SPPPE survey provided written comments. Of this number, 67% gave permission for their comments to be released. Five major themes were identified:

- **Strong leadership is a critical factor in increasing PCS staff satisfaction, positively facilitating change and promoting staff’s sense of self worth within the MGH professional practice environment.**
- **Effective teamwork and supportive, respectful communication between and among staff across PCS disciplines help to decrease conflict, improve patient safety and promote an effective practice environment that enhances patient centric care.**
- **Continued demands imposed upon staff including documentation, regulatory demands, staffing challenges on some units, availability of resources and support staff and decreased flexibility in assignments become sources of stress for providers and compromise overall work satisfaction within the professional practice environment.**
- **When PCS staff perceive the environment to be stressful, devaluing, compromising and restrictive, they often associate these challenges with leadership challenges and dissatisfaction with the professional practice setting.**
- **In the midst of a dynamic and changing professional practice environment, many PCS staff report overall satisfaction and enjoyment working at the MGH, continue to develop professionally and continue to be highly motivated to provide optimal patient care on a daily basis.**

This report provides direction for organizational leaders, who together with clinicians can continue to and address issues of concern thereby advancing MGH as a leader in patient care and a preferred employer of professional staff across disciplines. In a fiscal environment that continues to remain a challenge, leadership is essential. Since 1998, the PCS Executive Team has identified strategies that address issues voiced by clinicians. Attachment EP 1.e contains a list of issues and associated strategies/interventions employed to address them.

**External Evaluation of PPM**

Externally, MGH applies for Magnet recognition to validate that a strong professional practice environment exists. As the highest honor awarded to healthcare institutions for excellence in nursing services by the American Nurses Credentialing Center, this intensive review is the ultimate confirmation that a supportive professional practice model and environment is thriving within an organization.

**Adaptation of the PPM into Practice**

Every day, the PPM is adapted for use in clinical practice through the patient care delivery model. As depicted as the center piece of the PPM, Patient-Centeredness describes the Patient Care Delivery Model which is patient- and family-centered and interdisciplinary in nature (OOD 11). It articulates a care-delivery system that is supported by a philosophy of care and an environment that enhances patient outcomes.

Patient care is expected to be of the highest quality, comprehensive, accessible, supportive, and personalized. The vision statement for Patient Care Services says, “Patients are our primary focus, and the way we deliver care reflects that focus every day” (OOD 1). Patient- and
family-centered care optimizes this relationship. It creates a care-delivery system that is centered around the patient.

Decisions about care and the environment of care are made at the practice level by clinical staff and unit leadership through the patient care delivery model (OOD 11). Authority, responsibility, and accountability for the nursing care of patients and families rest with Registered Nurses. Within the nurse-patient relationship, the nurse creates a therapeutic environment that ensures mutual trust, safety, privacy, and respect. As a Staff Nurse comes to know a patient and the patient’s unique response to certain situations, he/she designs a care plan based on that knowledge and best practices. The nurse’s practice has two components: doing for and being with. Doing for includes assessment, diagnosis, planning, intervention, and evaluation of outcomes; while being with refers to behaviors that create an environment where patients can heal. Nursing care requires nurses to be present to patients and families to listen, to know, to advocate for throughout the healthcare experience.

Staff Nurses at MGH are afforded an environment that optimizes professional practice and enhances patient care. The nurse-patient relationship, central to the work of nursing, is based on mutual trust and respect and is therapeutic in nature. The partnership forged between a nurse and patient, as well as family and community, is essential to promoting health, managing illness, and negotiating changes in lifestyle patterns. Nurses identify concerns related to the human experience (i.e., birth, health, illness, and death) and engage in clinical reasoning processes to identify problems, define outcomes, and generate interventions based on goals shared by the nurse, the patient, and the family.

The following two plans of care illustrate the delivery of interdisciplinary, patient- and family-focused care. Both Mr. A and Ms. B’s nurses advocated for their patients and included the patient, family and other members of the healthcare team in shaping the plan of care.

**Plan of Care: Mr. A**

Mr. A. was an 86-year-old male, with a history of prostrate cancer and recent diagnosis of small cell lung cancer with metastases to lymph and retroperitoneal lymph nodes. He was admitted to a medical inpatient unit for evaluation of lower back pain on 8/10/12. He was diagnosed with T11-12 cord compression. His code status upon admission was Full Code. His son was the Health Care Proxy (HCP).

Upon admission, the physician ordered complete bed rest and insertion of Foley. All nursing interventions were explained and patient verbalized understanding of the plan of care. Patient requested to sit in chair for comfort and use urinal. Order for Foley catheter discontinued (Attachment EP 1.f). Patient’s report of pain was 10/10 in bed, but 0-1/10 when sitting in chair (Attachment EP 1.g).

Through consultation with Palliative Care, Mr. A’s plan of care for pain management was adjusted to include Oxycodone every 12 hours in addition to Oxycodone every four hours. Mr. A was involved in discussions regarding code status and requested DNR/DNI given his advanced age and metastatic cancer (Attachment EP 1.h)

Mr. A collaborated with the plan of care. He slept in the cardiac recliner throughout the night. He was placed on fall precautions and received frequent safety checks. He refused neurosurgical intervention for the cord compression, but was interested in wearing the TLSO brace when out of bed (Attachment EP 1.i). Mr. A demonstrated good understanding of his illness. He and his sons discussed chemo with the healthcare team and decided against
further treatments. Additionally, Mr. A expressed agreement with hospice philosophy of care (Attachment EP 1.j).

A family meeting on 8/12/12 confirmed the patient’s and families’ understanding of the DNR/DNI status and appropriateness for hospice services in the future. They understand the possibility of all discharge options and agree that safety for the patient is greatest concern (Attachment EP 1.k. All medications and interventions were reviewed on a consistent basis with the patient (Attachment EP 1.l).

As the patient became weaker throughout his admission, he began to refuse labs, food and all treatments. He requested Morphine for the pain and expressed a desire to “die peacefully.” He was moved to Comfort Measures Only (CMO) (Attachment EP 1.m).

The patient died on 8/22 at 6:30 am.

Plan of Care: Ms. B

Ms. B was an 81-year-old female admitted to a surgical inpatient unit on 7/15/12 with complaint of worsening low back pain radiating down her posterior lower left leg. Her medical history include non-Hodgkin’s lymphomas stage IV (in remission), aortic stenosis, atrial fibrillation, hypertension and s/p gastric bypass surgery in 2004. Her code status was Full Code at time of admission. Her daughter was her Health Care Proxy (HCP).

During her initial weeks of her hospitalization, Ms. B was instructed on all interventions, procedures and plan of care. She was encouraged to ask questions as needed. A goal was set to eat all meals out of bed and to commence ambulation (Attachment EP.1.n). Both patient and family included in discussion of the MRI results. Patient complained of pain was 4-7/10 and a consult was submitted to the Pain Service (Attachment EP 1.o). The patient’s hospital course was complicated by episodes of hypotension, clonic pneumatosis, fever/bacteremia, pneumonia, persistent anemia requiring periodic transfusions, malnutrition and urinary retention. The plan of care for pain was to keep the level under 5/10 while increasing mobility. Goal was maintained for patient to be out of bed for means and to ambulate with a rolling walker (Attachment EP 1.p).

On 8/8/12 a goal was established so that the patient would understand the plan of care and next steps for diagnosis and treatment. Ms. B voiced that she received information regarding the plan of care and understood it (Attachment EP 1.q).

On 8/20/12, the patient developed 3+ pitting edema and was unable to move to the chair with assistance. Te nurse continued to assess the patient’s knowledge of the plan of care and the goal for mobility was decreased to out of bed twice during the day (Attachment EP 1.r). The following goals were established with the patient: use a food diary to monitor nutrition and PO intake; offer toileting to facilitate spontaneous voiding; keep SPO2>94; and maintain universal fall precautions (Attachment EP 1.s).

On 8/21/12, the NG tube was pulled per the patient’s request (Attachment EP 1.t). The patient’s pain because more persistent and her daughter requested something to make her more comfortable. Morphine was initiated with good effect. Her code status was changed to DNR/DNI following a discussion with the physician, nurse, patient and two daughters. There was also a request for the Chaplain (Attachment EP 1.u). Staff Chaplains visited the patient three times and provided the Sacrament of the Anointing of the Sick while she was surrounded by family and friends (Attachment EP 1.v). Patient was transitioned to Comfort Measures Only (CMO) and received IV Morphine Continuous Infusion. This decision was made by the family and patient (Attachment EP 1.w).
Modification of the PPM

As mentioned in the first portion of this source of evidence – development of the PPM – the MGH PPM has evolved since 1996. Ten years after its initial debut in 1996 (Attachment OOD 11.a), the components of the PPM were modified (Attachment OOD 11.b) to be better aligned with current practice. In recent months, initial informal conversations have occurred suggesting that the “Research” component of the PPM be expanded to “Research and Evidence-Based Practice.” This recommendation and others will be discussed at upcoming Patient Care Services Executive Team retreats and meetings.

It is noteworthy to mention that the MGH PPM and the Staff Perceptions of the Professional Practice Environment survey have emerged into an administrative program of research at MGH (TL 10). The survey data collected since 1997 is a wonderful data source that is rich for mining information about the professional practice environment.

The CNO and the Executive Director of Patient Care Services Operations pursued Doctorates in Nursing Science degrees (graduated May 2011) and both of their capstones focused on the professional practice environment. The focus of the CNO’s capstone underscored her belief that the professional practice environment is the single most accurate measure of nurse leader success across constituencies and the means by which nurse leaders can best advance the profession, discipline, and science of nursing.

In her capstone, the CNO noted that the primary objective of the Chief Nurse is to improve the environment in which health care delivery is provided. Thus, the Chief Nurse must influence others to achieve positive patient/organizational outcomes. In this capacity, Chief Nurses must effectively lead by empowering others while always monitoring, measuring, and transparently communicating data and outcomes related to the professional practice environment.

Attachment EP 1.x contains a summary of the CNO’s capstone work in which provides a framework to guide leaders about how to influence professional practice at the bedside. (This summary is in draft form and is the first chapter of a book edited by the CNO, Executive Director of PCS Operations, and the Director of the Yvonne L. Munn Center for Nursing Research at MGH. The book titled, “Fostering Nurse-Led Care: Professional Practice for the Bedside Leader from Massachusetts General Hospital” is being published by Sigma Theta Tau and will be available for sale at the upcoming 2012 Magnet Conference.)
The CNO’s framework demonstrates the dynamic and changing interrelationships between the elements necessary to improve the professional practice environment. The graphic incorporates four areas of influence that result in shared understanding between constituents in the environment of care that have the potential power to improve the environment in which they practice. They include 1) philosophical underpinnings; 2) professional practice model; 3) evidence from the evaluation of the professional practice environment using the SPPPE survey; and, 4) evidence from the literature, theory and research.

In her description of the framework, the CNO notes that a critical success factor of the Chief Nurse is the ability to scan the environment and detect signals to inform the operational and strategic direction. This consistent evaluation of the professional practice environment is core to understanding the impact of changes to the increasingly complex health care delivery system. Identifying approaches for accommodating this complexity is a key step in improving the quality of patient care and in retaining nurses in the workforce. The CNO notes that Elizabeth Barrett’s work suggests that “knowingly participating in change by being aware of what you choose to do, feeling free to do it, and acting intentionally”, should be guiding principles of Chief Nurse practice and should be a part of how the Chief Nurse encourages the interdisciplinary team to sort through clinical problems at the bedside. The use of a theoretical approach with exquisite leadership skills represents an important aspect of how a Chief Nurse might begin to measure, implement, and enhance an evidence-based approach to improving the professional practice environment.

The Executive Director of Patient Care’s Services Operation’s capstone study focused on identifying the organizational characteristics that are highly correlated with the work satisfaction of MGH nurses using two different practice environment measurement tools. The tools included the MGH Staff Perceptions of the Professional Practice Environment Tool (RPPE) and Lake’s Practice Environment Scale of the Nursing Work Index (PES-NWI).
The RPPE has been administered to MGH nurses and other clinicians throughout Patient Care Services every 12-18 months since 1998. The PES-NWI survey has been administered to MGH nurses every two years since 2010 through NDNQI. For this study, the two scales were administered concurrently.

In the sample 1,404 nurses, the three organizational characteristics of autonomy, control over practice and internal work motivation from the RPPE tool were noted as critical to MGH Nurses’ sense of work satisfaction and explained over 50% of variance. Components from the PES-NWI didn’t factor significantly into MGH nurses’ sense of work satisfaction.

The study results are timely as care redesign efforts ensue. It is critical that nurse executives know what components of the professional practice environment are important to their staff so they can be preserved and strengthened (Attachment EP 1.y).
Massachusetts General Hospital
Patient Care Services

Four Point Plan - 1996

- Improve communication
- Develop a Professional Practice Model
- Position nurses and health professionals to have a strong, positive voice in the institution
- Address salaries and resource allocation
**PROFESSIONAL PRACTICE MODEL: 1996**

We Value accountability, responsibility, diversity, resource effectiveness, & our core value — patient-focused care.

Collaborative Decision-Making is built on the premise of "teamness" & team learning, i.e., the network of relationships between people who come together to develop & implement actions or strategies toward a desired outcome.

The concepts of Privileging, Credentialing & Peer Review engage the full circle of accountability to patients, peers, our professions, & the MGH so that our patients & their families receive quality care from competent providers.

A Philosophy statement is derived from the values, principles, & beliefs that support the individualized work of each discipline. At MGH, each clinical discipline is guided by its own philosophy which synthesizes the beliefs of its practice.

The possession of a body of knowledge from Research is the hallmark of a profession. Research is the bridge that translates academic knowledge & constructed theories into direct clinical practice.

Professional Development is essential to our ability to provide quality care, to achieve personal & professional satisfaction, & to advance our careers. Our activities include orientation, in-service training, formal & continuing education, & clinical advancement activities.

