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Information Series - Nursing



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The primary purpose of this Information Series is to inform nurses and midwives in Western Australia.
Copies of the Information Series are available from:

Office of the Chief Nursing Officer
Department of Health
189 Royal Street
East Perth Western Australia
Australia 6004

www.ocno.health.wa.gov.au

Volume 1 Number 1 April 2008

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Foreword

Welcome to this Information Series produced by the Office of the Chief Nursing Officer. The purpose of the series is to provide nurses and midwives with contemporary information that will increase knowledge and allow professional debate to occur, which will lead to practice development.

The first publication in the series has focused on an Annotated Bibliography which reviews the literature on models of nursing and midwifery care published between 2000-2007.

The bibliography reflects the changing patterns in healthcare and the challenges faced by nurses and midwives. The bibliography is divided into specialty areas including aged care, community care, midwifery, mental health and professional practice domains.

I would like to acknowledge and thank Associate Professor Jan Lewis, the author of the “Models of Care” Annotated Bibliography for undertaking this work. The publication will be a valuable information resource for nurses and midwives and those who require to make decisions about healthcare.

I encourage all nurses and midwives to read and use the information contained in the Information Series, which will allow us to work together to improve our health services to the Western Australian community.

Dr Phillip Della

Chief Nursing Officer, Department of Health,
Western Australia

Adjunct Professor, Curtin University of Technology

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The changing patterns of health care delivery have increased the complexity of the practice environments. Challenges facing nursing are a changing health care environment, with higher consumer expectations and increased demands for transparency of accountability, demands due to changing technology and growing pressures for economic constraint. Evidence-based practice models have intensified rather than simplified nursing care delivery. In this context the changing composition of the nursing workforce and the uncertain supply of a nursing workforce is an added pressure. There is an impetus to investigate new modalities to support the practice of nursing.

This Annotated Bibliography reviews the literature on models of nursing care published from 2000-2007.

The choice of appropriate models of care is influenced not only by the needs of the patient but what is possible in terms of the availability of skills, the requirements of particular specialties and the interface with other health care professionals.

This bibliography investigates a number of key areas of concern and is intended to inform appropriate decision making.

Amador, L. F., Reed, D., & Lehman, C. A. (2007). The acute care for elders unit: taking the rehabilitation model into the hospital setting. *Rehabilitation Nursing [NLM - MEDLINE]*, 32(3), 126.

Older Americans are living longer than ever before. Those over the age of 65 years account for almost 13% of the population and one third of all hospitalizations. Older adults are much more likely than younger adults to develop complications during hospitalization. With the increasing number of older adults at higher risk of hospitalization, it is more important than ever to study and develop ways to minimize the cascade of dependency that can occur during hospitalization. The Acute Care for Elders unit model has been shown to improve the processes of hospital care, discharge outcomes, and the prevention of functional limitations for the acutely ill older adult.

Chang, E., Hancock, K., Hickman, L., Glasson, J., & Davidson, P. (2007). Outcomes of acutely ill older hospitalized patients following implementation of tailored models of care: A repeated measures (pre- and post-intervention) design. *International Journal of Nursing Studies*, 44(7), 1079-1092.

The objective of this study is to evaluate the efficacy of models of care for acutely older patients tailored to two contexts: an aged care specific ward and a medical ward. Action research was used to develop the models of care in two wards: one for an aged care specific ward and another for a general medical ward where older patients were admitted. The models developed were based on empirical data gathered in an earlier phase of this study. Results: The models were successful in both wards in terms of increasing satisfaction levels in patients and nurses, increasing functional independence as measured by activities of daily living, and increasing medication knowledge. Findings indicate that models of

care developed by nurses using an evidence-based action research strategy can enhance both satisfaction and health outcomes in older patients.

Cormack, C., Hillier, L., Anderson, K., Cheesman, A., Janine, C., Fisher, M., Romeo, L., Usher, H., Wilcox, J., Graves, N. (2007). Practice change: the process of developing and implementing a nursing care delivery model for geriatric rehabilitation. *Journal of Nursing Administration*, 37(6), 279.

The authors describe a participative management approach that was used to develop and implement a nursing care delivery model for geriatric rehabilitation. This approach led to a sense of shared decision making and established consensus among the majority of staff. An integrated primary and modular nursing model that incorporated a geriatric resource nurse role was developed to maximize accountability and continuity of care. Ongoing evaluation will further clarify the impact of this model on staff and patient outcomes.

