

CHAPTER 9

Magnetism and the Nursing Workforce

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ABSTRACT

The focus of this chapter is to highlight practice exemplars and research findings related to the five components of the new Magnet Model®. A brief overview of the historical development and professional evolution of the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® is presented followed by a brief overview of the original fourteen forces of magnetism. Content related to empirical practice-based research framed under the components of transformational leadership; structural empowerment; exemplary professional practice; new knowledge, innovation, and improvement; and empirical outcomes is presented and discussed. The authors provide key findings from scholarly publications and describe how the findings contribute to the creation of work environments based on the tenets of magnetism. The chapter concludes with a brief over of the ANCC Pathway to Excellence Program®.

In her September 1980 Presidential address to the American Academy of Nursing (AAN), Linda Aiken articulated the scope of the nursing shortage; over 80% of American Hospitals do not have the adequate staffing with some 100,000 vacancies in hospital nursing positions, which is having a crippling effect on day-to-day operations (AAN, 1983; ANA, 2010 reissue). In order to identify ways to

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help solve this problem, the Governing Council of the AAN appointed a Task Force on Nursing Practice to examine the characteristics of systems facilitating professional practice in hospitals (McClure, Poulin, Sovie, & Wandelt, 2002). Selected AAN Fellows were asked to nominate potential Magnet hospitals that demonstrated success in recruiting and retaining professional nurses on their staffs (AAN, 1983; ANA, 2010 reissue).

Out of the 165 hospitals nominated, 46 were selected with 41 participating. Five of the nominated hospitals were unable to participate because of scheduling problems. A staff nurse representative along with the director of nursing engaged in separate group interviews and articulated their concepts of the conditions that made their hospital a good place to work. The 14 Forces of Magnetism evolved from this original Magnet Study. Aiken's (1994) study demonstrated lower Medicare mortality in Magnet Hospitals. Aiken, Havens, and Sloane's (2009) research documented that American Nurses Credentialing Center (ANCC) Magnet hospital designation is a valid marker of good nursing care. An associated energy is created in nurses of Magnet-designated facilities as a forum for nursing staff to showcase their work is created, resulting in a great deal of organizational pride (Horstman et al., 2006). The following is a brief overview of the original 14 Forces of Magnetism as defined by the ANCC (2005, 2008a, 2008b).

Force 1. Quality of Nursing Leadership: Knowledgeable, strong, risk-taking nurse leaders follow a well-articulated, strategic, and visionary philosophy in the day-to-day operations of the nursing services. Nursing leaders, at all levels of the organization, convey a strong sense of advocacy and support for the staff and for the patient. The results of quality leadership are evident in the nursing practice at the patient's side (ANCC Magnet Recognition Program, 2005). Drenkard (2005) indicated that the chief nurse officer (CNO) must be the role model for living the concepts in the Magnet Forces.

Force 2. Organizational Structure: Organizational structures are generally flat, rather than vertical, and decentralized decision-making prevails. The organizational structure is dynamic and responsive to change. Strong nursing representation is evident in the organizational committee structure. Executive-level nursing leaders serve at the executive level of the organization. The CNO typically reports directly to CNO. The organization has a functioning and productive system of shared decision-making (ANCC Magnet Recognition Program, 2005). Batcheller (2010) noted that the CNO's tenure is affected when there is a conflict with the chief executive officer and that the challenge nurse leaders face are to develop a competency model and roadmap in becoming transformational leaders.

Force 3. Management Style: Health care organization and nursing leaders create an environment supporting participation. Feedback is encouraged and

valued and is incorporated from the staff at all levels of the organization. Nursing serving in leadership positions are visible, accessible, and committed to communicating effectively with staff (ANCC Magnet Recognition Program, 2005). Caroselli (2008) stressed that although the role of the chief nurse executive was complex, daunting, risk-laden, it provided unprecedented opportunities to influence the care of patients in a very broad context.