Standards of Practice exist to ensure that the highest quality of care is maintained regardless of the number of professionals providing care, or the experience of those professionals.

Our core value of patient-focused care & our belief that the patient/family-nurse relationship are critical to the development of our professional practice model, i.e., our Patient Care Delivery Model.

Understanding the philosophical & Theoretical foundation of our practice is an important part of professional development & the overall change processes we undertake.
We value accountability, responsibility, diversity, resource effectiveness, & our core value --- patient- and family-centered care.

Professional development is essential to our ability to provide quality care, to achieve personal & professional satisfaction, and to advance our careers. Our activities include orientation, in-service training, formal & continuing education, & clinical advancement activities.

The possession of a body of knowledge from research is the hallmark of a profession. Research is the bridge that translates academic knowledge & constructed theories into direct clinical practice.

Standards of practice exist to ensure that the highest quality of care is maintained regardless of the number of professionals providing care, or the experience of those professionals.

Collaborative decision-making is built on the premise of “teamness” and team learning, i.e., the network of relationships between people who come together & implement actions or strategies toward a desired outcome.

Our primary core value is patient-centeredness and we believe that the patient/family-nurse relationship is critical to the delivery of safe, quality care.

Narratives provide an opportunity to share stories that have meaning to them at the same time describe concerns, intuition, inner dialogues, evolving understanding, feelings of doubt, challenge and conflict. Makes the often invisible components of practice, visible.

Using Benner’s novice to expert skill acquisition framework, through reflective practice and portfolio development, clinicians have the opportunity to advance their clinical practice at career at the bedside through the Clinical Recognition Program.

Through interdisciplinary teamwork and innovation, opportunities to ensure the delivery of patient care and the structures that support it continue to meet the changing needs of the populations we serve.
## Staff Perceptions of the Professional Practice Environment Scale
### Organizational Characteristics and Definitions

<table>
<thead>
<tr>
<th>Organizational Characteristic</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>The quality or state of being self-governing and exercising professional judgment in a timely fashion</td>
<td>Aiken, Sochalski &amp; Lake, 1997</td>
</tr>
<tr>
<td>Clinician-MD Relations</td>
<td>Relations with physicians that facilitate exchange of important clinical information</td>
<td>Aiken, Sochalski &amp; Lake, 1997</td>
</tr>
<tr>
<td>Control Over Practice</td>
<td>Sufficient intra-organizational status to influence others and to deploy resources when necessary for good patient care</td>
<td>Aiken, Havens &amp; Sloan, 2000</td>
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<tr>
<td>Communication</td>
<td>The degree to which patient care information is related promptly to the people who need to be informed through open channels of communication</td>
<td>Shortell, Rousseau, Gillies, Devers &amp; Simons, 1991</td>
</tr>
<tr>
<td>Teamwork</td>
<td>A conscious activity aimed at achieving unity of effort in the pursuit of shared objectives</td>
<td>Zimmerman, Shortell, Rousseau, Duffy, Gillies, Knaus, et al, 1993</td>
</tr>
<tr>
<td>Conflict Management/Handling Disagreements</td>
<td>The degree to which managing conflict is addressed using a problem-solving approach</td>
<td>Zimmerman, Shortell, Rousseau, Duffy, Gillies, Knaus, et al, 1993</td>
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<tr>
<td>Internal Work Motivation</td>
<td>Self-generated motivation completely independent of external factors such as pay, supervision and co-workers</td>
<td>Hackman and Oldham, 1976, 1980</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>A set of attitudes, practices and/or policies that respects and accepts cultural differences</td>
<td>The Cross Cultural Health Care Program, 2000</td>
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</table>
### Staff Perceptions of the Professional Practice Environment Survey

An Abbreviated List of Survey issues Identified with Respective Interventions/Outcomes

1998-2012

<table>
<thead>
<tr>
<th>SPPPE Survey Issue Identified (survey year)</th>
<th>Interventions/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for recognition of clinical work (1998)</td>
<td>The Senior Vice President and Chief Nurse charged the Professional Development Committee within Collaborative Governance with the responsibility to design an interdisciplinary recognition program. The first-of-its kind interdisciplinary Clinical Recognition Program was implemented in 2002).</td>
</tr>
<tr>
<td>Requests for additional educational opportunities (1998)</td>
<td>The Center for Clinical &amp; Professional Development was expanded to include orientation, training and continuing education opportunities for clinical and support staff.</td>
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<td>Improve access and communication within Social Services (2000)</td>
<td>Beepers assigned to all Social Workers.</td>
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<tr>
<td>Need for more in-services on various cultures to deliver culturally competent care (2001)</td>
<td>The Culturally-Competent Lecture Series was launched to augment the day-long culturally-competent care curriculum offered by The Center for Clinical &amp; Professional Development. Developed unit/department culturally-competent care resource manuals.</td>
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<tr>
<td>Request for increased Nursing Director availability (2001)</td>
<td>Nursing Director span-of-control was analyzed and reduced.</td>
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<tr>
<td>Need to enhance communication (2002)</td>
<td>Numerous communication strategies employed:</td>
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<td></td>
<td>- Increased use of email to improve communication</td>
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<td>- Creating the Fielding the Issues column in Caring Headlines (a question and answer column presenting timely information)</td>
</tr>
<tr>
<td>Request for cultural sensitivity discussions in Social Services (2003)</td>
<td>Establishment of a Cultural Competence Committee to explore issues and assess learning needs within the Department regarding cultural sensitivity.</td>
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<tr>
<td>Concerns identified regarding support from the Department of Food and Nutrition (2002-2003)</td>
<td>Food and Nutrition/Nursing Task Force established.</td>
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<tr>
<td>Common Patient Problems* (2002 – 2006)</td>
<td>Interventions occur at the unit level led by unit-based CNSs. Examples include:</td>
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<td>- Pain management (standard was articulated; CNS was hired).</td>
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<td></td>
<td>- Skin care (wound care task)</td>
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<tr>
<td>SPPPE Survey Issue Identified (survey year)</td>
<td>Interventions/Outcomes</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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| *nursing only                             | force/education program launched  
  • Respiratory care (tracheostomy rounds implemented  
Presented findings of SPPPE Common Patient Problem Survey at the National Association of Clinical Nurse Specialists NACNS). Subsequently, the survey was completed nationally by the NACNS membership to determine common patient problems on the national level. |
| Request for assistance re: public speaking and talking to the media (2004) | Launched media and public speaking programs through The Center for Clinical & Professional Development |
| Request for conflict resolution skills training 2005 - 2006) | The program, “Workforce Dynamics: Skills for Success” was launched through The Norman Knight Nursing Center for Clinical & Professional Development to present information/skills to work with a multigenerational workforce, negotiation, and preparing for and effectively engaging in difficult conversations. Focused conflict resolution interventions implemented. |
| Need to identify strategies to support the aging nursing workforce (2006) | Multi-site qualitative study designed to explore concerns of the aging nursing task force (with University of Michigan Health Care System and Shands at the University of Florida). Results are currently being analyzed. Applied for and received a grant ($10,000) from the Center for Integration of Medicine & Innovative Technology (CIMIT) to host a summit to more fully explore the opportunities to support the aging nurse population with emerging technologies. The “coming of age” summit was held on November 15, 2007. |
| Need to align work of collaborative governance committees with emerging strategic issues (2008) | Redesigned collaborative governance communication and decision-making committee structure to align with strategic goals |
| Need to develop tools to facilitate the ability of nurse leaders to correlate key data, eg., nursing-sensitive indicators, patient and staff satisfaction data (2010) | Developed a relational crosswalk of core measures to provide at-a-glance information about unit-or department-based metrics. |
| It was noted that effective teamwork and supportive, respectful communication between and among staff across disciplines helps to decrease conflict, improve patient safety and promote an effective practice environment that enhances patient-centric care (2011) | Launched Innovation Unit initiative on 12 units which includes interventions such as interdisciplinary rounds, the Attending Nurse role to facilitate interdisciplinary care planning, and a number of methods to promote patient and family involvement in the plan of care. |
**PROGRESS NOTES**

Enter name and unit number on both sides of EVERY sheet. Addressograph plate to be used when available. Name and number to be written distinctly when plate is not available.

All entries in the patient record, written or electronic, authenticated by the author. An authentication will include the author's signature and credentials along with either a legible pager number or printed first and last name to assist in uniquely identifying the author.

**UNACCEPTABLE ABBREVIATIONS:** Applies to all handwritten and electronic 'free text' entries

<table>
<thead>
<tr>
<th>QD</th>
<th>QOD</th>
<th>MS</th>
<th>MSO₄</th>
<th>MgSO₄</th>
<th>hs</th>
<th>ss</th>
<th>µg</th>
<th>U</th>
<th>IU</th>
<th>os</th>
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<td>.5 (i.e., use 0.5mg)</td>
<td>1.0 (i.e., use 1mg)</td>
<td>Apothecary Symbols (e.g., amp, grain)</td>
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Please Use Both Sides

**DATE** | **TIME** | **NPI:** 3p-79

8/1/12 4am

#1 KNOWLEDGE: Pt. A0x3. All nursing interventions explained to pt. Pt. verbally understood. Using current appropriately plan cont to assess learning needs.


Frequent visual checks. #1 TP: FE: Aetna. SCI chilenged/diagnosis. VSS, NO CP/pertinent cont. on lesion/diagnosis. B/wanage. A0p. Pt. tolerating drip prior to red status. Pills under water. Voiding manual amounts & providing UA sent. #3 OCM: thrombosis cont. on vent reg. mis. to be placed in venous to incidence. Pt. received IL NS klovs.

#1 This plan: Monitor hemodynamic stability. 

Pt. c/o 10/10 IVP, given 1mg oxycodone Parr & good effect. Plan: cont. to monitor for pain & pain med effectiveness.
PROGRESS NOTES
Enter name and unit number on both sides of EVERY sheet. Addressograph plate to be used when available. Name and unit number to be written distinctly when plate is not available.

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UNACCEPTABLE ABBREVIATIONS:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
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<tbody>
<tr>
<td>QD</td>
<td>Every day</td>
</tr>
<tr>
<td>QOD</td>
<td>Every other day</td>
</tr>
<tr>
<td>MS</td>
<td>Nightly</td>
</tr>
<tr>
<td>MSO₄</td>
<td>Magnesium sulfate</td>
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<tr>
<td>MgSO₄</td>
<td>Magnesium sulfate</td>
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<td>hs</td>
<td>Hourly</td>
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<td>ss</td>
<td>Sublingually</td>
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<td>µg</td>
<td>Micrograms</td>
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<td>U</td>
<td>Units</td>
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<td>IU</td>
<td>International units</td>
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<td>½</td>
<td>One-half</td>
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<td>1</td>
<td>One</td>
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<tr>
<td>Apothecary Symbols</td>
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<td>(e.g., amp, grain)</td>
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DATE | TIME | Addendum
---|------|---

Orders for Foley catheter. Provider in room and crew, cont. on PU are admitted using q4h, pr. did receive 1 dose long IV. Need to start.
**Nursing Progress Note**

**NURSING PROGRESS NOTE**

**date**
8/11/12  5pm (7am-7pm)

**time**

Knowledge Deficit: All medications and interventions have been reviewed with the pt. Pt reports no questions at this time. Plan: Continue to assess the learning needs of the pt.

Discharge Plan: No plan for discharge at this time. Case management following. Plan: Continue to collaborate with the medical team and case management.

Tissue Perfusion/Gas Exchange: HR 60s, SBP 120s denies chest pain and palpitations. HCT is 34.8. Pt is on Heparin TID SC for DVT prophylaxis. On room air, SpO2 is in the high 90s, denies SOB/DOE. Plan: Continue to assess hemodynamic status.

Infection: No fevers, chills or rigors; WBC-8.4. Pt was started on IV Ceftriaxone for +UTI, urine CNS is pending. Blood cultures are pending. Plan: Continue to assess for s/s of infection.

Safety: Pt is alert and oriented x3; can be strong willed at times and won’t accept help with ADL’s. Pt started spinal XRT this morning; CT of the spine is pending. On PO Decadron Q6H, lower extremities are weak; legs buckle when transferring to the wheelchair or toilet. Pt is a max assist with a walker. Brace shop will provide a TLSO brace for the pt to wear while OOB. Pt call light is in reach and uses it appropriately. Frequent safety checks are made. Radiation Oncology and Neurosurgery are following the pt. Plan: Continue to assess and maintain the safety of the pt.

Pain: Pt c/o 10/10 pain only with movement, it is worse when standing. Pt has received PO Oxycodone 10mg PRN with good relief. When the pt is sitting in the chair and not moving pain is 0-1/10. Palliative care will consult on the pt. Plan: Continue to assess pt comfort level.
PROGRESS NOTES

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DATE | TIME  | Full note to follow in LMR
|------|-------|-------------------------
| 8/11/18 5PM | Full note to follow in LMR

Recieved consult, chart received, met & patient.

In brief: 80 y/o w. prostate car +
recent dx of sc lung cancer + rmts to retroperitoneal node + spine. Now w/ urology:
back pain MRI = 11-12 cm. tumour.

Suggest:

1. Pain: Agree to dexamethasone + RT (started today)

Please start oxycetin 10 mg Q12h
in addition to oxycetin 10 mg-15 mg Q4h

2. Constipation - agree to current regimen

Please offer bisacodyl suppository

3. O2C - discussed w/ Drs. CRK

At length this evening. Pt. Clear

He would like his code status to be DNAR/DNI in the setting of advanced age + metastatic cancer.

Will continue to follow w/ you. BR.
NURSING PROGRESS NOTE

date  time

8/12/12   03:00   NPN 7p-7a   DNR/DNI

#1 Knowledge Deficit: Alert and oriented times three. Pleasant and cooperative. Evening medications and plan of care explained to patient. Pt verbalized understanding. Pt HOH. Sleeping on and off throughout night in the cardiac recliner chair. Plan: continue to assess pts learning needs.