Gretchen, E. A., Kathleen, H. W., George, R. S., & Douglas, A. (2007). Reduced mortality: the unexpected impact of a telephone-based care management intervention for older adults in managed care. *Health Services Research*, 42(4), 1632.

This analysis evaluated mortality over 24 months for Medicare managed care members who participated in the Care Advocate Program (CA Program) designed to link those with high health care utilization to home- and community-based services. Findings suggest that the care advocate model of social care management affected mortality while the program was in progress, but not after completion of the intervention phase. Key model elements accounted for the findings, which include individualized

targeting, assessment, and monitoring; consumer choice, control, and participant self-management; and bridging medical and social service delivery systems through direct linkages and communication.

Hancock, K., Chang, E., Chenoweth, L., Clarke, M., Carroll, A., & Jeon, Y-H,. (2003). Nursing needs of acutely ill older people. *Journal of Advanced Nursing*, 44(5), 507-518.

The aims of this study were to determine: (1) important aspects of nursing care as perceived by older patients, their family member/carer who observed care during hospitalization, and nurses; (2) satisfaction levels of patients, family/carers and nurses on nursing care received; and (3) mismatches between nursing care priorities and satisfaction with nursing care. Patients, carers and nurses perceived that carrying out doctors' orders was the most important aspect of nursing care, followed by physical care, psychosocial care and discharge planning. Nurses and carers rated physical care, psychosocial care and discharge planning more highly than patients. Patient care was rated highly by patients in terms of importance, but rated moderately in terms of satisfaction. Carers' and patients' ratings of satisfaction with physical care were lower than nurses' ratings of opportunities to provide it. The importance of discharge planning was rated highly by all nurses but all groups were only moderately satisfied with this aspect of care.

McCormack, B. (2004). Person-centredness in gerontological nursing: an overview of the literature. *International Journal of Older People Nursing*, 13(3a), 31-38.

This paper explored the concept of person-centredness and person-centred practice in order to add clarity to discussions about the term in the context of gerontological nursing. The literature-based exploration discusses the meaning of the word person and the way this word is translated into person-centred practice. It is argued that there are four concepts underpinning person-centred nursing: 1 being in relation; 2 being in a social world; 3 being in place; and 4 being with self. The articulation of these concepts through existing models of person-centred practice in nursing raises the recurring themes of knowing the person, the centrality of values, biography, relationships, seeing beyond the immediate needs and authenticity.

Allen, S. M., & Ciambone, D. (2003). Community care for people with disability: blurring boundaries between formal and informal caregivers. *Qualitative Health Research, 13*(2), 207-226.

Health care for individuals with a disability is increasingly shifting from institutional settings to the “community”, with assistance by those in the formal sector. In this article, the authors examine 5 case studies illustrating interactions and relationships between people with a disability and their caregivers, using qualitative data collected as part of a community study of disability conducted in a medium-sized city in the north eastern United States. Employing the task specificity framework, they explore the implications of using either formal care providers to fill needs that are more typically met by family and friends or family caregivers to provide care that is best provided by the formal sector. Although the narratives illustrate the negative implications of mismatched care substitution, it is concluded that the framework is less applicable to emerging systems of community care.

Doherty, W. J., & Mendenhall, T. J. (2006). Citizen health care: a model for engaging patients, families, and communities as coproducers of health. *Families, Systems & Health, 24*(3), 251-263.

Citizen health care is a way to engage patients, families, and communities as coproducers of health and health care. It goes beyond the activated patient to the activated community, with professionals acquiring community organizing skills for working with individuals and families who see themselves as citizens of health care - builders of health in the clinic and community - rather than merely as consumers of medical services. Over the past 7 years, the authors and their colleagues have developed and field-tested a structured process for implementing this model into

everyday practice settings. In this article, we describe the origins of the model, its core tenets and practices, and examples of its implementation in community settings. We discuss how citizen health care differs from other models of collaborative and community-based work, and we outline research and training directions.

Koehler, J. A., Cha, J., & Smith, C. E. (2002). A model for using novel nursing interventions to meet the challenges of community health Needs. *Home Health Care Management Practice, 14*(2), 129-136.