Force 4. Personnel Policies and Programs: Salaries and benefits are competitive. Creative and flexible staffing models that support a safe and healthy work environment are used. Personnel policies are created with direct care nurse involvement. Significant opportunities for professional growth exist in administrative and clinical tracks. Personnel policies and programs support professional nursing practice, work/life balance, and the delivery of quality care (ANCC Magnet Recognition Program, 2005). Laschinger, Finegan, Shamian, and Wilk (2001) identified that by linking structural empowerment with psychological empowerment, employees' emotional connectedness with the work setting were positively influenced. Jasovsky et al. (2005) reported on a cost-effective on-line system for collecting the demographic data for the Magnet monitoring reports.

Force 5. Professional Models of Care: There are models of care that give nurses the responsibility and authority for the provision of direct patient care. Nurses are accountable for their own practice as well as the coordination of care. The models of care (i.e., primary nursing, case management, family-centered, district, and holistic) provide for the continuity of care across the continuum. The models take into consideration patients' unique needs and provide skilled nurses and adequate resources to accomplish desired outcomes (ANCC Magnet Recognition Program, 2005). Wolf and Greenhouse (2007) believed that successful transformation and integration of a care delivery model into the DNA of the organization must be led by the CNO with unrelenting passion. The model should serve as the foundation for assessment, planning, organizing, job description, a reward and recognition system, recruitment, staff development and research.

Force 6. Quality of Care: Quality is the systematic driving force for nursing and the organization. Nurses serving in leadership positions are responsible for providing an environment that positively influences patient outcomes. There is a pervasive perception among nurses that they provide high-quality care to patients (ANCC Magnet Recognition Program, 2005). Magnet hospital nurses always rate the essential element of 'working with other nurses who are clinically competent' as "important" for quality of care and "present" in Magnet hospitals. Magnet hospital staff consider specialty certification, advanced education, and both formal and informal peer review as evidence of clinical competency (Kramer & Schmalenberg, 2004). Gawlinski (2007) stressed that outcome variables should be measured before (at baseline) and after the practice

change. Measurement at these time points allows comparison and evaluation of the effects of practice change. The sustainability of the practice change can also be evaluated by measuring the process and outcome variables 6–12 months after implementation.

Force 7. Quality Improvement: The organization has structures and processes for the measurement of quality and programs for improving the quality of care and services within the organization (ANCC Magnet Recognition Program, 2005). Hinshaw (2006) reported that translating the Institute of Medicine's recommendations, *Keeping Patient Safe: Transforming the Work Environment of Nurses* into practice required an extensive collaboration among nurse administrators and nurse researchers to advance the quality of care. This was supported by Kramer and Schmalenberg (2005) who reported that the Magnet Recognition Program stimulated valuable and insightful research related to outcomes since staff nurses identified process/functions most essential to quality patient care.

Force 8. Consultation and Resources: The health care organization provides adequate resources, support, and opportunities for the utilization of experts, particularly advanced practice nurses. In addition, the organization promotes involvement of nurses in professional organizations and among peers in the community (ANCC Magnet Recognition Program, 2005). Evidence-based practice for advanced practice nurses incorporates critical thinking, accessing research resources, using evidence-based tools such as clinical practice guidelines and implementing the recommendations into clinical practice (Kleinpell & Gawlinski, 2005; Kleinpell, Gawlinski, & Burns, 2006).

Force 9. Autonomy: Autonomous nursing care is the ability of a nurse to assess and provide nursing actions as appropriate for patient care based on competence, professional expertise, and knowledge. The nurse is expected to practice autonomously, consistent with professional standards. Independent judgment is expected to be exercised within the context of their interdisciplinary and multidisciplinary approaches to patient/resident/client care (ANCC Magnet Recognition Program, 2005). Magnet hospitals have demonstrated better patient outcomes, safer patient care, increased autonomy and greater nurse satisfaction through mentoring programs (Fundeburk, 2008).

Force 10. Community and Health Care Organizations: Relationships are established within and among all types of health care organizations and the other community organizations to develop strong partnerships that support improved client outcomes and the health of the communities that they serve (ANCC Magnet Recognition Program, 2005). Collaboration among faculty, students and community partners contributes to learning opportunities while meeting the needs of communities (Sternas, O'Hare, Lehman, & Milligan, 1999).