#3 Alt Tissue Perfusion: SBP 120's. HR 60's. Denies CP/SOB. 02 sat > 95% RA. HCT 34.8. Receiving SQ Heparin TID for DVT prophylaxis. On Amlodipine every other day. Urinal at bedside. Patient with complaints of constipation. Had BM times 2 after suppository 8/11. Received Colace/Senna and Miralax as ordered. Plan: monitor vital signs.

#4 Infection: Afebrile. Receiving IV Ceftriaxone BID for + UTI, Urine culture pending. WBC 8.4. Blood culture times 1 with no growth thus far. Plan: continue antibiotics as ordered.

#5 At Risk For Injury: Fall Precautions. Call bell in reach. Patient using call appropriately to ambulate to BR. Patient unsteady and weak, but able to ambulate to BR with walker and 1 assistance. Frequent safety checks made. Patient sleeping in recliner chair during the night. Remains on Decadron every 6 hours for cord compression on spinal MRI. Plan: awaiting brace shop to provide TLSO brace for patient to wear when OOB, maintain safety precautions.


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Palliative Care Service Consultation
Date: 8/11/12
Time: 5pm

Admission Date: 8/10/12
Admitting physician: [Redacted]
Referring provider: [Redacted]

Reason for Consultation: Pain and symptom management, goals of care

HPI:
Information for this consultation was gathered from a review of the medical record and interviews with the patient, nurse, and resident physician. The patient is considered to be an accurate reporter. The patient's recent and remote medical history are well-documented in the medical record.

86M h/o prostate cancer and recent diagnosis of small cell lung cancer with metastases to lung and retroperitoneal lymph nodes, who was admitted for evaluation of back pain; MRI today shows evidence of T11-T12 cord compression.

[Redacted] has a long history of prostate cancer diagnosed ~20 years ago. Six months ago he was evaluated for voiding difficulty and hematuria with negative cystoscopy. CXR at that time showed pulmonary nodules, CT scans at Lahey clinic confirmed diffuse abnormalities including multiple pulmonary nodules and retroperitoneal lymphadenopathy with bony involvement. Biopsy of his lung lesion revealed small cell lung carcinoma, poorly differentiated. He has since had a acute on chronic decline in leg strength and increasing low back pain. He was seen by his PCP on 8/3/12 for these issues who found pt in pain when getting up from chair and with pain across lumbar spine. He was re-evaluated in clinic on 8/10/12 with new midline tenderness to palpation in the lumbar spine. He was admitted to MGH Medicine service for symptom palliation and workup of his back pain. MRI-spine revealed T11-T12 cord compression.

He was started on dexamethasone 10mg IV x1, and 4mg q6hr PO. Seen by neurosurgery but declined consideration for surgery. Seen by rad/onc and agreeable to RT (5 fractions) with the goal of pain control. He is incontinent of urine at baseline, no fecal incontinence, no saddle anesthesia, no foot drop though he does have falls on occasion. He lives in his own home with a roommate (another retired gentleman). He report his roommate helps him out some but "has his own troubles". Patient states his room mate comes and helps him up when he falls. He reports having to urinate about once an hour at night. He states he feels dizzy when he gets up at night sometimes.

Patient reports the pain in his lower back (left side > right) is "always there" and progressively worsened over the past 2 weeks. The pain is 7/10 now and responds to oxycodone. He has used 30 mg po oxycodone in the past 24 hours with incomplete relief. "It is always there". Pain is worse with lying flat. He had been sleeping in a recliner for the past week. He reports both his legs feel weak "like they may give out on me". Reports using a walker in the hospital has been helpful.

He became constipated at home after starting oxycodone. He has moved his bowels since admission but not satisfactorily. His appetite is "not great" but is eating some at each meal. He denies weight loss.

Palliative Care Review:
Pain Issues
Pain description: Left lower back, worse with lying flat or with any movement
Pain intensity (0-10) 7/10
Interference with daily life (0-10) 9/10
Worst it's been in last two weeks (0-10) 10/10
Best in the last two weeks (0-10) 5/10

Review of Symptoms (Underlined symptoms are reviewed and present)
Constitutional: Denies; Anorexia; Drowsiness; Fatigue; Fever; Weight Loss
Ears, Nose, Mouth, Throat: Denies; Secretions; Xerostomia
Cardiovascular: Denies; Chest pain; LE swelling
Respiratory: Denies; Dyspnea; Cough
GI: Denies; Nausea; Vomiting; Abdominal pain; Constipation; Diarrhea
GU: Denies; Urinary retention; Urinary incontinence
Musculoskeletal: Denies; Bone pain; Joint pain; Muscle pain; lower back pain
Skin: Denies; Pruritus; Decubitus ulcers; Dry skin; Rash
Neurological: Denies; Dizziness; Agitation; Sedation
Psychiatric: Denies; anxiety; Depressed mood; Hallucinations
Endocrine: Denies; Staroid side effects; Cold/heat intolerance
Allergic/Immunologic: Denies; Immunosuppressed; Neutropenic
Hematological/Lymphatic: Denies; Bruising; Bleeding; Lymphedema; Lymphadenopathy
All other ROS have been reviewed and are negative.

Performance status
ECOG (0- fully active; 1- restricted strenuous activity; 2-ambulatory, unable to work; 3- limited self-care, bedchair> 50 waking hours/wk; 4- bed-chair confined, no self-care.)
Two weeks ago, or prior to admission: 2
Current performance status:3

Information Sharing
Patient's awareness of illness:Terminal
Information preferences: Fully involved
Speak to family: 2 sons- Richard and Peter
Family's awareness of illness:Aware and involved

Advance directives
Health Care Proxy: Co-proxies son's Richard and Peter
Location of Proxy document: At patients lawyers office
Attitude towards place of death: home
Funeral arrangements/ wishes:Not discussed

Limitations on Life Sustaining Treatments: DNR/DNI per today's discussion

Spiritual History
Religious/spiritual orientation: Not discussed at this visit
Involvement in Spiritual Community:
Need for further Chaplaincy support:

Past Medical History:
1. recent diagnosis of widespread poorly differentiated small cell cancer
2. prostate cancer - s/p radical prostatectomy and XRT, found to have recurrent nodule at anastomosis site (~1999, PSA 10), started on ADT with decline in PSA, d/c'd and PSA 10 in 1/2012, re initiated on ADT. Developed hematuna and difficulty bleeding, underwent cystoscopy without significant findings, but recurrent problems prompted further w/u and found to have pulm nodules on CXR.
3. Hypertension
4. Hyperlipidemia
5. EPICONDYLITIS
6. RETINAL DETACHMENT
7. gastrointestinal bleeding - diverticulosis and hemorrhoids on prior colo
8. GERD, gastric ulcer - non bleeding ulcers on antrum and bulb on EGD 1999
9. Anemia
Social History:
Immigrated from Vienna in 1939, divorced since 1981, ex-wife died 5/06. Has two sons of own and one by marriage, Peter and Richard.
Patient Coping: Well- "I have had a good life".
Support system: Sons live nearby but patient lives alone with a roommate
Family support: Patient states his sons are there for him
Family coping: unable to assess
Financial issues: not assessed
Education: Engineer
Work: retired microwave engineer for Miter corporation
Hobbies/Joys: not discussed
Habits-Tobacco: quit in 1970
Alcohol: no recent, occasional in the past
Recreational drugs: None

Family History:
Maternal – died in 60s of ICH
Paternal – died at 86 of "old age"
Siblings – COPD 2/2 smoking, Brother died of lung ca, no other siblings
Children – Peter (age 52 yo) and Richard (55 yo), both healthy

Physical Examination:
Vital signs: BP 130/63, HR 63, RR16, spo2 on RA 95%
General appearance: Alert oriented, good historian, in pain when moves, HOH- hearing aide right ear, speech fluent
Eyes: vision intact, sclera clear
Ears, Nose, Mouth, Throat: moist mucous membranes, no thrush
Cardiovascular: RRR 51S2 no murmurs
Respiratory: Non labored at rest
Gastrointestinal: BS present, softly distended, No HSM, no rebound
Musculoskeletal: No joint deformities; strength grossly intact, no spinal or paraspinal tenderness to palpation
Skin: without rash, sores
Neurologic: II-XII grossly intact
Neuropsychiatric: Oriented, appropriate with full range of affect

Laboratory Studies:
After review of recent laboratory data and independent review of radiographic records, the results are summarized as follows:
08/11/2012 NA 131 (L), K 3.9, CL 95 (L), CO2 21.9 (L), BUN 59 (H), CRE 1.73 (H), EGFR 38, GLU 149 (H)
08/11/2012 ANION 14
08/11/2012 CA 10.1, PHOS 3.3, MG 2.3 (H)
Radiology Studies:

**Type:** CTThorSpnBoneWO  
**Date/Time:** 08/11/2012 15:34  
**Impression:** Findings consistent with metastatic involvement of the spine as on MRI. Metastatic involvement of the lungs. Left renal hydronephrosis.

**Type:** MRI CSpBneWWO  
**Date/Time:** 08/10/2012 23:28  
**Impression:** 1. Interval development of a large heterogeneously enhancing mass with areas of central necrosis involving the T11, T12, and L1 vertebral bodies with extension into the central canal, neuroforamina, and paraspinal muscles/soft tissue structures as described above. Multiple new lesions and areas of abnormal enhancement involving the T2, T4, T8, T11, T12, as well as L1 through S1 vertebral bodies. Constellation of these findings is consistent with diffuse metastatic involvement of the thoracic and lumbar spine with associated severe CSF space compromise at T11 and T12 levels. 2. Mild-to-moderate anterolisthesis of L5 upon S1 with associated bilateral L5 pars defects, unchanged. 3. Multilevel cervical, thoracic, and lumbar spondylitis.

**Impression:** 86M h/o prostate cancer and recent diagnosis of small cell lung cancer with metastases to lung and retroperitoneal lymph nodes, who was admitted for evaluation of back pain; MRI today shows evidence of T11-T12 cord compression for which Neurosurgery is consulted. Patient reports that he would not be interested in surgery at this time but may be interested in Radiation if it would help his symptoms.

**Suggestions:**

1) **Pain:** In back r/t metastatic disease and SCC  
   - Agree with Decadron 4mg Q6 per primary team  
   - Agree with RT (treatment 1/5 received today)  
   - Start oxycodone 10 mg BID for long acting pain coverage  
   - Continue Oxycodone 10 mg Q 4 prn  
   - If opioid needs continue or escalate may transition to Fentanyl patch and dilaudid for BTP given elevated creatinine.

2) **Constipation:** 3 small BM's today but feels constipated from opioids  
   - Please offer a suppository this evening (nursing aware-patient agreeable)  
   - Continue SENNOSIDES 2 TAB PO BID  
   - POLYETHYLENE GLYCOL 17 GM PO Daily  
   - DOCUSATE SODIUM 100 MG PO TID  
   - BISACODYL RECTAL 10 MG PR Daily PRN

3) **Coping:**
Struggling with concerns regarding likely loss of independence and pain.

Advanced care planning:
- HCP: Son's Richard and Peter
- Code status: DNR/DNI - confirmed wishes today
- Understanding of Illness/GOC: Patient verbalizing a good understanding of his illness: "I have a new small cell poorly differentiated cancer that does not have a good outlook as it has infested my lungs and my bones and a few other places, it is the cause of my back pain because it is pressing on my spinal cord." He reports that upon diagnosis he and his oncologist at Dana Farber, his PCP and his sons discussed having chemotherapy. After careful consideration he decided that the risk for the side effects of chemo outweighed the benefits. Patient states he understands his time is limited. We discussed his preferences for code status today and he confirmed he does not wish to have CPR administered in the event of a precipitous worsening of his condition given his advanced age and metastatic cancer. He states "if that happens it is time for me to go and frankly I hope I don't hang around too much longer in this state." He is accepting of any and all interventions if the goal is to maintain his comfort or help improve his functional ability. He is hopeful that he may be able to remain in his home for more time but realizes he may require more help or going to a nursing facility in the near future. Up until this event he has been driving. He understands he cannot drive now or in the future if on pain medications. He reports he had skilled nursing at home for a short time recently but they discharged him because he was not homebound. We discussed home hospice as a possibility for future help at home. Patient is in agreement with the hospice philosophy of care. He requests I return tomorrow when his sons are available to further discuss hospice at home VRS hospice in a facility based on his response to RT/and other possible pain management interventions (? possible vertebroplasty) in terms of his functional status.

Thank you for involving Palliative care in the care of this gentleman. Will continue to follow with you and attempt to connect with patients sons on 8/12/12 at his request.

Time spent 85 minutes >50% in counseling re: pain management and over all goals of care.
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DATE | TIME   | Palliative care: Family Meeting 12:30 - 1:30 pm

Pt. reports pain better on long acting pain medication. More comfortable rest pain. No any movement. Hires hands last night feels better.
No nausea. Mental status intact.
Eating well - likely the influenced by decreased. From Peter + Richard.

O: VSS Alert, pleasant appearance

Comatose.

H 130/90, HR 102, RR 24, SpO₂ 96%.

Resp: normal, chest clear, crackly bases.

Abd: soft, nontender, + BS

Int: ? edema

Amb.: #10, Open. Patient admit to recent relapse of small cell lung cancer, 2 met. to retrosigmoid approach. Need receiving RT for T11-12 and continued.