The aging population growth, shortened hospital stays, reduction in home care services reimbursement, and the looming nursing shortage will all drastically increase community health care needs and caregiving challenges. Unique and traditional methods of care delivery provided via innovative interventions can be used to address these needs. Many research-based nursing interventions can be administered at a distance (e.g. video, telehealth, and even robotic “nurses”) or without the nurse being present through volunteers or delegation, thus increasing community-based care. A model categorizing and guiding use of these nursing interventions is described.

Milone-Nuzzo, P., & Pike, A. (2001). Advanced practice nurses in home care: Is there a role? *Home Health Care Management Practice, 13*(5), 349-355.

The current challenges affecting home care make the environment ripe for the development of new models of advanced practice nursing in home care. This article explores the barriers and benefits of advanced practice nursing in home care and describes the changes needed to fully integrate the advanced practice nurse into the home care delivery system.

Mollica, R. (2003). Coordinating services across the continuum of health, housing, and supportive services. *J Aging Health, 15*(1), 165-188.

This article describes trends in three areas of state long-term care policy for elderly low-income Medicaid beneficiaries - providing home care services to residents in subsidized housing and assisted living; offering nursing home residents opportunities to relocate to community settings; and integrating acute and long-term care services for beneficiaries who are dually eligible for Medicare and Medicaid. The information was obtained from reports and studies on state policy, site visits, and interviews with state officials. Multiple initiatives responding to consumer preferences and fragmentation of the delivery systems were identified. Key components were consumer demand; the availability of nursing facility alternatives; and state priorities for controlling expenditure growth. States use Medicaid to develop broad service menus that include in-home, community, residential, and institutional services. Several states are conducting demonstration programs that improve coordinating or integration of long-term care with the acute care system

Allen, P., Schumann, R., Collins, C., & Selz, N. (2007). Reinventing practice and education partnerships for capacity expansion. *Journal of Nursing Education*, 46(4), 170.

Two alternative models offering solutions to the nursing shortage in Texas enhance communication between schools of nursing and acute care service agencies to strengthen the partnership between education and practice. These initiatives use the valuable asset of onsite nurses in practice to clinically instruct nursing students, thus replenishing the number of clinical instructors and freeing clinical space to overcome the obstacles in increasing capacity. Forming practice-education partnerships and integrating technology support, including using simulations and online courseware to train qualified nurses, reinvent the combining resources to address a common need. Moving into the last year of grant funding, both projects show initial promise in meeting project goals of increasing capacity in nursing education.

Eustace, L. (2001). Mandatory continuing education: past, present, and future trends and issues. *Journal of Continuing Education in Nursing [NLM - MEDLINE]*, 32(3), 133.

Mandatory continuing education (CE) for nurses continues to be a viable means by which nurses can remain competent in the face of ever-increasing knowledge and technology in the health care setting. A multiplicity of CE providers, offering a variety of teaching approaches, exists to ensure nurses remain competent and advance in their fields of practice. Presently, more research must be conducted to measure the effectiveness of CE programs on patient care outcomes. Scholarly investigation may assist in justifying mandatory CE for nurses if positive patient care outcomes can be identified. Several states are regulating professional nursing practitioners by

requiring CE. Although some states have not endorsed mandatory CE for nurses, it is likely that more state boards of nursing will continue the slow but steady trend of requiring CE for relicensure - especially if research establishes positive patient care outcomes.

Griffiths, M. J., & Czekanski, K. (2003). Meeting the needs of the health system: a refresher course for registered nurses. *Journal of Continuing Education in Nursing [NLM - MEDLINE]*, 34(4), 162.

To address the shortage of nurses experienced by a healthcare system, faculty from a baccalaureate nursing program collaborated with the affiliated healthcare system members to offer a refresher course to facilitate the return of inactive nurses to the workforce. The program included didactic content, simulated laboratory experiences, and precepted clinical experiences on the employing units. This article describes the scope of the program and focuses on recommendations for future course implementation, including implementing a systematic evaluation of each participant's knowledge base at the beginning of the course and an extended course time frame to allow for greater integration of content.

Johnson-Crowley, N. (2004). An alternative framework for teacher preparation in nursing. *Journal of Continuing Education in Nursing*, 35(1), 34-43.

Little nursing research has been done to explore the effectiveness of teacher preparation models. Nursing still uses traditional survey-type teacher preparation programs, yet educational research using these same models shows limited success in promoting student's teacher competence and confidence, limiting their desire to teach.