Force 11. Nurses as Teachers: Professional nurses are involved in educational activities within the organization and community. Students from a variety of academic programs are welcomed and supported in the organization; contractual arrangements are mutually beneficial. There is a development and mentoring program for staff preceptors for all levels of students (including students, new graduates, experienced nurses, etc.). Staff members in all positions serve as faculty and preceptors for students from across academic programs. There is a patient education program that meets the diverse needs of patients in all of the care settings of the organization (ANCC Magnet Recognition Program, 2005). Walker, Urden, and Moody (2009) found that clinical nurse specialists most influenced the “Magnetic Forces” of “Nurses as Teachers,” “Consultation and Resources,” and Professional Development.

Force 12. Image of Nursing: The services provided by nurses are characterized as essential by other members of the health care team. Nurses are viewed as integral to the health care organization’s ability to provide patient care. Nursing effectively influences system-wide processes (ANCC Magnet Recognition Program, 2005). For example, a diabetes resource group transformed diabetes care in a Magnet hospital improving glycemic management, thus enhancing the image of this multidisciplinary group (Gerard, Griffin, & Fitzpatrick, 2010).

Force 13. Interdisciplinary Relationships: Collaborative working relationships within and among the disciplines are valued. Mutual respect is based on the premise that all members of the health care team make essential and meaningful contributions in the achievement of clinical outcomes. Conflict management strategies are in place and are used effectively, when indicated (ANCC Magnet Recognition Program, 2005). Teamwork has a three-pronged approach of motivations, behaviors, and information flow with timely communication, flexible and adaptive coordination, and cohesive and reliable cooperation (Salas, Wilson, Murphy, King, & Salisbury, 2008).

Force 14. Professional Development: The health care organization values and supports the personal and professional growth and development of staff. In addition to quality orientation and in-service education addressed in Force 11, Nurses as Teachers, emphasis is placed on career development services. Programs that promote formal education, professional certification, and career development are evident. Competency-based clinical and leadership/management development is promoted and adequate human and fiscal resources for all professional development programs are provided (ANCC Magnet Recognition Program, 2005). Sherill and Roth (2007) described the capabilities and the role of the librarian along with library resources for facilities on the Magnet journey while Halfer (2009) discussed the outcomes of grant funding for a one-year pediatric RN internship for new graduates for achieving Magnet status.

MAGNET RECOGNITION PROGRAM OVERVIEW

In 1992, the Magnet Recognition Program® was assumed by the ANCC to recognize health care organizations that provided nursing excellence. The program also provided a vehicle for disseminating successful nursing practices and strategies. Recognizing quality patient care, nursing excellence, and innovations in professional practice, the Magnet Recognition Program® provided consumers with the ultimate benchmark to measure the quality of care that they can expect to receive.

When *U.S. News & World Report* publishes its annual showcase of “America’s Best Hospitals,” being an ANCC Magnet® organization contributes to the total score for quality of inpatient care. ANCC is one of only a few organizations providing outside data to the ranking methodology. In the 2010 listing, 8 of the top 10 (80%) medical centers featured in the prestigious Honor Roll are Magnet-recognized organizations. In the Children’s Hospital Honor Roll, 6 of the top 8 (75%) hospitals were ANCC Magnet recognized (July 14, 2010). As of November 20, 2010, there are 378 Magnet designated facilities (www.anccnursecredentialing.org).

The Magnet Recognition Program is based on quality indicators and standards of nursing practice as defined in the newly revised 3rd edition of the *ANA Nursing Administration: Scope & Standards of Practice* (2009). The Scope and Standards for nurse administrators and other “foundational documents” form the base upon which the Magnet environment was built. The Magnet designation process includes the appraisal of qualitative factors in nursing. These factors, referred to as “Forces of Magnetism,” were first identified through the AAN’s research conducted in 1983 (*American Nurses Credentialing Center Magnet Recognition Program®: Application Manual: Recognizing Nursing Excellence*).