O: Pain: 2/2 SCC

Agree to increase in Oxygen.
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<td>to 20 mg Q12h  (basal, 35mg used for BP)</td>
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<td>- Agree to Zometa, RT + depletes -</td>
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<td>- Amics NSAIDS x 7 Creat 1.69</td>
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<td>① Constipation: RT opines</td>
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<td>② Coping / BOC :</td>
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<td>Met pt and HCP Peter/Richard</td>
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<td>Confirmed family understanding of pt’s wishes for DNR/DNI status and appropriateness for hospice services in the future. Discussed home hospice vs. hospice in a facility. Pt verbalized understanding of likely prognosis of months. Pt would like to go home even for a time if able. Understands he can no longer drive.</td>
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<td>All agree his safety is of greatest concern. They understand possibility of ① Rehab ② Home Hospice of RTC</td>
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<td>Caregivers can be arranged or SNF in - RN, PC</td>
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Please Use Both Sides
NURSING PROGRESS NOTE

Date       Time
8/12/12     5pm (7am-7pm)

DNR/DNI

Knowledge Deficit: All medications and interventions have been reviewed with the pt. Pt reports no questions at this time.
Plan: Continue to assess the learning needs of the pt.

Discharge Plan: No plan for discharge at this time. Case management following. Plan: Continue to collaborate with the medical team and case management.

Tissue Perfusion/Gas Exchange: HR 60s, SBP 150s denies chest pain and palpitations. HCT is 35.1. Pt is on Heparin TID SC for DVT prophylaxis. On room air, SpO2 is in the high 90s, denies SOB/OE. Plan: Continue to assess hemodynamic status.

Infection: No fevers, chills or rigors; WBC-5.7. Pt continues on IV Ceftriaxone for +UTI, urine CNS showed staph aureus and susceptibilities are pending. Blood cultures show no growth. Plan: Continue to assess for s/s of infection.

Safety: Pt is alert and oriented x3. Pt continues daily spinal XRT. On PO Decadron Q6H, lower extremities are weak; legs buckle when transferring to the wheelchair or toilet. Pt is a max assist with a walker. Brace shop will provide a TLSO brace for the pt to wear while OOB. Pt call light is in reach and uses it appropriately. Frequent safety checks are made. Radiation Oncology and Neurosurgery are following the pt. Pt received a dose of IV Zometa this afternoon. Plan: Continue to assess and maintain the safety of the pt.

Pain: Pain has improved after starting Oxycodin Q12H. Pt can receive PRN Oxycodone as needed, received once this shift. When the pt is sitting in the chair and not moving pain is 0-1/10. Palliative care is following the pt and met with his family today. Plan: Continue to assess pt comfort level.
NURSING PROGRESS NOTE

8/13/12  04:00  NPN 7p-7a  DNR/DNI

#1 Knowledge Deficit: Alert and oriented times three. Pleasant and cooperative. Evening medications and plan of care explained to patient. Pt verbalized understanding. Pt HOH. Sleeping on and off throughout night in the cardiac recliner chair. Plan: continue to assess pts learning needs

#2 Discharge Planning: Collaborating with team regarding plan of care. Case management/palliative care/rad Onc and neuro surgery following pt. s/p radiation 8/11. Plan: await discharge plans with hospice services when medically stable, XRT today

#3 Alt Tissue Perfusion: SBP 150’s. HR 70-80’s. Denies CP/SOB. 02 sat > 95% RA. Receiving SQ Heparin TID for DVT prophylaxis. On Amlodipine every other day. Urinal at bedside. Patient with complaints of constipation. Last BM 8/12. Received Colace/Senna and Miralax as ordered. Plan: monitor vital signs

#4 Infection: Afebrile. Receiving IV Ceftriaxone BID for + UTI, Urine culture pending. Blood culture times 1 with no growth thus far. Plan: continue antibiotics as ordered

#5 At Risk For Injury: Fall Precautions. Call bell in reach. Patient using call appropriately to ambulate to BR. Patient unsteady and weak, but able to ambulate to BR with walker and 1 assistance. Frequent safety checks made. Patient instructed that he needs to call for assistance to go to BR. Patient verbalized understanding. Patient sleeping in recliner chair during the night. Remains on Decadron every 6 hours for cord compression on spinal MRI. Plan: awaiting brace shop to provide TLSO brace for patient to wear when OOB, maintain safety precautions

#6 Alt Comfort: Patient with complaints with activity. Oxycontin BID and receiving Oxycodone PRN for BTP. Given times 2 thus far. Palliative care following pt. Sleeping at this time. Plan: monitor for increased pain
NURSING PROGRESS NOTE

date time

08/13/12 NPN 7a-7p 6p DNR/DNI

Knowledge Deficit - Pt with no questions voiced this shift. All meds and procedures explained to pt and pt verbalized understanding. Plan: Continue to educate pt about meds, procedures and plan of care.

D/C Planning - No d/c plans at this time. Plan: Continue to work with team and CM for d/c when stable.

Pain - Pt continues to have 4-8/10 back pain. Receiving 15mg oxycodone as ordered, prn: It does help with pain but does not elevate it. Awaiting brace shop to see pt for TSLO. Daily XRT as written. Plan: Continue to monitor pain, treat and assess efficacy of treatment. Await TLSO, continue XRT as written, done this afternoon.

F/E - Pt with very good PO intake of food and liquid. Voiding in urinal or BR when moving bowels. + BM of a large quantity this am. Na 129, B/CR 61/1.60 and trending down. Plan: Continue to monitor F/E and treat as needed.

ID - IV Ceftriaxone d/c'd and changed to PO Keflex. WBC 12.3, afebrile. Plan: Continue to monitor for s/s of infection and culture if needed.

GI/GU - +BM (large amount), semi formed and brown.
NURSING PROGRESS NOTE

date    time

Plan: Continue to monitor GI/GU and document any problems or difficulties.

Safety - Pt continues to be very impulsive when he needs to go to BR. He wants to do on own and resists help if at all possible. Re-inforced need to call several times and he has since complied. Remains up in cardiac chair for comfort. Awaiting TLSO.
Plan: Continue to monitor safety and implement all safety precautions as needed, continue to assess need for sitter and d/c once has been stable for a period of time.

UNACCEPTABLE ABBREVIATIONS: Applies to all handwritten and electronic 'free text' entries

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NURSING PROGRESS NOTE

8/14/2012  6A  NPN 7p-7a

**Knowledge Deficit:** patient alert and oriented x 3. calls appropriately for assistance. All meds/procedures reviewed with patient until able to verbalize understanding. Plan: continue to assess patient’s MS and review all meds/procedures prn.

**TP:** HR 70-80’s. SBP 120’s. denied cp/palp overnight. SC heparin TID. O2 sats mid 90’s on RA. No SOB noted at rest. Plan: continue to assess VS and administer meds as ordered.

**F&E:** denied abdominal pain/n/v. received bowel regimen as ordered. One large BM over evenings. Assist to BR with walker. Voiding in urinal. Takes pills whole with water. Tolerating diet. Plan: continue to assess I&O’s.

**ID:** afebrile. No rigors chills or sweats. Continues on p.o. antibiotics as ordered. Plan: continue to assess for s/s of infection and administer antibiotics as ordered.

**Comfort:** patient c/o 6/10 in lower back pain. Noticeably uncomfortable with repositioning and ambulation. Medicated with standing oxycontin BID and prn oxycodone when available. Standing Q6hr decadron as ordered. Continues on daily XRT. Plan: continue to assess for patient’s comfort and medicate with standing and prn meds as appropriate.

**Safety:** patient unsteady with ambulation with walker to BR. Requires assistance with activity. Fall precautions put in place. Patient wearing non skid footwear. Bed low and locked. Frequent assessment made for patient’s safety. Patient reminded throughout shift to use call light for assistance. Awaiting TLSO brace from brace shop. Plan: continue to assess for patient’s needs and use fall precautions.

### UNACCEPTABLE ABBREVIATIONS

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NURSING PROGRESS NOTE

date     time
8/20/12   7a-3p (2:15pm)    CMO

Knowledge Deficit: Pt. Alert and oriented, but at times agitated and impulsive. Pt. states repeatedly he “just wants to go from here to heaven comfortably.” All nursing interventions explained to pt. and he has verbalized no questions this shift. Pt. sleeping on and off through the day. Son Peter came to visit this afternoon. Questions answered. Plan- continue to provide information on interventions and answer questions as needed.

Discharge Planning: There is no active d/c plan in place at this time for pt. possible transfer to inpt. Hospice. Pt. is CMO. Plan- continue to maintain the patient's comfort at end of life.

Pain: pt. unable to rate pain with 0-10 pain scale. Pt. just reports he is uncomfortable. Especially when awake and repositioning. He continues on a morphine PCA pump. The settings were adjusted this morning due to increase in pain. PCA settings are now (2mg dose/6min lockout/1mg basal rate). Pt.'s pain is somewhat better at this time. He is less agitated and able to fall asleep for periods of time. Pt. beginning to have noted audible secretions. Notified H.O. who was going to order for a scopolamine patch. Also tried suctioning pt. with yankauer. He is able to cough, but not producing anything. Plan- continue to assess pt's pain and treat.

Elimination pattern: pt. wearing a Texas catheter to prevent skin breakdown and also to make voiding easier due to patients pain. Putting out yellow urine with some noted sediment. Pt's skin is red and excoriated in groin folds. Area cleaned well and barrier intact. Cream applied. Plan-continue to monitor pt. elimination pattern.

Safety: Pt. has made no attempts to get up OOB. He has good amt. of weakness in his legs and needs assist with repositioning. Frequent visual checks made through the day. Plan-continue to reposition pt. for comfort.

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NURSING PROGRESS NOTE

Date: 8/1/12  Time: 10:30 pm

KNOWLEDGE DEFICIT: Patient instructed on hand hygiene and respiratory practices; also instructed on patient's right to express safety concerns. Patient educated about all interventions and all questions answered. Plan to continue to explain procedures and plan of care, as well as encouraging questions as needed. Reinforce need to attempt to mobilize, need to use incentive spirometer, need to increase po intake, need for repeat MRI, need for Foley to be removed.


ALTERATION IN COMFORT: Pt without any c/o abdominal pain. States back pain 3-4/10 but today and tonight, pain increases when she gets OOB. Remains on Fentanyl patch 25mcg. Continues with 3 Lidocaine patches to her back. Continue Tylenol 975mg tid and Neurontin 300mg tid. Pt receiving Tinzidine 2mg at sleep. Pr restning now. Goal to keep pain under 5/10 but hope to increase mobility.

ALTERED MOBILITY: moving extremities well. States some baseline slight numbness in feet. OOB to chair with max assist to commode several times today. No ambulation as yet. Continue to encourage OOB, increasing endurance and strength, independence. Goal for OOB for meals and begin ambulation.

ALTERED SKIN INTEGRITY: coccyx reddened but blanchable. Barrier cream applied several times. Pr turned side to side and understands need to keep off buttocks and coccyx. Goal to have no skin breakdown and improving of redness. Lower extremities with edema, R>L. Pt had LENIS which were negative, socks on and off throughout the evening.

GEN: vss. Temp max 100.8 tonight but up to 101.8 early this pm. BC drawn. UA and c+s sent this evening. UA with >100WBC, 50-100 RBC. Vanco increased to q 12 hours rather than daily. Pt using incentive spirometer well. Coughing productively at times. BP improving to 104/58. AP remains 70-78. AFB contolled. On regular diet, eating small amounts with much encouragement. Ensure and supplements given Urine Foley
output almost 1500cc this shift. Foley ordered to be discontinued. Pt DTV 4-6am. Loose stool earlier today. Colace held. TPN discontinued. Continues on Flagyl IV q 8 hours, IV Vancomycin q 12 hours, and IV ceftriaxone q 24 hours for presumed inflammation of colon. Hct 26.5 WBC 11.0. Pt went for repeat MRI this evening due to continued pain.
Nursing Progress Note

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Signature should be legible and include name, licensure & pager #

NURSING PROGRESS NOTE

date time

08.02.12 Time 1830 Shift 7a-7p

Knowledge Deficit: Pt oriented to unit, call bell system, nursing plan of care. Interventions explained prior to implementation, all questions answered. Pt's knowledge base and learning needs assessed. Pt Plan: Continue to assess pts learning needs, explain interventions & answer questions.

Risk for Falls: Pt risk for falls assessed, hourly rounding maintained, pt A/O x3, floor clear from clutter. Pt verbalized understanding to call RN/PCA when needing assistance to reposition. Plan: continue to monitor for risk for falls.

Pain: Pt c/o 4-7/10 pain to lower back. Receiving Tylenol 650mg po TID, Neurontin 300mg po TID, Timandine qhs, Lidocaine patches x3 to lower back, and Fentanyl patch applied 8/1 with some relief. Pt assisted to reposition as needed. Pain service consulted. Plan: Continue to assess pain level, medicate as needed.

Impaired Skin Integrity/Risk for Infection: Coccyx noted to be slightly pink, blanchable, barrier cream applied with peri care, pt repositioned frequently off buttocks. Goal for redness to continue to improve and no skin breakdown. BLE with edema noted R>L. Pt had LENS 8/1 that were negative. Pt continues on abx Flagyl, Vanco, and Ceftriaxone IV through port in R CW, port had blood return, needle changed 8/1. Pt febrile this shift, tmix 102.3, MD aware. Tylanol given as ordered, encouraged IS use, CXR obtained, and blood cultures drawn results pending. CXR results show focal pneumonia and small R pleural effusion. Goal is for pt to become afebrile. Plan: Continue with abx, encourage IS use.

Impaired Mobility: pt OOB to recliner for most of the morning using ceiling lift. Pt mobility limited to pain. PT did not work with pt this shift dt low HCT and BP, Pt assisted to reposition in bed frequently. Fragmin given this am.

Alt Hemodynamics: HCT 25.3 ordered for 2 units of PRBCs but transfusion on hold dt pt's temp, MD ordered to hold blood until pt becomes afebrile. BP 90-80s/50s-60s MD aware, continues on telemetry A fib controlled. Plan: continue to monitor vital signs and recheck labs.