However, current educational research reveals that courses designed around a constructivist model have had success in getting students to feel competent and confident to take on the teacher role and to incorporate new ideas of teaching into their teaching repertoire. The Experimental Teaching Course: Models of Teaching and Learning is designed to enhance graduate nursing students' competence and confidence as they identify and develop their own personal educator models for teaching and learning.

Kenny, G. (2004). The tensions between education and models of nurse preparation. *British Journal of Nursing*, 13(2), 94-100.

This article seeks to explore the relationship that has evolved between the training and education models of nurse preparation since the creation of the NHS. Through the process of professional reflection it intends to investigate how each model develops the profession and enhances care delivery. It seeks to move away from an either/or approach that has dominated the nurse education debate, and instead seeks to identify the potential benefits, as well as the tensions, of trying to integrate these models into a modern context.

McAllister, M., & Osborne, S. R. (2006). Teaching and learning practice development for change. *Journal of Continuing Education in Nursing [NLM - MEDLINE]*, 37(4), 154.

The current expectation in health care for nurses to use research evidence when making decisions about patient care practices requires a change in the culture of nursing service delivery. There are many different approaches to support this change. One approach frequently referred to in contemporary literature is practice development, which aims not

just for understanding and acquiring new knowledge, but also for implementing change by improving clinical practice and increasing effectiveness in patient care. Its success depends on skilled change agents or facilitators. This article discusses strategies used in a workshop to educate and prepare practice development facilitators for effecting change.

McNeill, A. L., & Porter-O'Grady, T. (2007). Engaging transformation: Constructing a new model for nursing education and practice. *Nurse Leader*, 5(3), 30-34, 60.

A rapidly changing health care environment is forcing nursing leadership to examine the efficacy of nursing education and the relevance of current practice models. Competencies once thought essential to good nursing practice are less valued today. As a result, veteran nurses experience bewilderment and frustration regarding their job expectations, knowledge base, and work role. Remediating this situation calls for creating new models of nursing education and strong linkages between education and professional practice. One Dayton, Ohio, hospital has taken bold steps toward these goals by establishing an onsite university based on innovative partnerships with area nursing schools. The continuous learning opportunities offered by the university have not only bolstered nursing job satisfaction but also have helped the hospital make a strong impression in its highly competitive service area.

McAllister, M. (2007). New models of care in mental health. *Australian Nursing Journal*, 14(8), 37.

People who experience mental illness or psychiatric disability continue to be poorly served by an entrenched and outdated system of health care that succeeds in treating acute illness, but fails to offer adequate community education and prevention, early detection, or the full range of approaches that we know facilitates recovery and rehabilitation.

Novakovic, A. (2002). Work with psychotic patients in a rehabilitation unit: a short term staff support group with a nursing team. *Group Analysis*, 35(4), 560-573.

The author documents difficulties that arose in the work of a team working in a residential setting providing 24 hour care for patients with repeated or long-term admissions, and the different, inter-related and mutually dependent aspects of this work. Issues that emerged included the difficult nature of work with this patient group, collaborative work in the team, management issues and models of care, i.e. active rehabilitation ideology. Staff encountered problems which were not unique to this team, and which have wider implications for other staff working in similar roles and contexts with a similar patient group.

Penrod, J., Yu, F., Kolanowski, A., Fick, D. M., Loeb, S. J., & Hupcey, J. E. (2007). Reframing person-centred nursing care for persons with dementia. *Research and Theory for Nursing Practice [NLM - MEDLINE]*, 21(1), 57.

Alzheimer's dementia manifests in a complex clinical presentation that has been addressed from both biomedical and phenomenological perspectives. Although

each of these paradigmatic perspectives has contributed to advancement of the science, neither is adequate for theoretically framing a person-centred approach to nursing care. The Need-Driven Dementia-Compromised Behavior (NDB) model is discussed as an exemplar of midrange nursing theory that promotes the integration of these paradigmatic views to promote a new level of excellence in person-centred dementia care. Clinical application of the NDB promotes a new level of praxis, or thoughtful action, in the care of persons with dementia.

Stuart, G. W. (2001). Evidence-based psychiatric nursing practice: rhetoric or reality. *Journal of the American Psychiatric Nurses Association*, 7(4), 103-114.