The full expression of whether the Forces embody a professional environment is dependent on a strong visionary nursing leader who advocates and supports on-going professional development and excellence in nursing practice. As a result, the reputation and standards of the nursing profession are elevated. Magnet designation is considered the hallmark of nursing excellence; research has validated that the ANCC Magnet designation has a profound positive effect on nursing practice and patient care (Wolf, Triolo, & Reid Ponte, 2008).

In 2007, the Magnet Recognition Program undertook a statistical analysis of the 164 sources of evidence and reduced the 164 sources into 88, resulting in an alternative framework for grouping the criteria (Morgan, 2009). The new Model adopted in October 2009, has an overarching theme of Global Issues in Nursing and Health Care with five components (1) Transformational Leadership;

(2) Structural Empowerment; (3) Exemplary Professional Practice; (4) New Knowledge, Innovation and Improvement; and (5) Empirical Outcomes.

Drenkard (2009) and Wolf, Triolo, and Ponte (2008) described the new Magnet model and unveiled the ANCC Magnet Commission's vision that "Magnet organizations will serve as the font of knowledge and expertise for the delivery of nursing care globally." Drenkard subsequently (2010) outlined the business case for facilities on the Magnet® journey. The CNO needs to understand the data and articulate the potential for nursing excellence that results in decreased costs, improved productivity and improved health care outcomes. This strategy should positively affect how the CNO advocates for the level of support to engage in the process of participating in the Magnet Recognition Program. The ultimate outcome is improving costs through increasing nursing satisfaction, patient satisfaction and clinical outcomes.

Interestingly, the findings of Ulrich, Buerhaus, Donelan, Norman, and Dittus (2007) indicated that registered nurses in hospitals applying for Magnet recognition perceived better outcomes on certain factors than registered nurses employed in a Magnet-designated hospital. The significance of this finding is that nursing leadership should not become complacent once the hospital receives the Magnet recognition (Ulrich et al., 2007). Trinkoff and colleagues (2010) indicated that working in a Magnet-designated facility does not necessarily mean that nurses perceive working conditions, although working conditions have been found to be major factors in nurse retention.

TRANSFORMATIONAL LEADERSHIP

The new Magnet model re-emphasizes the importance of using a leadership style known as transformational leadership, which may create turbulence and involve atypical approaches to solutions. However, transformational leadership has been shown to be particularly effective in turbulent and uncertain environments (Adams, Erikson, Jones, & Paulo, 2009; Habel & Sherman, 2010). Transformational leaders have vision and influence; clinical knowledge and strong expertise relating to professional practice; and lead people when the need arises to be proactive in meeting the challenges and opportunities of the future.

The engagement and futuristic thinking of the nursing staff create a practice community that positions the entire organization to take full advantage of any current or emergent changes or innovations on the health care horizon (Meredith, Cohen, & Raia, 2010). Identifying and measuring success within the CNO population has proven complex and challenging for nurse executive educators, policy makers, practitioners, and researchers (Adams et al., 2009).

The CNO and the senior leadership team need to work in collaboration and as full partners to create a strategic vision for the future based on evidence, research and values. If workflow or physical redesign is in the strategic plan, it needs to include the foundation for a new health care facility and the framework for the post occupancy evaluation (Stichler, 2010). A systematic approach based on innovation must be developed within the environment to create that vision and enlighten the organization as to why change is necessary. At the same time, on-going transparent communication to every department asking how they intend to achieve and sustain that change is integral to stabilization and the creation of new ideas and innovation. Transformational leaders listen, challenge, influence and affirm as the organization evolves or undergoes work transition. Timely feedback and positive action for identified areas or opportunity reassure the nurses that their voices have been heard, and contribute to a culture of autonomy (Sharkey, Meeks-Sjostrom, & Baird, 2009).