Alt Elimination/Intake: Pt has fair pt intake, encouraged to increase pt this shift, receiving Ensure with meals. Foley replaced this am for pt's inability to void. Urine amber colored and at times cloudy, +loose BMs this shift, guiac x1 completed results positive, MD aware, pt is already on Flagyl. Plan: Ensure adequate hydration, monitor stools.

General: MRI results discussed with family and pt this shift.
NURSING PROGRESS NOTE

Date: 8/4/12   Time: 10:30 pm

KNOWLEDGE DEFICIT: Patient instructed on hand hygiene and respiratory practices; also instructed on patient's right to express safety concerns. Patient educated about all interventions and all questions answered. Plan to continue to explain procedures and plan of care, as well as encouraging questions as needed. Reinforce need to increase mobilization, need for use of incentive spirometer, need for antibiotics.


ALTERATION IN COMFORT: Pt without any c/o abdominal pain. States back pain 5/10-3/10 after meds. Still with good deal pain when mobilizing OOB. Remains on Fentanyl patch 25mcg. Continues with 3 Lidocaine patches to her back. Continue Tylenol 650mg tid and Neurontin 300mg tid. Pt receiving Tinazidine 2mg at sleep. Pt resting now. Able to sleep in good naps. Goal to keep pain under 5/10 but hope to increase mobility.

ALTERED MOBILITY: moving extremities well. States some baseline slight numbness in feet. OOB to chair with max assist to chair earlier today. Set up for 4 hours, tolerating well. Took a couple steps with walker. Continue to encourage OOB, increasing endurance and strength, independence. Goal for OOB for meals and ambulation with rolling walker.

ALTERED SKIN INTEGRITY: coccyx looking much better. Perineal area reddened due to loose stool. Barrier cream applied several times. Pt turned side to side and understands need to keep off buttocks and coccyx. Goal to have no skin breakdown and improving of redness. Lower extremities with edema, R>L. DSD intact over old portacath site.

GEN: vvs. Pt afebrile tonight. Pt using incentive spirometer well. No cough tonight. Remains on IV Cefepime q 12 hours and po Flagyl tid. BP remains 94/52. AP remains 70-84. A fibr controlled. On Regular diet, eating small amounts with much encouragement. Eating soup that daughter brought. Try to give Ensure

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NURSING PROGRESS NOTE

date  time
8/8/12 7a-3p, 250pm

General — 81 year old admitted with increase acute lower back pain was admitted with Team 4. Patient was transferred to Team 5.

Pain — Goal: Patient to be able tolerate pain when OOB with the new medication. Patient is order for Lecocaine 5% 3 patches, Tylenol 650mg PO RTC, Neurontin 300mg PO TID, TItracaine 2mg PO at night, and Oxycodone 1.25-2.5mg PO once a day before PT. Fentanyl patch was discontinued today. Receiving lidocaine patches, Tylenol and neurope during the day. Patient seems comfortable while in the bedrecliner. When OOB or repositioning patient’s pain is increasing. Seabrook heating pad for relief is at the bedside. Pain service is following. Plan — continue to assess pain and medicate as needed

Impaired Skin Integrity — Goal: Patient to have no new noted skin breakdown areas this shift. Sacral and groin areas are pink, blanchable. Barrier cream applied. Denies numbness and tingling. Sten-strips to right chest wall, no drainage noted. Edeas noted to all extremities, MD is aware. Max temp was 106.0. Team and ID are aware. Blood cultures sent 8/7 results pending. Plan — encourage PO fluids and notify MD with any changes

Impaired Mobility — Goal: Patient is to be able to tolerate getting OOB with PT or nursing staff with decreased pain by the end of the shift. Patient was OOB with 2 max assist and RW to the recliner. Gait was shuffled, slightly unsteady. Reposition with 1-2 assist in the bed. Working with PT, no formal session today. Plan — encourage OOB and monitor BP

Alteration in Elimination — Goal: Patient to have an increase in appetite and tolerating more PO fluids by the end of this shift. Order for regular diet with supplements (Entyve, only cold). Nutrition is following, recommend a feed tube. Would like a calorie count daily. No c/o n/v. Tolerating PO fluids. Abdomen soft not tender. +BS, +Flatus. +BM, loose. Held all bowel medication. Foley is draining to gravity. Possible voiding trial tomorrow. Plan — encourage PO fluids

Knowledge Deficit — Goal: Patient will understand each plan of action by the end of this shift. Plan of care reviewed with patient with verbal understanding. Hand and respiratory hygiene reviewed with patient. Plan — continue to assess patient’s knowledge base and educate as needed using the appropriate teaching methods.

Risk for Falls — Goal: Patient will no fall today. Universal fall precautions in place. Bed is lowest and locked position. Call light in reach. Floor clear of clutter. Patient has on non skid socks. Plan — continue to assess risk for falls and follow universal fall precautions

Misc — Patient is AdOx3. Lungs sounds clear. Denies CP and SOB. Patient baseline blood pressure is low. HCT 26.6, MD is aware. Patient order one unit of PRBCs to be transfused. Blood is transfusing with no reaction noted. Daughters are very concerned and anxious about their mother, max emotional assist was provided. Discharge is still in progress, no date has been set.
NURSING PROGRESS NOTE

Alteration

Date: August 20, 2012
Time: 6:30 am (11-7)

NURSING PROGRESS NOTE

Alteration in Comfort Goal: Patient will rate pain 0-10 and sleep more than 4 hours overnight. Clop, 6/10 p.r.n. 800 mg oxycodone 1.25 mg with stated relief able to sleep after dose, will continue to assess pain level and modify as needed.

Knowledge Deficit Goals: Patient will state understanding of information discussed. All interventions explained to patient and answered patient verbalized understanding. Will continue to assess patient’s knowledge of plan of care and instruct as needed.

Alteration in Mobility Goal: keep increased in skin breakdown. Patient with increase swelling of buttocks and left leg which has 5+ pitting edema. Left foot is cool to touch but intact no further sensation moving toes and + pulse by Doppler. Thrombolytic remains intact to coocxy show further pain level and modify as needed.

Pillows to decrease swelling. Able to assist with turning. Declined wearing AFO or Prevento boots during night/night during.</p>
NURSING PROGRESS NOTE

Date       Time

August 20, 2012  6:30 am (11-7am)

Altered Airway Clearance-Patient with weak cough-difficult time clearing secretions which are thin and white. Modified CPT done for patient did not tolerate percussion on back or using accepella. Turned side to side frequently and vibration done-able to clear secretions this am with tonsil tip. Will use saline neb if needed and continue Atrovent neb QID. No wheezing noted-has Albuteral if needed. O2 saturations remain > 94% on RA. Goal is to have patient clear secretions and maintain sat > 94%.

Alteration in Nutrition/Elimination-Tube feeding continues at 50cc hour-increased to 65 cc hour for no aspirate. NG tube remains patent. Food intake is maintained for poor po intake and patient to be weighed daily. DTV 3-5 am with no urge to urinate. Bladder scanned for > 600cc-S/C for 650 cc-will be DTV 11:30-1:30 pm. Will offer toileting schedule to facilitate spontaneous voiding.


General-Heme consult for ? HIT-labs to be done this am.
NURSING PROGRESS NOTE

Date            Time          8/21/12          0730          1900-0700

Alteration in skin integrity: Goal: To prevent further skin breakdown. Pt has duoderm to coccyx which is intact. Skin is otherwise intact, no redness. Pt has biopsy site to back with steri strips OTA and is C/D/I. Pt has BLE 3+ edema. Both feet elevated on pillows so that heels are floating off pillow. L heel reddened. Pt unable to tolerate predalon boot or AFO due to c/o leg pain. Capsaicin cream applied to R knee. Pt turned and repositioned q2h and as needed for skin care and comfort. Plan: Monitor dressing and CSM and notify MD of changes.

Alteration in Nutrition: Goal: Pt will increase PO intake and she will tolerate nocturnal tube feeds. Pt has minimal appetite. Taking sip of water and ice chips throughout the night to wet mouth. Two Cal HN started at 2000 @ 70cc/hr. At 0500 pt began to pull out feeding tube, which this writer removed per her wish. No c/o N/V. Plan: continue to monitor I & O and encourage PO intake.

Alteration in Elimination: Goal: Pt void. Pt was DTV 8-10pm. Bladder scanned at 2100 for 637cc. Covering MD notified that daughter would like foley reinserted due to discomfort of straight caths and respiratory status. Foley placed at 2200 with 600cc amber urine. Urine output over night was 300cc. Since Lasix IV she has had only 60cc UOP. Plan: continue to monitor.

Alteration in comfort: Goal: patient to rate pain (using visual analog scale) 5 or below today. Pt repositioned q2h for comfort. Pt was c/o pain “all over” and very restless with facial grimacing. Given Oxycodone 1.25mg PO x3 with fair--minimal effect; Daughter’s requesting something to make her more comfortable. Given Morphine 5mg IV x1 with good effect. Seen by Dr Kassels this am and plan to give Morphine 0.5-1 mg q1h PRN for comfort. Plan: Assess pain level q4h and reassess pain level after one hour of administration for effectiveness.

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**NURSING PROGRESS NOTE**

**Date**

**Time**

**Ineffective Airway Clearance:** Goal: Pts O2 sat to remain >94% on RA. Sats have been 92-94% on RA.

Placed on 1L NC overnight for comfort, sats were 96% on 1L NC. Lung sounds congested with wheezing to B lungs. Given Atrovent nebs QID as ordered and Albuterol Nebs QID PRN (x2) for congestion with some effect. Chest PT done q2h with turning. Pt is able to bring up minimal secretions only using suction. Unable to obtain sputum culture. RR were 22-24 with labored breathing. Covering MD notified and in to see patient. Ordered for Lasix 10mg IV x1, BP was 88/54, he was notified and said to give it, while administering dose he again called to say not to give it. Pt received Lasix 5mg IV total and stopped. Congestion appeared to worsen during the night and he was paged again, defers to Dr Kassel in the morning re: lasix. Dr Mahmood was called at 0500 for c/o increased respiratory distress, O2 sats low 90s on 1L NC and HR 120-140, given Lasix 10mg IVP x1 with little effect. Pt placed on 3L NC with sats in upper 90s, pt later removed O2 and refused to wear. Plan: continue to monitor respiratory status.

**Knowledge deficit:** Goal: Today Patient will verbalize understanding of pain regimen and need for turning/mobility. Patient instructed regarding hand hygiene practice, respiratory practices, and patient right to express safety concerns. All questions answered, encouraged patient to continue to ask questions. Plan: continue to explain events and procedures to patient; encourage patient to ask questions.

**Risk for falls:** Goal: To prevent fall precautions during hospitalization. Pt is A/O x 3. Universal fall precautions maintained. Call light within reach, floor clean of clutter and equipment minimized. Bed is in lowest position. Goal is to prevent falls during this hospitalization. Plan: continue above interventions.

**General:** Two daughters present with patient throughout the night. Discussed with Jean early in the evening her mother’s wishes/code status. Dr Kassels in to see pt/family this morning and pt expressed wishes “enough is enough.” Changed to DNR/DNI at 0715. Chaplin called and in to see pt and family at this time.
PROGRESS NOTES

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DATE TIME

3/11/22 8am

Chaplain

Saw patient with a call from her nurse. Patient is Catholic by religion. She was with her 3 daughters. At patient's request, we prayed together and she received Holy Communion. We then spent some time talking about her life and family with laughter and with special memories. Patient is strong today and God will return later the morning.

3/11/22 9:55am

Chaplain

Chaplain responded to call to give pt S.O.S. It was surrounded by family and friends who gathered with this chaplain in prayer around the pt's bed. Chaplain led family in prayer blessing. Pt received S.O.S.
RROGRESS NOTES

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DATE TIME

8/24/12 5:10 pm

DEPARTMENT: Chaplain

Chaplain made follow-up visit per request of family. It is supported by the children’s circle of love. Chaplain gave presence, + prayer + Holy Communion + prayer + family.
Nursing Progress Note

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Signature should be legible and include name, licensure & pager #

NURSING PROGRESS NOTE

date time

08.21.12 Time 1830 Shift 7a-7p

Comfort Measures: Pt transitioned to CMO around 6am, per pt request and family agreement. Pt was alert and oriented this morning able to talk to family and nurse. Pt at time of note is still responsive but resting with eyes closed more frequently. Initially receiving Morphine 0.5mg-1mg IV q1h increased to 1-4mg and was started on Morphine 1mg/hr drip with a 10cc normal saline piggyback to insure infusion. Decision was made by family and pt to begin Morphine continuous infusion d/t pt noted discomfort and continued difficulty with breathing. Pt repositioned for comfort. Skin warm to touch. Pt diaphoretic at times, linens changed as needed, and ice packs applied. Foley intact, pt had lg amt of urine output following administration of Lasix 10mg IVP this am, output per hour since decreased and become amber in color. Scopolomine patch placed behind R ear. Family at bedside and chaplain has come several times throughout the day. Emotional support provided to family as needed throughout shift. Dr. Kassels and Palliative Care involved in plan of care.
Chapter 1
Influencing Professional Practice at the Bedside

Jeanette Ives Erickson, RN, DNP, FAAN

Invisible architecture is to the soul of your organization what physical architecture is to its body. Invisible architecture, not the building, determines whether you are a good hospital, a great hospital, or just another hospital.

–Joe Tye, CEO, Values Coach, Inc.