The most desirable basis to substantiate clinical practice is the evidence of well established research findings. Developing evidence-based care involves defining the clinical question, finding the evidence, analysing the evidence, using the evidence, and evaluating the outcome. Practice guidelines and clinical algorithms are useful tools for applying research findings in a practical way. Other mental health professionals are actively incorporating an evidence-based approach into their practice, training, and research activities. This article raises questions about whether psychiatric nursing has evidence-based models of care, is contributing to advancing knowledge related to the nature, process, and outcomes of psychiatric care, and is incorporating evidence-based psychiatric nursing care in its educational programs.

Adams, J. (2006). An exploratory study of complementary and alternative medicine in hospital midwifery: Models of care and professional struggle. *Complementary Therapies in Clinical Practice*, 12(1), 40-47.

Complementary and alternative medicine (CAM) is increasingly popular amongst midwives in Australia. A growing number of hospital midwives are personally integrating one or a range of CAM within their midwifery practice. This paper reports findings from one section of a larger exploratory study examining grass-root practitioners' understandings and experiences of complementary therapies in nursing and midwifery. Thirteen in-depth interviews were conducted with midwives working in New South Wales public hospitals and currently integrating CAM within their general midwifery practice. Analysis illustrates how midwives' explanations of, and affinity claims regarding, CAM feed into wider ongoing issues relating to professional autonomy and the relationship between midwifery and obstetrics.

Cragin, L., & Kennedy, H. (2006). Linking obstetric and midwifery practice with optimal outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing : JOGNN*, 35(6), 779.

The objective of this study was to compare midwifery and medical care practices and measure optimal perinatal outcomes using a new clinometric instrument. The study found that midwifery patients had more optimal care processes (less use of technology and intervention) with no difference in neonatal outcomes, even when pre-existing risk was taken into account. Conclusion: Even among moderate-risk patients, the midwifery model of care with its limited use of interventions can produce outcomes equivalent to or better than those of the biomedical model.

Freeman, L. M., Adair, V., Timperley, H., & West, S. H. (2006). The influence of the birthplace and models of care on midwifery practice for the management of women in labour. *Women and Birth*, 19(4), 97-105.

This paper examined how the settings in which midwives practice (the birthplace) and models of care affect midwives' decision making during the management of labour. The majority of midwives who participated worked in models of care which provided women with continuity of carer and care, however, this was not found to influence the way the midwives provided labour care. Instead, practice was found to be relatively homogenous regardless of whether the midwives worked in independent, team, or hospital-based practice. The birthplace setting in which the labour care took place did influence midwifery practice. The majority of midwives provided labour care in large obstetric hospitals and identified practices dominated by the medical model of care. Practice was described as being influenced by intervention and the need for technology, however, this did not prevent the majority of women from perceiving they were actively involved in the decision making process and that they worked in partnership with their midwives. The midwives' decision making processes were influenced by the needs of the women rather than the hospital protocols. The midwives in this study had adopted a humanistic approach to care whereby technology was used alongside relationship-centred care.

Goodman, S. (2007). Piercing the veil: The marginalization of midwives in the United States. *Social Science & Medicine*, 65(3), 610.

This paper investigates the marginalization of certified nurse-midwives (CNMs) in the US. This marginalization occurs despite ample evidence demonstrating that a midwifery model delivers high-quality cost-effective care. Currently midwives attend only 7% of births, compared to 50-75% of births in other developed countries. Given the escalating costs of health care and relatively poor maternal and child health indicators in comparison with other developed countries, these findings are disturbing. This paper investigates this paradox through a qualitative case study of two prestigious but declining midwifery services in a large US city. Fifty-two multi-sited in-depth interviews were conducted along with an analysis of relevant archival sources. It was found that institutions successfully altered maternity care and diminished midwifery services without accountability for their actions. These findings illuminate the larger political-economic forces that shape the marginalization of midwifery in the US.

Homer, C. S. E. (2006). Challenging midwifery care, challenging midwives and challenging the system. *Women and Birth*, 19(3), 79-83.

The purpose of this paper is to generate debate and discussion about the state of midwifery services in Australia today. While numerous reports have been published that highlight what women want in maternity care, widespread change has not occurred. This paper presents the story of Alice (a real woman with a fictitious name). Alice's story highlights the challenges that women face in dealing with a system that is often inflexible. While the health systems, and those who work within them, usually have

the best intentions to try to provide the type of care that women want, they are not always successful. The paper summarises the evidence and support for models of continuity of midwifery care and outlines a series of strategies to ensure that change can occur. Finally, the paper challenges all midwives to work towards widespread, system-level change in Australian maternity services.