Quality of nursing leadership includes competency, skill and educational level at all levels, measurement of nurse satisfaction is measured and involvement of nurses at all levels in decision-making. Of Kramer, Schmalenberg, and Maguire's (2010) structures and leadership practices essential for a Magnet (healthy) environment, the most instrumental was nurse managers who shared their power; requested evidence to make autonomous decisions; held staff accountable in positive, constructive ways for decision making; promoted group cohesion and teamwork and resolved conflicts constructively. Direct care nurses involved in formal and informal work groups are inspired to identify and make differences in their complex adaptive health care environment (Lacey, Teasley, & Cox, 2009; Upenicks & Sitterding, 2008). Nurse Managers need to empower nurses, provide support, create opportunities for nurses to increase their competencies, and reward and advance staff nurse autonomy (Kramer & Schmalenberg, 2003). There needs to be a high level of commitment and congruence between mission, vision, values, philosophy and strategic plan (Whitaker, 2009) and the management styles requires effective horizontal and verbal communication (Espinoza, Lopez, & Stonestreet, 2009).

The CNO should be visionary and influence others toward achievement of goal with open communication. Visibility and accessibility of the CNO reflects an evidence-based approach for the transformative nurse executive practice (Jost & Rich, 2010). Tagnesi, Dumont, and Rawlinson (2009) stressed that the CNO's rounding on all shifts and units help to maintain the pulse of the workforce and the pressing issues, thus improving communication and patient safety. Porter-O'Grady (2009) claims that, the pursuit of change and the creation of culture of innovation will certainly not be an option for the foreseeable future. Several instruments are available to evaluate the workplace (Berndt,

Parsons, Paper, & Browne, 2009). Weston (2009) reported that the Veterans Administration facilities measure RN's perceptions of the professional practice that contributes to enhanced nurse satisfaction, providing areas of focus for nurse executives.

STRUCTURAL EMPOWERMENT

Structural empowerment can be defined as a strong professional practice flourishing, encompassing, accessing and redesigning the nursing practice environment. Eaton-Spiva et al. (2010) described a project that provided a framework for current an on-going evaluation of the practice environment. The mission, vision, and values come to life to achieve outcomes important to the organization. Strong relationships and partnerships are developed with community organizations, volunteer activities and professional organizations. Porter, Kolcaba, McNulty, and Fitzpatrick (2010) reported a unique nursing labor management partnership, demonstrating the positive effect of nursing labor management partnership on nurse turnover and satisfaction.

There is collaboration with community-based organizations with high quality outcomes resulting from networking with nursing and developing sustainable partnerships. Fiscal resources are used to support community activities. Ballard (2010) advocates providing refresher education on the self-governance structure and implementing a nurse manager support group to share successes and role modeling. This helps build a strong self-governance structure. Kowalik and Yoder (2010) discussed a concept analysis of decisional involvement that is intended to distinguish decision-making, the act of deciding, from participation in decisional involvement, making a choice to participate in a process. The authors indicate that since there is a gap between which decisions staff nurses are actually involved in and which decisions they prefer to be involved in making, future research should be conducted to examine the variables causing this gap, followed by interventions tested to address these issues.

The image of nursing is enhanced when the CNO exerts influence on strategic planning and decision-making at the highest level. Nursing needs to receive recognition throughout the organization, including cash rewards of the senior leadership team (Stroth, 2010).

Professional development, a continuous learning environment, is evident as nurses are encouraged to grow as professionals and adequate fiscal and human resources are allocated (Cooper, 2009). Covell (2009) stated that evidence related to the impact of continuing professional development activities on patient and organizational outcomes provides administration with empirical support for decision making related to the allocation of funding for the nurses at

the bedside. Cimiotti and colleagues (2005) indicated that nurses from Magnet hospitals have a positive perception of nursing competence in their work environment. The high scores related to a positive perception of nursing competence were positively correlated with high levels of professional certification on the Perceived Work Environment (PWE) instrument. Management needs to be foster and support excellence through development of clinical competence, leadership capability and support for national specialty certification (Bryne, Schroeter, & Mower, 2010; DeCampli, Kirby, & Baldwin, 2010; McDonald, Tulai-McGuinness, Madigan, & Shively, 2010). Sherman and Pross (2010) developed future leaders to build and sustain health work environments at the unit level.