Florence Nightingale is viewed as the inspiration for modern-day nursing. Nightingale first published “Notes on Nursing” in 1859, educating everyone on the critical importance of the environment of care and nurses’ responsibility for ensuring that setting is based on an understanding that healing environments have an impact on patients, families, and the care team. Over one hundred and fifty years later, understanding Nightingale’s thinking, her ability to inspire all who knew her, and the key message that data is of critical importance to inform and advance clinical practice is still important. Nightingale worked tirelessly to improve sanitation laws and the physical design of health care institutions. She is said to be the first health care biostatistician (Dossey, 2000).
Today through research and patient satisfaction surveys, we understand that patients perceive health care quality is better when the environment is clean and quiet and when nurses are responsive to their questions and concerns (Studer, Robinson & Cook, 2010). Key to this quality is the chief nurse, whose job it is to improve the environment in which health care delivery is provided. This chapter, which is structured in a step-by-step outline format, discusses the important components of a chief nurse's perspective gained over 40 years of administrative practice.

Developing Environments of Care

Nurse satisfaction runs high when administrative nurses are responsive to nurses’ needs and create an environment of care that is built upon mutual respect and is safe. One of the primary responsibilities of the chief nurse is developing healthy, safe work environments to promote the highest standard of care for patients and staff. This responsibility coincides with providing a safe environment for nurses. Aligning this work demonstrates to all that quality, safety, and promoting the integrity of the nurse-patient relationship in a safe environment of care is of paramount importance.

The Professional Practice Environment

In the current care delivery environment and executive nursing practice literature, several competing “names” represent the nursing environment concept. These terms include a) work environment (McClure, Poulin, Sovie & Wandelt, 1983), b) practice environment (Lake, 2002), c) professional practice environment (Ives Erickson, 1997), and d) healthy work environment (Sherman & Pross, 2010). Given the rapid pace of today’s health care organizations, we must measure, understand, and improve the work environment. This chapter uses the term professional practice environment (PPE), operationally defined as the organizational culture that advances the clinical practice of nurses and other health professionals by ensuring unity of purpose and organizational alignment. The theoretical foundation of the PPE advocates collaborative decision-making to ensure that all stakeholders have the opportunity to knowingly participate in change (Ives Erickson, 2012).
A Call to Action

Today, the environment of care, especially for professional nurses, can be described as not for the faint of heart—the work can be demanding and emotionally draining. Yet nursing, with over three million practicing nurses in the United States (U.S.) alone, remains the most trusted profession (Jones, 2011). Perhaps that is why the Institute of Medicine (IOM) has called together national leaders twice over the past two decades to assess, analyze, debate, and confirm the important role that all nurses play in every aspect of the health care delivery system. The first report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (IOM, 2004), identified solutions to problems in hospitals, nursing homes, and other health care organization work environments that threaten patient safety through their effect on nursing care. The 2010 Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health* provides an important blueprint and a call to action to transform nursing to meet the needs of the patients we serve (IOM, 2010).

Like Nightingale’s call to action during the Crimean War, the IOM calls upon nurses to improve access to care, to improve nursing education and training, and for all nurses to practice at the top of their profession. The timing of this report coincides with the 2010 Affordable Care Act, commonly referred to as health care reform. This represents the broadest overhaul of health care since the 1965 creation of Medicare and Medicaid. With the nursing profession representing the largest segment of the national health care workforce, nurses are playing a pivotal role and will continue to play a pivotal role in the future of health care in the U.S. and internationally.

What’s clear is that as health care reform unfolds, hospitals are going to be called upon to do more with less to reduce the rising expense of U.S. health care. Along with this is the fact that the nation and many countries throughout the world are facing difficult economic times. Care redesign, cost control, and the elimination of waste will be the primary focus of health care organizations for the foreseeable future. The more volatile the economic climate, the more we need to remain true to our values. We must continue to use every resource at our disposal to ensure we deliver the highest quality care to our patients and families. To that end, designing and developing an environment that supports the nurse-patient relationship is key.
Sacrificing quality of care is not an option. Limiting access to care is not an option. If we are to maintain the same high standards of patient care, we must learn how to provide that care differently. We must be innovative in our thinking. True reform cannot be achieved through payment reform alone. Some of the barriers and challenges confronting the profession (and the nation) as we work to improve health care delivery while reducing costs need to be discussed candidly. We know that nurses are going to play a key role in health care reform by being a part of the decision-making and policymaking efforts that will define our future by addressing the PPE (Ives Erickson, 1997).

The Role of the Chief Nurse
At the Massachusetts General Hospital, we believe the PPE is the single most accurate measure of nurse leader success across constituencies and the means by which nurse leaders can best advance the profession, discipline, and science of nursing. Presently, many nurse leaders are evaluated differently depending on institutional-specific competencies and criteria set by subordinates, peers, and superiors (Adams et al., 2008). However, most if not all constituent criteria are included or correlated to measures of the PPE. Nearly every professional nursing organization, including Sigma Theta Tau International, the International Council of Nurses (ICN), the American Nurses Association, the American Organization of Nurse Executives, and the American Nurses Credentialing Center have all emphasized the importance of the PPE. However, it was not until relatively recently in nursing’s 200+ year history that the PPE concept has become identified as a viable means by which to explain, value, and advance nursing (Ives Erickson, 2012).

Simply stated, the primary objective of the chief nurse is to improve the environment in which health care delivery is provided. Thus, the chief nurse must influence others to achieve positive patient/organizational outcomes, as research in the area by Adams and Ives Erickson (2011) and Adams, Ives Erickson, Jones, and Paulo (2009) has shown an identified relationship between nursing leadership, practice environments, and patient outcomes. With the chief nurses’ emphasis on developing the practice environment, they will in turn be developing staff ambassadors that improve patient and organizational outcomes.
In this capacity, chief nurses must effectively lead by empowering others while always monitoring, measuring, and transparently communicating data and outcomes related to the PPE.

The Practice Environment Conceptual Framework

As mentioned, this chapter is structured in a step-by-step outline format, discussing important components of a chief nurse’s perspective gained over 40 years of administrative practice. The resulting compilation of ideas is represented as a thorough yet early conceptual model. The Practice Environment Conceptual Framework, as represented in Figure 1.1, provides a frame for leadership thinking when you want to influence professional practice at the bedside.

**FIGURE 1.1**
Representations of dynamic interactions within a professional practice environment.
The representation was developed to demonstrate the dynamic and changing interrelationships between the elements necessary to improve the PPE. The graphic incorporates four areas of influence that result in shared understanding between constituents in the environment of care that have the potential power to improve the environment in which they practice. These areas are described in detail in the following sections.

Philosophical Underpinnings
The Merriam-Webster Dictionary (2011) defines underpinnings as something that serves as a foundation: “a basis, a support.” Who we are as nurses and leaders is shaped by many influences, including values, family, friends, colleagues, and life experiences. Who I am as a nurse leader was greatly influenced by two of my educators. Sister Mary Consuela White, RN, RSM, head of the Mercy Hospital School of Nursing, exuded professionalism. She was a woman of great stature, who continuously pushed me and all who encountered her to continuously learn. Her early work was an influence on the importance of creating learning environments. Also, Muriel Poulin, EdD, RN, FAAN, who led the graduate program in nursing at Boston University, was an especially influential nursing role model when I was a graduate student at Boston University, especially after she and others published the Magnet Hospital study in 1983.

Their work, values, and teachings became the basis for how I approach clinical practice and leadership. Recently, the text Magnet Hospitals Revisited (McClure & Hinshaw, 2002) supported the authors (McClure, et al., 1983) of the original text, which described healthy practice environments that impacted nurse and patients, noting that “it is the combination of element (forces of Magnetism) that creates a positive practice environments.” They added, “more than a matter of strategy, it is the quality of administration and leadership that distinguishes Magnet hospitals from others.”

Professional Practice Model
The Massachusetts General Hospital (MGH) Patient Care Services Professional Practice Model (PPM) provides a framework that guides professional practice
across multiple health care disciplines (Ives Erickson, 1997). The PPM was designed to facilitate the interdependent relationships between staff nurses and other health professionals within the context of their own practice (Ives Erickson, Hamilton, Jones & Ditomassi, 2003).

The intent of the original MGH PPM was to provide clinicians a framework to explore, develop, learn, and articulate their contributions to patient care. The MGH PPM is driven by the commitment to provide the highest quality care to patients and their families. Developed and disseminated in 1996 and revised in 2007, the MGH PPM is grounded in values and beliefs that embrace patient-centered care in partnership with the nurse and other providers of care within the patient care environment.

In total, the MGH PPM symbolizes the delivery of seamless, knowledge-based patient care and demonstrates the importance of each component as part of a greater whole. The MGH PPM is predicated on the availability of resources; qualified professionals; and an institutional commitment to safe, timely, efficient, equitable, cost-effective, quality patient care (IOM, 2001).

The importance of a professional practice model has been well documented since the first criteria for identifying Magnet hospitals were identified in 1983 (McClure et al.). Salient elements of a professional practice model were identified as:

- Autonomy
- Control over practice
- Collaborative relationships with physician colleagues

The MGH PPM built upon that foundation and incorporated additional emphasis on the following elements:

- Organizational behavior
- Descriptive theory models
- Importance of clinical narratives as an aspect of culture

Disch, Sochalski, and Seamon (2004) suggested that a strategy for improving the health care system would be to create a database to a) monitor nurses’ work
environments; b) measure the correlations between staffing and patient outcomes; and c) support policy development. MGH nurse leaders and other researchers viewed developing an instrument to measure the effectiveness of the MGH PPM or the PPE as an essential approach to enhance clinicians’ roles and working conditions and to align their relationship to both patient and organizational outcomes (Ives Erickson, 1997; Lake, 2002).

Understanding the organizational concepts supportive of activities to advance clinical practice and improve the environment of care provides us with an opportunity to gain insights into how best to measure the impact of the MGH PPM. The research literature provides evidence that organizational structures are needed to enhance safety, efficiency, and timeliness of care. The MGH PPM is explored in detail in Chapter 2, “Professional Practice Model: Strategies for Translating Models into Practice.” This concept is especially important because it advances and gives a foundation for organizational alignment and influencing professional practice at the bedside.

Evidence from Research, Literature, and Theories

Leaders influencing care at the bedside must develop, support, and utilize evidence to inform and influence the delivery of high-quality, safe care. At MGH, what has emerged is based on a commitment to the creation of a culture of inquiry that fosters a healthy exchange of ideas, competition of ideas, and a commitment to optimize care through knowledge. The art and science of nursing are advanced through the utilization and integration of knowledge and the dissemination of evidence in practice. Nurses are not the only developers of knowledge; we have the unique opportunity to integrate new and developing knowledge across the discipline(s) and assimilate that knowledge with our own nursing voice to better patient outcomes, the organization, and discipline. Developing, coordinating, and integrating our own work along with current evidence developed by others is a constant effort to optimize care delivery at the bedside.
Evidence from Assessment of the Professional Practice Environment

Initial efforts to identify a comprehensive measure of the effectiveness of the MGH PPM led to the development of the MGH Staff Perceptions of the Professional Practice Environment (PPE) survey (Ives Erickson et al., 2004). In 2007, the MGH PPM was updated as a direct result from feedback by clinical nursing staff responses to the PPE. This change was a direct result of feedback from nursing staff that the organizational efforts to create a narrative culture and to include patients and families in all levels of decision-making were part of the organizational culture (see the PPM figures in Chapter 2). Whereas the original MGH PPM led to the development of the original version of the PPE survey, the revised MGH PPM led to the Revised Professional Practice Environment (RPPE) survey instrument (Ives Erickson, Duffy, Ditomassi & Jones, 2009).

The PPE/RPPE survey instruments were designed as a multidimensional measure of professional clinical practice in the acute care setting. The results from the survey provide the leadership with a report on the clinician’s perception of the PPE from eight organizational characteristics:

- Autonomy
- Clinician-MD relations
- Control over practice
- Cultural sensitivity
- Teamwork
- Communication
- Conflict management
- Internal work motivation

The RPPE survey provides clinical staff with a mechanism for sharing their perceptions of the environment. Those results guide chief nurses with an evidence-based approach towards improvement efforts. Accordingly, they initiate adjustments in the practice environment within the overall institution.
and at the unit level. Subsequent surveys provide input on the effectiveness of organizational improvement efforts, which can be quantified at the same time that chief nurses identify new insights for further action. Evidence documenting changes are used as measures of effectiveness reported to support the quality of patient care outcomes as well as giving a voice to clinical nursing staff. As an example, at MGH, all clinical nurses and other professional providers who are invited to participate in the survey have a significant response rate (61% on the returns in 2006, 58% in 2008, and 53% in 2010).

Four current publications describe the development, psychometric evaluation, and utilization of the PPE and RPPE survey (Chang, 2009; Halcomb, Davidson, Caldwell, Salamonson & Rolley, 2010; Ives Erickson et al., 2004; and Ives Erickson et al., 2009). The original research conducted at MGH in 2002 demonstrated that the tool produces reliable and construct-valid scores (Ives Erickson et al., 2004). In 2006, MGH leadership conducted a psychometric validation study of the RPPE survey instrument demonstrating parity to those reported in 2002 (Ives Erickson et al., 2009). Additional research conducted in Australia and Taiwan confirmed that, when adjusted for minor cultural differences, the PPE survey instrument and its eight organizational characteristics were an effective method for assessing the professional practice across cultures (Halcomb et al., 2010), Chang, 2009). These studies, validating the PPE and RPPE survey instruments provide chief nurses with an evidence-based mechanism to evaluate the professional practice environment of nurses and other clinicians under their purview.

NOTE

Chapter 13, “Measuring the Hospital Work Environment: Development, Validation, and Revision of the Professional Practice Environment Scale,” includes a complete discussion of the PPE.

Providing further support of the necessity of evaluating the professional practice environment is the significant body of literature relating the professional practice environments to both patient care and organizational outcomes such
as nurses’ turnover behavior, intention to leave the profession (Chiang & Lin, 2008), and the quality of health care (Aiken et al., 2001; IOM, 2004). Adams and colleagues (Adams et al., 2008; Adams et al., 2009) have expanded on these findings and further suggested relationships between the chief nurse, the professional practice environment, and organizational/patient outcomes. These relationships include concerns of the chief nurse, which have been well articulated in the literature, such as:

- A nursing shortage
- Threatened patient safety associated with gaps in knowledge related to nurse staffing
- Ineffective tools to measure nursing workload
- Challenges to developing environments of care healthy for patients and their care providers (Ives Erickson, Bridge, Chisari & Ditomassi, 2010)

Additionally, there is increased interest in public and professional understanding of the PPE for nurses and its effect on the quality of health care globally (ICN, 2010).