Reid, T. (2000). Maternal identity in preterm birth. *J Child Health Care*, 4(1), 23-29.

The development of maternal identity appears to be considerably delayed in the event of preterm birth. Women with high risk pregnancies may be afforded some protection by means of adaptation prior to birth. Tactile contact appears to make the experience more real for women who are attempting to make the transition to motherhood. Even in a group of moderate risk preterm infants, the psychological challenges facing mothers experiencing neonatal intensive care are considerable. Conflicting responsibilities and time pressures contribute significantly to the stressful experience of mothers in Neonatal Intensive Care Unit.

Walker, S. B., Moore, H. D., & Eaton, A. (2004). North Queensland midwives' experience with a team model of midwifery care. *Australian Midwifery*, 17(1), 17-22.

This qualitative study investigated midwives' perception of a team midwifery model of care implemented in North Queensland, Australia. A midwifery model of care is the use of primary health care principles to deliver care throughout the woman's entire pregnancy and postpartum period in partnership with other members of the health care team. Four focus groups

were undertaken with 22 midwives to determine their perception of the team midwifery model of care. The study found the experience of the team midwifery model of care for midwives had been influenced by organisational characteristics, team structures, and accountability. Recommendations from this study include the need for an appropriate environmental scan and implementation of planning process and team building before the introduction of any new model of care, transportability of health care services to any new model of care, and a shared governance to allow midwives to meet both organisational and professional goals.

Waters, D., Picone, D., Cooke, H., Dyer, K., Brodie, P., & Middleton, S. (2004). Midwifery-led care: finding evidence for an antenatal model. *Australian Midwifery*, 17(2), 16-20.

Conducted as the first phase of the Improving Patient Outcomes Project, a structured literature review aimed to determine an evidence base for the development of a midwifery-led antenatal model of care. In particular, evidence was sought for those

elements of antenatal care that were proven effective and were valued by women. There is good quality evidence that women are satisfied with receiving antenatal care from midwives and that antenatal visit schedules can be made more flexible. The literature provided practical assistance in defining maternity outcome measures but was not able to provide a strong evidence base for all aspects of antenatal care. This paper reports on a systematic approach to reviewing literature in which the intuitive and practical experience of expert reviewers and clinicians contributes to assessing the overall quality of currently available research evidence. This combined approach ensures a judicious and sensitive application of available evidence to the development of safe and appropriate models of care.

Alt Styer, K. (2007). Development of a unit-based practice committee: a form of shared governance. *AORN*, 86(1), 85-88, 90, 92-93.

Nursing leaders at one facility challenged staff nurses in the post-anaesthesia care unit (PACU) to implement a modified process of shared governance, a model that allows staff nurses to influence their practice. As a result of this initiative, PACU nurses were able to collaborate with other perioperative staff members, ultimately increasing patient safety - successes included increased staff nurse participation in educational projects; increased interdisciplinary collaboration; personal and professional development for the nurses involved; and recognition from a highly esteemed, national organization.

Dellagiacoma, T. (2007). Eight essential factors for successful nurse-led services. *Australian Nursing Journal*, 14(10), 28.

Nurse-led services, alternatively known as expanded nursing roles such as postoperative follow up clinics, chronic leg ulcer treatment clinics, booking and follow up coordination, preadmission clinics, problem-based projects such as failure to attend programs, and ear nurse specialist clinics are increasing. Maher, Gustafson and Evans (2006) developed the British National Health Service Sustainability Model as an audit tool which includes the following ten factors: benefits beyond helping patients; credibility to affected staff of benefits from the improved process; adaptability of improved process; staff involvement and training to sustain the process; staff attitudes toward sustaining the improved process; senior leaders' responsibility taking; staff action toward the leader; effectiveness of the system to monitor progress of the improvement; fit with the organisation's strategic aims and culture; and infrastructure to sustain (staff, facilities, equipment, etc)

Faithfull, S., & Hunt, G. (2005). Exploring nursing values in the development of a nurse-led service. *Nursing Ethics*, 12(5), 440-452.