EXEMPLARY PROFESSIONAL PRACTICE

There should be an understanding of the role of nursing with advancement of the role in the care delivery system and the relationship to patient, families, communities, and the interdisciplinary team. There needs to be an application of new knowledge and evidence with professional practice environments creating empowerment and engagement in the workplace that lead to optimal care (Fasoli, 2010). Professional models of care define and promote the professional role and incorporate evidence-based practice. Several models included Family-Centered Care, Benner's Novice to Expert, King's Theory of Goal Attainment and Watson's Theory of Human Caring or Primary Nursing (Jost, Bonnel, Chacko, & Parkinson, 2010). Buerhaus, Donelan, DesRoches, and Hess (2009) indicated that hospital CNOs and nurse managers should focus on reducing threats to physical and mental safety, promoting a blame-free culture, increasing respect for nurses, and improving RN involvement in decisions that affect unit operations and patient care.

Regardless of the practice model selected, a common language needs to be developed that showcases the major themes of the practice model. The practice model needs to be integrated into the language of the organization, and play a prominent role in nursing practice (Storey, Linden, & Fischer, 2008). An example is the O'Rourke Patient Care Model; a unifying mental picture that ties together the health workplace attributes with a professional model of practice that create and sustains the desired healthy workplace (Cornett & O'Rourke, 2009).

Staffing systems incorporate, patient needs, staff member skills sets and staff mix (Gordon, Buchanan, & Bretherton, 2008). Kramer and Schmalenberg (2005) found that more effective staffing structures were enabled by attention to factors identified by staff, partially influenced by scores on the on the Perception of Adequacy Staffing (PES) scale. Hickey, Gauvreau, Conner,

Sporing, and Jenkins (2010) described the relationship of nurse staffing skill mix and Magnet® Recognition to instructional volume and mortality for congenital heart surgery.

Consultation and resources include internal and external resources such as the hospital medical library (Sherwill-Navarro & Roth, 2007). Another example is using advanced practice nurses for their consultative vote. There has been continued growth in number and diversity of advanced practice nurses in academic health science centers as well as other facilities. This requires the availability of mechanisms for centralized administrative oversight and professional support of these populations (Ackerman, Mick, & Witzel, 2010). The Clinical Nurse Specialist (CNS) role is vital to attaining and maintaining Magnet Recognition; individuals in this role serve as consultants, resources and teachers and help lead professional development activities (Walker et al., 2009).

Participation in professional nursing organizations and participation community organizations is encouraged. Autonomy involves adherence with national professional nursing standards. Keys (2009) notes that autonomy requires that all nurses are able to practice without interference in their scope of practice. Policies and procedures shape the practice of nursing with access to appropriate literature and databases.

Peer review must be in place at all levels. Nurses as teachers include orientation, mentoring, patient and family education, clinical and leadership development, and scholarly initiatives. The University of Pittsburgh has online modules (Preceptorship: The Bridge Between Knowledge and Practice) that systemizes the process of training preceptors to ensure a more uniform experience for both preceptor and the student (Burns & Northcut, 2009).

Interdisciplinary relationships include committee and taskforces. Patient care documentation supports interdisciplinary decision-making. Teamwork is essential in interdisciplinary care teams; teamwork processes are vital within nursing teams and should be evaluated (Kalish, Lee, & Salas, 2010; Kalish, Weaver, & Salas, 2009; Parsons, Clark, & Cornett, 2007). Since positive nurse-physician relationships are essential to a Magnet organization, one should read 20,000 nurses tell their stories (Schmalenberg & Kramer, 2009).

NEW KNOWLEDGE, INNOVATION, AND IMPROVEMENT

Magnet organizations are ethically and professionally compelled to contribute to new knowledge, innovation and quality improvements. This component includes new models of care, application of existing evidence, new evidence and visible contributions to nursing science (ANCC Magnet Recognition Program, 2008). Conducting research generates new knowledge, and Evidence-based Practice

(EBP) integrates new knowledge into practice but requires dissimilar resources and processes (Reigle et al., 2008).