**Knowing Participation in Change**

Elizabeth Barrett’s (2010) mid-range theory of power, defined as knowing participation in change offers an expanding understanding of how the professional practice environment can influence the characteristics just described. Barrett’s work operationalized further the fundamentals of Martha Rogers’s conceptual system or the science of unitary human beings (Rogers, 1990). From the Rogerian perspective, Barrett described the dimensions of power, which included the capacity to participate knowingly in change (Barrett, 1989).

Barrett utilized Rogers’s theory of power to assist nurses in understanding people and the culture they worked in. As Barrett’s understanding of power developed, she proposed her theory as being power-as-freedom and power-as-control. Within this concept, power is not static nor is it linear but varies based
on how the person or the environment change. Barrett (2010) described these changes as:

- Nature of awareness of experiences
- Type of choices made
- Degree to which freedom to act intentionally is operating
- Manner of involvement in creating changes

Power is traditionally thought of as dominance or manipulation (power-as-control). Power-as-freedom might be another way to look at how leadership supports and advances the eight characteristics, especially in the arena of autonomy over practice and decision-making. It may also be a factor associated with leadership influence over the eight characteristics measured in the PPE/RPPE.

The Adams Influence Model (AIM) (Adams, 2009) suggests that power is equal to being influential over multiple issues and across domains. This idea is synergistic with Barrett’s definition of power that indicates knowing participation is essential to enact influence or power. The AIM is based on the operational definition, “Influence is the ability of an individual (agent) to sway or affect another person or group (target) about a single issue based on authority, status, knowledge-based competence, communication traits and/or use of time and timing” (Adams, 2009). Influence is a key determinant in motivation, decision-making, and securing support and resources (Yukl & Falbe, 1990). Adams describes influence as an essential part of the nurse leader’s role in maximizing professional practice/work environments and patient and organizational outcomes (Adams, Ives Erickson, Jones, & Paulo, 2009).

Improved Satisfaction

In the English vernacular, the word *motivation* was originally derived from the Latin concept *movere* meaning “to move” or something that causes a person “to act” (Merriam-Webster Dictionary, 2011). The study of the phenomenon of motivation to work is extremely complex. As motivation is not directly observable, it can only be inferred from an individual’s behavior. This inference
has resulted in the formulation of many theories based on multiple foci including human behavior, goal setting/attainment, and rewards.

A Conceptual Model
In their seminal work on motivation, Steers and Porter (1979) developed a conceptual model, assuming that motivation can best be understood within a framework that involves the interrelationship between the following factors:

- **Characteristics of the individual**: At least three major characteristics have been shown to affect the motivational process, including interests, attitudes, and needs.

- **Characteristics of the job**: The focus is what an employee does at work, how much feedback is provided, and whether the work offers intrinsic rewards.

- **Characteristics of the work environment**: The two major categories here include characteristics of the immediate work environment, including the work group and those characteristics associated with organization-wide actions.

Steers and Porter (1979) additionally suggest that when an organization designs jobs, the goals of the organization are paramount, but other factors should be considered, including individual needs and organizational climate. The functions, expectations, and roles of the job itself are a very important factor in the motivation of employees. Feelings of job satisfaction motivate people to go to work and to remain within an organization. The dynamics between these major sets of variables can be expanded to see the influence of needs and interests, which motivate a person to work, and of the job and environment, which might affect the person’s effort and performance.

Maslow’s Hierarchy of Needs
Another prominent theory that has considerable impact on the study of motivation was developed in the 1942 book *Motivation and Personality* by Abraham H. Maslow (1987). Maslow’s theory of human motivation is known as
New Hierarchy Theory (Kast & Rosenzweig, 1985), but is now better known as Maslow’s Hierarchy of Needs (Wikipedia, 2010).

Maslow’s model is inclusive of the concepts of physiological, safety, love/belonging, esteem and self-actualization needs. It is representative of the tenants of a Professional Practice Environment. These first-level needs—physiological, safety, love/belonging, and esteem—must be achieved to maximize a professional practice environment. The fifth and final need is self-actualization. Self-actualization is the equivalent of a “Magnet-like” professional practice environment where staff are supported and developed to influence positive outcomes. As lower needs are satisfied, the higher needs of esteem and self-realization including achievement, mastery, confidence, independence, recognition, and the realization of all that one is capable of becoming emerge as dominant.

People attach meaning to and derive satisfaction from their experiences (Davis, 1977). Some believe that the needs of employees can be satisfied by providing wages and letting employees then use money to acquire their own satisfaction. However, this economic approach does not hold up when applying Maslow’s needs hierarchy because money applies mostly to the first two needs. The needs priority model (Davis, 1977) identifies that gratified needs are not as strongly motivating as unmet needs. That is, people are motivated by what they are seeking more than what they already have. The study of Maslow’s needs hierarchy is useful in understanding that people do not work only for money. They have individual differences in the motivation to work.

Motivation
Motivation as discussed within Maslow’s theory is linked to self-actualization and does not decrease as lower-level needs become satisfied. As people experience growth and self-actualization, they want more and seek new ways to discover and uncover life experiences (Dale, 1978; Kast & Rosenzweig, 1985). Actualization as a goal of a positive professional practice environment is realized as staff conceptualizes, utilizes evidence, and works to continually inspire
and develop knowledge (Adams, 2011). Self-actualization for people includes choosing an occupation that allows them to receive certain satisfaction from accomplishing tasks while at the same time searching for more. To the degree that a PPE promotes the search for personal fulfillment, people will find their work a challenge and will experience an inner satisfaction or self-actualization (Davis, 1977).

Another approach applicable to the study of work motivation within the professional practice environment surrounds motivation theories. Motivation theory grew out of the work of Harvard professor Henry Murray (McClelland, 1975), who developed a system for classifying individuals according to the strength of various needs that have the potential for motivating behavior. Theories centering on this concept articulate that the majority of an individual’s performance can be explained by the intensity of the individual’s need for achievement. Murray believed that people have the need for achievement, order, affiliation, dominance, and change (Litwin & Stringer, 1968) and this “needs for achievement” concept was further explained by McClelland and Burnham (1976) as the desire to perform to high standards or to excel at the job.

Organizational Influences

In addition to the need for understanding the individual in the motivation to work, the characteristics of an organization also influence the behavior of its members and serve to differentiate one organization from another (Sisk and Williams, 1981). Because chief nurses are well-established, identified leaders of nursing within organizations, they also are essential in setting the organizational climate.

Though several variables such as needs, values, expectations, and leadership style of managers and informal leaders have been identified as influencing the development of the organizational climate, the chief nurse leader’s relationships, work standards, and goals also impact the climate (Litwin and Stringer, 1968). Litwin and Stringer (1968) found that the need for achievement, affiliation, and power as defined by McClelland (1975) were affected by organizational climate.
Summary

A critical success factor of the chief nurse is the ability to scan the environment and detect signals to inform the operational and strategic direction. This consistent evaluation of the professional practice environment is core to understanding the impact of changes to the increasingly complex health care delivery system. Identifying approaches for accommodating this complexity is a key step in improving the quality of patient care and in retaining nurses in the workforce. Barrett’s work suggests that knowingly participating in change by being aware of what you choose to do, feeling free to do it, and acting intentionally should be guiding principles of chief nurse practice and should be a part of how the chief nurse encourages the interdisciplinary team to sort through clinical problems at the bedside. The use of a theoretical approach with exquisite leadership skills represents an important aspect of how a chief nurse might begin to measure, implement, and enhance an evidence-based approach to improving the professional practice environment.

This framework identifies opportunity for the focus of the chief nurse to influence organizational change when all nurses have the freedom to knowingly participate in change. The representation was developed to demonstrate the interrelationships between the elements needed to improve the professional practice environment and to assist chief nurses in anticipating needed PPM changes that should be consistent with culture change. Figure 1.1, shown earlier in the chapter, incorporates four areas of influence that result in shared understanding between constituents in the environment of care. These constituents have the potential power to improve the environment in which they practice. Consistent with Barrett’s theory of power as freedom, access to organizational structures that enable the nurse to work at the top of the profession can affect a nurse’s willingness to participate in change. This work begins to identify a relationship between nurses’ perceptions of their ability to influence.

Exploring the relationship between employee work motivation and the leadership understanding of employee needs can strengthen motivation and enhance professional practice. In short, work motivation might serve as a
CHAPTER 1: Influencing Professional Practice at the Bedside

proxy for a positive professional practice environment or vice versa. Within this context, chief nurses must respond to the motivation of individuals and design, develop, and refine the professional practice environment to maximize motivation and performance toward improving patient and organizational outcomes.

Future research might further link freedom of control and the ability to change organizational culture. A deeper understanding of culture and freedom to participate in change is needed. Further studies should explore any association between freedom to participate in change and other key characteristics. Increasing nurse autonomy, control over practice, and giving nurses a strong voice in decision-making should be explored as a mechanism to improve the professional practice environment.

References


CHAPTER 1: Influencing Professional Practice at the Bedside


A Multi-instrument Evaluation of the Professional Practice Environment

Marianne Ditomassi, DNP, RN, MBA

This study identified organizational characteristics that are highly correlated with the work satisfaction of RNs using 2 practice environment measurement tools. In the sample, the organizational characteristics of autonomy, control over practice, and internal work motivation are critical to RNs’ sense of work satisfaction. As care redesign efforts ensue, the need to preserve and strengthen the professional practice environment remains a priority for nurse executives.

Nurses value work environments that support their ability to provide high-quality patient care consistent with the standards of their profession. In this context, a primary goal is to create and sustain environments that facilitate nursing practice, enhance the quality of patient care, and improve outcomes. A professional work environment for nurses, particularly in the inpatient setting, is recognized for the relationship with staff retention, good patient outcomes, and safe patient care. Additionally, factors in practice environments include a voice in practice decisions, collaborative interdisciplinary team relationships, adequate resources, and strong leadership influencing empirical outcomes.

Research suggests that practice environments with less clinician control over resources or the authority to apply those resources were highly associated with negative nurse-sensitive work outcomes and quality of care. The impetus for this secondary analysis of staff nurse perception survey data was an effort to understand key drivers of RN satisfaction with a goal of providing an evidence base to inform organizational care delivery redesign.

Background and Significance

As suggested in the Institute of Medicine (IOM) Future of Nursing report, care delivery redesign is the new work of healthcare. Redesign affords an opportune time to discover and/or reaffirm the specific organizational characteristics in the professional practice environment that are important to professional practice and are essential to the environment of care for RNs.

Although there are few validated instruments available that have been used to evaluate and measure the professional practice environment in care delivery, the Practice Environment Scale of the Nursing Work Index (PES-NWI) and the Revised Professional Practice Environment Scale (RPPE) were selected for this study because of prevalence in the literature and demonstrated ability to effectively evaluate a comprehensive population.

Practice Environment Scale of the Nursing Work Index

The PES-NWI was developed using factor analytic techniques on the original NWI data. The PES-NWI, a 31-item scale, measures 5 components: nurse participation in hospital affairs; nursing foundations for quality of care; nurse manager ability, leadership, and support of nurses; staffing and resource adequacy; and collegial nurse-physician relations. Nurse participation in hospital affairs assess the extent to which nurses feel they have an impact on overall hospital administration and policy. Nursing foundations for quality of care assesses nurses’ perception that the hospital supports a clear philosophy and nursing model of care.

Nurse manager ability, leadership, and support assesses that nursing leadership is supportive of nurses,
views errors as learning opportunities, and provides constructive feedback and recognition. Staffing and resource adequacy assesses whether there are sufficient resources to meet practice demands. Lastly, collegial nurse-physician relations assesses the quality of collaborative working relations between physicians and nurses in care delivery. Leiter and Laschinger validated the PES-NWI when they replicated Lake's factor structure using a large, diverse sample of nurses in Canada. This study provided support that the NWI-PES is a reliable means of assessing 5 professional practice domains.

Revised Professional Practice Environment Scale

At the Massachusetts General Hospital (MGH), nurse scientists and nursing administrators critically reviewed existing professional practice/work environment literature and instruments. They noted that in addition to the 3 Magnet hospital characteristics of autonomy, control over practice, and interpersonal communications with physicians, nurses must provide culturally sensitive, competent care to diverse populations of patients; serve as an integral member of an interdisciplinary team; and use constructive ways to resolve workplace conflicts. To this end, the Professional Practice Environment Scale (PPE) was developed to incorporate these additional constructs. The PPE is a 40-item scale that measures 8 components: autonomy, control over practice, clinician-physician relationships, communication, teamwork, conflict management, internal work motivation, and cultural sensitivity. Each PPE item is rated on a 4-point Likert scale (strongly agree, agree, disagree, strongly disagree).

Autonomy is the quality or state of being self-governing and exercising professional judgment in a timely fashion. Control over practice signifies sufficient intraorganizational status to influence others and to use resources when necessary for good patient care. Clinician-physician relations are associations with physicians that facilitate exchange of important clinical information. Communication about patients is the degree to which patient information is relayed promptly to the people who need to be informed through open channels of communication. Teamwork is a conscious activity aimed at achieving unity of effort in pursuit of shared objectives. Handling disagreement and conflict using a problem-solving approach represents the degree to which managing discord is addressed using a problem-solving approach. Internal work motivation is self-generated drive completely independent of external factors such as pay, supervision, and coworkers. Cultural sensitivity is a set of attitudes, practices, and/or policies that respect and accept cultural differences.