This article considers the development of nurse-led services as a part of a pilot study and explores the therapeutic nature of the role of the nurse. In particular it suggests a need for reconsideration of the fundamental values of nurse-led care in the context of changing organizational culture. Within the UK there has been pressure from policy makers to extend the role of the specialist nurse and create new nursing roles, shifting the boundaries between professional health groups. The philosophy of nurse-led initiatives has therefore been driven mainly from a service redesign and clinical need standpoint rather than necessarily focusing on enhancing patients' experience and the changes in organizational culture required to achieve this. While several studies have focused on the safety, comparative cost and comparative patient outcomes in nurse-led care in relation to traditional or doctor-led care, little attention has been given to the changing organizational values underlying the nursing role. Exploring this context is essential if new nursing roles are to provide more than relief for bottlenecks in the system and also meet their potential for providing patient centred and innovative models of care.

Hartranft, S., Garcia, T., & Adams, N. (2007). Realizing the anticipated effects of the clinical nurse leader. *Journal of Nursing Administration*, 37(6), 261.

More than 90 members of the American Association of Colleges of Nursing and 190 practice sites have partnered to develop the clinical nurse leader (CNL) role. The partnership has created synergy between education and practice and nurtured innovation and diffusion of learning on a national basis. In this ongoing department, the editor, Jolene Tornabeni, MA, RN, FAAN,

FACHE, showcases a variety of nurse leaders who discuss their new patient care delivery models in preparation for the CNL role and CNLs who highlight partnerships with their clinical colleagues to improve patient care. In this article, the authors explore the actual implementation of the CNL role within the microsystem of the hospital unit and discuss a typical day in the life of a CNL, how the role achieves lateral integration, and the impact the role has had on quality outcomes and satisfaction for the patient and nurse.

Hocker, S., & Trofino, J. (2003). Transformational leadership: the development of a model of nursing case management by the army nursing corps. *Lippincott's Case Management*, 8(5), 208-213.

Management philosophy and culture of any organisation must match the nursing profession's core value of caring. Organisational conflict symptomatology includes communication barriers and widely differing values. Employment of accountability based systems and bringing nurses into governance prevents conflict and improves job satisfaction. This article identifies the barriers to case management program development and discusses strategies for its successful implementation. Today's most successful organisations will implement an institution-wide commitment to a culture within which excellence flourishes. Creative staffing models and professional practice partnerships such as nursing case management will be supported and encouraged by executive leadership; they work as a team and will be jointly accountable for patient outcomes. The US Army Nursing Corps has the framework necessary to develop a premier nursing organisation. Case management departments may adopt these techniques to improve working relationships and leadership capacity within their organisations.

Knowles, G., Sherwood, L., Dunlop, M. G., Dean, G., Jodrell, D., McLean, C., et al. (2007). Developing and piloting a nurse-led model of follow-up in the multidisciplinary management of colorectal cancer. *European Journal of Oncology Nursing*, 11(3), 212-223.

One of the main challenges of colorectal cancer follow-up is the detection of early disease in order to influence survival and improve outcome. Yet, the benefits of follow-up are not only related to survival. It is well documented that patients can experience an array of problems following colorectal cancer surgery which impact upon quality of life, therefore symptom management plays an important part in the overall spectrum of follow-up care. In addition, there is emerging evidence to suggest that clinical nurse specialists are well placed in the multidisciplinary team to co-ordinate such follow-up programs. This paper reports on a pilot study designed to assess the feasibility of a follow-up program led by nurse specialists for patients with colorectal cancer. Key outcome areas were adherence to an agreed follow-up protocol, quality of life, patient and clinician satisfaction and a cost-analysis of the new model. The study was conducted over one year with 60 patients. This redesign resulted in a smoother pathway of follow-up care, improved quality of life and acceptance to both patients and clinicians alike. The introduction of a nurse-led follow-up model is expected to demonstrate cost savings over a 3 year rolling follow-up program.

Ponte, P. R., Kruger, N., DeMarco, R., Hanley, D., & Conlin, G. (2004). Reshaping the practice environment: the importance of coherence. *Journal of Nursing Administration*, 34(4), 173-179.

Today's nurse leader is challenged to create a practice environment that fosters multidisciplinary collaboration, professional development, and a culture of safety.

Fostering a sense of coherence among staff nurses about their place within the nursing department and the nursing department's place within the broader organisation is essential to the development of such environments. When nurses have a sense of coherence about their work setting, they are more likely to feel confident that the care of patients and families is fully supported by the organisation in which they work. The authors describe the concept of coherence, discuss findings from a preliminary study regarding attributes that may contribute to coherence in individual nurses, and describe systems and programs that have been implemented in a large academic medical centre to foster a sense of coherence in individual nurses, the nursing department and the institution as a whole

Tappen, R. M., Hall, R. F., & Folden, S. L. (2001). Impact of comprehensive nurse-managed transitional care. *Clinical Nurse Research, 10*(3), 295-313.