Achieving quality outcomes, best practices, and nursing excellence requires dissemination of new knowledge. Translating research into practice advances professional nursing practice, provides patients with care that is evidence based and fosters an environment grounded in the ANCC Magnet Recognition Program components (Atkinson, Turkel, & Cashy, 2008). Dols, Bullard, and Gembol (2010) believe that leaders maintain high levels of staff nurse motivation by disseminating findings through presentations and publications, and recognizing and celebrating these accomplishments; the best motivator for change is the implementation of a practice change based on research conducted at the facility. In addition, nurse executives can learn effective strategies for creating or refining nurse research programs by discussing the barriers and challenges with all levels of nursing staff (Weirbach, Glick, Fletcher, Rowlands, & Lyder, 2010).

Nurse researchers, executives and professionals must collaborate and share successes, lessons learned and insights in real time if nursing is to reduce the long lag time between innovation and adoption (Simpson, 2009). Knowledge management (KM) can serve as a framework for identifying, organizing, analyzing and translating knowledge into practice. KM has been applied in the development of clinical decision support systems to translate clinical practice guidelines into nursing practice (Anderson & Willson, 2009). Knowledge networks (KNs) are leadership tools that can increase social capital and innovation in organizations. Electronic or online KNs can maximize efficiency and effectiveness of communications and collaboration (MacPhee, Suryaprakash, & Jackson, 2009).

The quality improvement program should have a comprehensive plan that assesses, analyzes, and evaluates clinical and operational process and outcomes. There is ongoing monitoring, evaluation, and improvement of nurse-sensitive outcomes. There are clinical and operational indicators that are benchmarked with external entities. Cornell, Riodan, and Herrin-Griffith (2010) reported that a number of significant differences in the time spent on a variety of activities, but the duration and frequency of nurse activities were not drastically altered by the additional technology.

Anderson, Mokracek, and Lindy (2009) found the success of the Best Practice Council was attributed to clear directions, an aggressive timeline, and a short-term commitment required of team members who remained focused and on track. Jurkovich, Karpiuk, and King (2010) provided examples of perioperative excellence to attain Magnet recognition. Kane and Preze (2009) describe the nurses' perceptions of subspecialization in pediatric cardiac intensive care unit and quality outcomes.

Beal, Riley, and Lancaster (2008) and Riley, Beal, and Lancaster's (2008) work provided new insights into key elements essential for the development of scholarly practice, embracing scholarly nursing practice while balancing care giving with professional development. The participants believed others saw them as knowledgeable, approachable, receptive to teaching, and genuinely interested in the learning of others. Messmer and Gonzalez (2006) created a culture for promoting nursing research and clinical scholarship while Messmer, Jones, and Rosillo (2002) used nursing research projects to meet Magnet recognition program standards.

Turkel, Reidinger, Ferket, and Reno (2005) created a model for the integration of evidence-based practice and nursing research as part of the journey toward achieving Magnet recognition. Implementation of this model created a culture of scholarly inquiry for the registered professional nurse. An outcome of this initiative was the development of a nursing research fellowship for direct care registered nurses within the same organization (Turkel, Ferket, Reidinger, & Beatty, 2008). When the organization received the original Magnet designation and subsequent redesignation, the research fellowship received an exemplar from the appraisers. The success of these initiatives resulted in the creation of the Chicagoland Research Consortium, where 17 hospitals in the area collaborate and network around the areas of education, evidence-based practice and nursing research (Ferket, Reidinger, & Turkel, 2007).

Strout, Lancaster, and Schultz (2009) described a clinical Scholars Model as a grassroots approach to develop a cadre of clinical nurses with the EPB and research skills. Wise (2009) viewed the evidence-based practice committee as the mechanism that encourages nurses to guide their clinical practice and make recommendations. Simpson (2010) showed how engaged nurses could lead the way to improved outcomes through technology.