The professional practice environment was psychometrically evaluated through (a) item analysis, (b) principal components analysis (PCA), and (c) internal consistency reliability using Cronbach's coefficient of the resulting subscales and total score. The psychometric evaluation indicated initial evidence of the reliability and validity of the PPE scores in a sample of 849 nurses in active practice in a large urban acute care setting. Results of the PCA supported the theoretical underpinnings of the 8 PPE subscales.

The RPPE emerged from the original PPE and measures the same 8 organizational characteristics. The 40-item PPE underwent revision in 2005 based on the need for greater item clarity and a realignment of strategic goals. In 2006, the construct validity of the RPPE was evaluated, and results indicated that the multidimensional RPPE scores were psychometrically sound measures of the 8 components of the PPE in an acute care setting. As a leader in the evaluation and improvement of professional practice environments, MGH has conducted a series of studies using the PPE or RPPE every 12 to 18 months since 1999. The PPE and RPPE have also been shared with more than 90 healthcare organizations around the world, and resulting studies and publications are increasingly appearing in the literature. Replication studies at various institutions including at sites in Australia and Taiwan supported the score reliability and validity of the 8 components across samples and cultures.

Measuring Professional Practice

The nursing professional practice environment is a complex construct to conceptualize and measure. The theoretical underpinnings are rooted in the sociology of organizations, occupations, and work. It has been suggested that there is a relationship between leadership, work environments, and outcomes. Thus, developing strong professional practice environments should be an emphasis of nursing leadership, particularly during times of care redesign facilitating opportunities to improve care delivery.

As leaders make decisions about organizing care, they must consider how best to organize professional staff to address the complexity and unpredictability of the work. Leadership is instrumental in addressing these workplace characteristics. When organizing many clinicians in a large-scale task, decision making over the work to be performed and coordination of the work effort across staff are key issues. A strong professional practice environment is characterized by greater nurse presence with the patient, which makes preventive and monitoring action possible, and by greater decision-making authority.
and flexibility for the nurse, which supports rectifying action that is appropriate and efficient. These theoretical considerations are the underpinning of the construct nursing practice environment, which Lake defines in terms of organizational characteristics that facilitate or constrain professional nursing practice.

**Job Satisfaction**

The relationship between the professional practice environment and job satisfaction is explored in this study. Job satisfaction is a highly studied complex phenomenon that has implications for both workers and leaders in an organization. Table 1 highlights some of the current and most pertinent job satisfaction literature.

**About the Study**

**Aim**

The aim of this study was to determine the extent to which organizational characteristics (as measured by the PES-NWI and RPPE) explain nurses’ work satisfaction. Specifically, the following research question was answered: After controlling for the influence of age, years in the profession, and years worked at the organization, to what extent do the PES-NWI sub-scales of (a) nurse participation in hospital affairs; (b) nursing foundations for quality of care; (c) nurse manager ability, leadership, and support of nurses; (d) staffing and resource adequacy; and (e) collegial nurse-physician relations, and the RPPE sub-scales of (a) autonomy, (b) control over practice, (c) RN-MD relations, (d) communication, (e) teamwork, (f) conflict management, (g) internal work motivation, and (h) cultural sensitivity, explain RNs’ overall work satisfaction as measured by a single-item, 4-point Likert scale, with higher values indicating greater satisfaction.

**Methods**

The study reported in this article consisted of a secondary analysis of the nursing data from the

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<tr>
<th>Authors</th>
<th>Job Satisfaction Findings</th>
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<tbody>
<tr>
<td>Lu et al29</td>
<td>Job satisfaction depends not only on the nature of the job, but also on the expectations that individuals have of what their job should provide.</td>
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<tr>
<td>Herzberg and Mausner30</td>
<td>Achievement, recognition, the work itself, and responsibility are “motivator” factors that are intrinsic to the nature and experience of doing work and were found to be job “satisfiers.” Extrinsic or “hygiene” factors, such as company policy, administration, supervision, salary, interpersonal relations, and working conditions were found to be job “dissatisfiers.”</td>
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<tr>
<td>Spector31</td>
<td>Identified appreciation, communication, coworkers, fringe benefits, job conditions, the nature of the work itself, the nature of the organization itself, an organization’s policies and procedures, pay, personal growth, promotion opportunities, recognition, security, and supervision as important to job satisfaction</td>
</tr>
<tr>
<td>Aiken et al32</td>
<td>Noted that nurses were more likely to experience both job dissatisfaction and burnout when there were inadequate staffing levels.</td>
</tr>
<tr>
<td>Manojlovich33</td>
<td>Poor nurse-physician communication has been linked as an important variable in job dissatisfaction for nurses and is supported by the direct relationship identified by between collegial nurse-physicians relations and job satisfaction.</td>
</tr>
<tr>
<td>Pierce et al34</td>
<td>Use of a nursing or professional practice model as the basis for care has also been associated with greater nursing job satisfaction</td>
</tr>
<tr>
<td>Blegen35</td>
<td>Conducted a meta-analysis and found that job satisfaction was most strongly negatively associated with stress and positively correlated with organizational commitment, communication with supervisor, autonomy, recognition, routinization, communication with peers, fairness, and locus of control.</td>
</tr>
<tr>
<td>Hinshaw et al36</td>
<td>Autonomy has been associated with important work-life factors, such as work satisfaction. Thus, work environments that provide access to information, support, resources, and the opportunity to learn support nurses’ control over the content of their practice and increase staff satisfaction.</td>
</tr>
<tr>
<td>Porter-O’Grady and Malloch37</td>
<td>Shared or collaborative governance communication and decision-making structures are effective in engaging nurses’ participation in key decisions that impact practice and quality of work.</td>
</tr>
<tr>
<td>Manojlovich and Laschinger38</td>
<td>Identified that leadership contributes directly to participation in hospital affairs, staffing adequacy, and collegial relations. Staffing adequacy and collegial relations, in turn, contribute to job satisfaction; leadership also contributes indirectly to nursing job satisfaction via paths through staffing adequacy and collegial relations.</td>
</tr>
</tbody>
</table>
2010 Staff Perceptions of the Professional Practice Environment (SPPPE) survey administered to nurses at an academic medical center for 3 weeks in 2010. The 2008 institutional review board (IRB) approval for the RPPE was extended to the 2010 administration of the survey and included the addition of the PES-NWI scale. An expedited IRB review was approved for the secondary analysis.

The 2010 SPPPE survey contained 4 major content areas: (a) demographic information, (b) the RPPE,21 (c) the PES-NWI,10 and (d) a single overall work satisfaction item that has been integral component of the SPPPE survey since its inception. The SPPPE survey was distributed electronically using Qualtrics (Salt Lake City, Utah). In June 2010, all in the study sample staff received 4 e-mail messages, each including an anonymous link to the specific discipline's SPPPE survey. Once survey data were collected electronically using Qualtrics, information was downloaded into SPSS 17.0 (SPSS Inc, Chicago, Illinois) and analyzed. The survey was voluntary, and all survey responses were completely confidential, and only de-identified data were available for analysis.

Preparing Data for Hypothesis Testing

Prior to undertaking stepwise multiple regression analysis, descriptive statistics were computed for all study variables and examined for random and systematic missing data, marked skewness, and the presence of outliers. No systematic missing data were found, and random missing data were handled using median substitution. No marked skewness was noted in the data related to the continuous variables. All scales’ scores had acceptable internal consistency reliabilities as assessed by a Cronbach $\alpha \geq .70$, as presented in Table 2.

Results

The study sample consisted of 1,404 nurse participants. As represented in Table 2, the typical participant was (a) approximately 40.6 ± 12 years old, (b) has been a nurse an average 16 ± 12 years, and (c) worked at MGH an average of 12.2 ± 10.2 years. Colinearity diagnostics were examined using the guidelines specified by Tabachnick and Fidell39 of a condition index greater than 30 and 2 variance proportions greater than 0.50 between predictors. No colinearity between predictors was noted. Thus, the demographic variables, the 5 PES-NWI subscales, and 8 RPPE subscales were entered in a stepwise fashion in the multiple regression analysis. Table 3 reports these results.

As identified in Table 3, a total of 52.5% of the variance was explained by 7 of the 16 predictors, namely, the PES-NWI resource adequacy characteristic score and 6 of the 8 RPPE characteristic scores: internal work motivation, autonomy and leadership, control over practice, managing conflict using a problem-solving approach, teamwork, and cultural sensitivity. No demographic variables contributed to the variance in a statistically significant manner.

Table 2. Descriptive Statistics and Internal Consistency Reliabilities—Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of Items</th>
<th>Cronbach $\alpha$</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic characteristic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, y</td>
<td>9</td>
<td>.91</td>
<td>2.1</td>
<td>.6</td>
</tr>
<tr>
<td>Years in nursing</td>
<td></td>
<td></td>
<td>16.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Years at MGH</td>
<td></td>
<td></td>
<td>12.2</td>
<td>0.2</td>
</tr>
<tr>
<td>PES-NWI (1- to 4-point scale)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse participation in hospital affairs</td>
<td>9</td>
<td>.91</td>
<td>2.1</td>
<td>.6</td>
</tr>
<tr>
<td>Nursing foundations for quality of care</td>
<td>10</td>
<td>.91</td>
<td>1.9</td>
<td>.5</td>
</tr>
<tr>
<td>Nurse manager ability, leadership, and support of nurses</td>
<td>5</td>
<td>.92</td>
<td>2.1</td>
<td>.7</td>
</tr>
<tr>
<td>Staffing and resource adequacy</td>
<td>4</td>
<td>.90</td>
<td>2.2</td>
<td>.6</td>
</tr>
<tr>
<td>Collegial nurse-physician relations</td>
<td>3</td>
<td>.95</td>
<td>2.1</td>
<td>.6</td>
</tr>
<tr>
<td>RPPE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy/leadership</td>
<td>5</td>
<td>.85</td>
<td>2.9</td>
<td>.6</td>
</tr>
<tr>
<td>Nursing-MD relations</td>
<td>2</td>
<td>.87</td>
<td>2.9</td>
<td>.6</td>
</tr>
<tr>
<td>Control over practice</td>
<td>5</td>
<td>.85</td>
<td>3.0</td>
<td>.5</td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
<td>.83</td>
<td>3.0</td>
<td>.5</td>
</tr>
<tr>
<td>Teamwork</td>
<td>4</td>
<td>.81</td>
<td>2.8</td>
<td>.5</td>
</tr>
<tr>
<td>Conflict management</td>
<td>9</td>
<td>.86</td>
<td>2.6</td>
<td>.4</td>
</tr>
<tr>
<td>Internal work motivation</td>
<td>8</td>
<td>.82</td>
<td>3.4</td>
<td>.4</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>3</td>
<td>.80</td>
<td>3.2</td>
<td>.5</td>
</tr>
<tr>
<td>Work satisfaction (1- to 4-point scale)</td>
<td>1</td>
<td></td>
<td>3.2</td>
<td>.7</td>
</tr>
</tbody>
</table>

Note: N = 1,404.
Thus, regardless of age, number of years as an RN, or number of years worked at MGH, nurse participants who reported greater scores in resource adequacy, internal work motivation, autonomy and leadership, control over practice, managing conflict using problem-solving approaches, teamwork, and cultural sensitivity were more likely to report greater work satisfaction than their counterparts. Despite the statistical significance of the contribution made by these variables, caution should be exercised in interpreting these results because of the small amount of variance contributed by at least 4 of the predictors. It is highly likely that the large sample size contributed to the statistically significant contribution displayed for these variables. More research is needed to determine if the above results could be replicated with groups in other settings.

Discussion
A healthy work environment helps to establish a desirable workplace and provides the infrastructure that positively impacts the effectiveness of the work itself. The results of this study support the findings of previous research, including those of McClure et al., who found that autonomy and control over practice were associated with the professional practice environment; Kramer and Schmalenberg, who reported their association to job satisfaction; and Forbes et al., who found that control over practice was positively correlated with nurse autonomy and job satisfaction. Current study findings also confirm those of Weston, who reported that higher levels of autonomy and control over practice have been associated with increased performance and improved patient outcomes, and Laschinger and Havens, who found that control over practice strongly predicted nurses’ perceptions of the effectiveness of patient care. In addition, higher reported levels of control over practice were positively associated with nurse executives’ perceptions of the quality of patient care delivered.

In addition, findings from this investigation are further supported by research citing that nurses are mainly motivated by the opportunity to help other people, whereas the subjective elements of nursing that make the job altruistic and interpersonal are viewed as the most important job motives.

Implications for Care Redesign
Current study findings support the results of extant research contributing to implications that span across nursing education, practice, policy, research, and theory. As the healthcare reform implementation efforts continue to emphasize an increase in data-driven affordable care, nursing leaders must ensure that all nurses have a focused and effective voice regarding the value nursing brings to patient care outcomes and play a lead role in influencing and leading the new era of healthcare. The RPPE and PES-NWI instruments have been well documented as a means to measure, value, and quantify organizational structures that support nurses in the care of their patients. Using these validated tools in tandem can provide nurse executives, directors, and managers with a wide-ranging, evidence-based mechanism to guide the practice and articulate the message, work, and value of the discipline across social, political, and economic factors affecting patient care and nursing practice.

The IOM recommendations regarding the future of nursing mandate that healthcare organizations support nurses in leading, developing, and adopting innovative, patient-centered care models. The RPPE and PES-NWI are important pieces in this change to not only ensure patient-centered, safe, effective, timely, efficient, and accessible care, but also to maximize the quality of the nursing work environment. With a focus on autonomy, control over practice, and internal work motivation of nurses, nurse executives are supporting the development and enhancement of the professional practice environment.
Positive professional practice environments are proxies not only for good patient outcomes but also for innovation and creativity. The new models, roles, and changes will be identified and led by nurses working in these environments supporting the exploration of new ideas.

References


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