EMPIRICAL OUTCOMES

Outcomes need to be categorized in terms of clinical outcomes related to nursing, workforce outcomes, patient and consumer outcomes, and organizational outcomes. Quantitative national benchmarks should be established. Valey, Aiken, Sloane, Clarke, and Vargas' (2004) findings reinforce the need for change in the workforce that reduces nurses' high levels of job burnout and risk of turnover while maintaining patients' satisfaction with their care. Kalish (2010) found that the difference in perceptions between registered nurses and nursing assistants for missed nursing care pointed to a lack of teamwork in the form of closed-looped communications, inadequate leadership, team orientation, trust, and shared values. Clark (2009) stresses that training health staff in

teamwork basics establishes a healthier workplace and creates the conditions for safer patient care provision. The Report Card of Nursing must demonstrate excellence.

The quality infrastructure system needs to promote, support and improve patient safety. Armstrong, Laschinger, and Wong (2009) demonstrated an important link between the quality and nature of a hospital nurses' work environment and the level of the patient safety climate in those same environments. A unit-based leadership model involving an attending physician, nurse leaders, and a quality specialist, collaborating on relevant and shared issues resulted in a decrease in hospital-acquired infections (Jost & Rich, 2010). Bacon and Mark (2010) demonstrated that work engagement and availability of support services had a significant impact on patient satisfaction. Albanese and colleagues (2010) engaged clinical nurses in quality and performance improvement activities. The implementation of the "Present on Admission Indicators" delegated responsibility to charge nurses to design and implement strategies for early recognition of suboptimal patient outcomes from care received at other facilities.

Meredith, Cohen, and Raia (2010) found that the best approach to engaging direct care registered nurses in evidence-based practice was their EBP fellowship, a 3–6 month part-time position for a staff nurse to research a nursing service priority. Their Transforming Care at the Bedside (TCAB) work was so successful that it was adopted by all the acute-care inpatient staff. An example was establishing Pyxis supply centers on inpatient units and installing two profile Pyxis medication dispensing towers on larger nursing units that resulted in expedient, convenient, and safe medication administration. Perez, Batcheller, and Chapell (2009) found that when participating in TACB, change takes time and perseverance, but is more likely to be successful due to frontline involvement. Stefanck (2008) recommended having a medication-dispensing machine in each patient room after participating in the TACB multi-site study.

There must be an integration of the American Nurses' Association Code of Ethics and Patient Bill of Rights guiding clinical decision making (Fowler, 2008). When research and evidence-based practice initiatives are incorporated into clinical operations process, nurses perceive they provide high quality of care with outcomes documented. One example of this integration could be palliative care with the goal to add life to the child's life not years to the child's life (Palliative Care for Children, AAP position paper, 2000).

Berndt et al. (2009) developed a tool to evaluate a healthy workplace index. Anderson, Manno, O'Connor, and Gallagher (2010) used a national database of nursing quality indicators data to study excellence in nursing leadership.

ANCC PATHWAY TO EXCELLENCE®

Not all facilities have the financial or human resources to pursue the Magnet journey. However, health care facilities that want to demonstrate their excellent nursing environments have another option—the ANCC Pathway to Excellence® designation (AMN Healthcare, Inc. and Nursezone.com, October 2009). In 2003, the Texas Nurses Association (TNA) began work to positively affect nurse retention by improving the workplace for nurses and established the Texas Nurse-Friendly™ Program for small/rural hospitals. The program was partially funded with a five-year grant from the U.S. Health Resources and Services Administration (HRSA). The goal of this program was to improve both the quality of patient care and professional satisfaction of nurses working in small and rural hospitals in Texas. The first Nurse-Friendly hospitals were designated in May 2005.

The ANCC Pathway to Excellence® credential is granted to health care organizations that create work environments where nurses can flourish. The designation supports the professional satisfaction of nurses and identifies best places to work. To earn Pathway to Excellence status, an organization must integrate specific Pathway to Excellence standards into its operating policies, procedures, and management practices. Confirmation of the essential Pathway to Excellence elements is obtained through written documentation and an online nurse survey whereas the confirmation of the Magnet Recognition standards is obtained through written documentation and a comprehensive site visit (ANCC Pathway to Excellence Program brochure, 2008).

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