The purpose of this study was to test the effectiveness of nurse-managed transitional care on the quality of care and functional ability of individuals following discharge from subacute units. Registered nurses employed on subacute units in a skilled nursing facility provided the nurse-managed transitional care. Using a quasi-experimental design, data were collected on admission to the subacute unit, at the time of discharge, 1 week following discharge, and 3 months following discharge on 242 treatment and comparison participants. The treatment group participants' overall function and quality of the care environment were significantly higher than the comparison group at 1 week and 3 months following discharge. Participants did not differ significantly on basic activities of daily living or number of readmissions.

Wiles, R., Postle, K., Steiner, A., & Walsh, B. (2003). Nurse-led intermediate care: patients' perceptions. *International Journal of Nursing Studies, 40*(1), 61-71.

Intermediate care currently forms one of the UK Government's main initiatives for improving the quality of post-acute care. This paper examines patients' and carers' experiences of a nurse-led unit, which aims to provide intermediate care for people no longer acutely ill. Drawing on findings from qualitative interview data, the authors demonstrated that patients viewed this model of care as acceptable but that they had markedly inconsistent experiences of care and reported considerable variation in their perceptions of the Unit's purpose. Some possible reasons for this are explored. Implications for the development of good quality nurse-led intermediate care are outlined.

Blasdell, A., Klunick, V., & Purseglove, T. (2002). The use of nursing and medical models in advanced practice: does education affect the nurse practitioner's practice model? *Journal of Nursing Education*, 41(5), 231-223.

Defining the scope of advanced practice requires that the practice of nurse practitioners be considered a unique health provider role. It has also been asserted that for nursing practice to be viewed as a profession it is essential that it is based on theory. Theory and theoretical frameworks are intended to provide guidance and rationales for professional clinical practice, but as advanced practice roles evolve in nursing, the incorporation of nursing theory becomes problematic.

Boykin, A., Schoenhofer, S.O., Smith, N., St Jean, J. & Aleman, D. (2003). Transforming practice using a caring-based nursing model. *Nursing Administration Quarterly*, 27(3), 223-230.

Today's health care environments are calling for new models of care delivery grounded in essential values. This article describes the results of a 2 year funded research project that intentionally grounded an acute care unit in the perspective of nursing as caring. Outcomes of care for patients, families, staff and the organisation are described.

Coombs, M., & Lattimer, V. (2007). Safety, effectiveness and costs of different models of organising care for critically ill patients: Literature review. *International Journal of Nursing Studies*, 44(1), 115-129.

New ways of working in critical care are emerging in response to increasing demands for care in the context of a limited critical care workforce. This review appraised the comparative safety, effectiveness and costs of new ways of working in critical care.

Examples of comparative empirical research on new ways of working were limited, but the review revealed research activity in the areas of: impact of workload; nursing, medical and organisational factors affecting patient outcomes; and methods to support workforce calculations.

Cumbie, S., Conley, V., Burman, M. (2004). Advanced practice nursing model for comprehensive care with chronic illness. *Advances in Nursing Science*, 27(1), 70-80.

New models of providing patient care to chronically ill persons are needed that can facilitate a more integrative approach to patient care. The purposes of this article are to describe the utilisation of a theory synthesis process for the development of a client-focused approach for advanced practice nurse (APN) management of chronic illness and to present the *Model for Promoting Process Engagement*. The model was developed as a theory driven intervention to address complexities of chronic illness care. This APN practice model is the direct result of the synthesis of a number of differing theoretical models developed by the authors in previous individual research endeavours.

Dunkley, M., Hughes, R., Addington-Hall, J., & Higginson, I. (2003). Translating clinical tools in nursing practice. *Journal of Advanced Nursing*, 44(4), 420-426.

The widespread use of clinical tools in nursing practice reflects their usefulness in guiding patient care, evaluating treatment effectiveness and conducting audits. Cultural awareness and the provision of culturally competent care is a high priority for nurses in the UK, given patterns of increasing ethnic diversity. However, meeting the individual needs of patients can be difficult when language barriers hinder communication. One way to address these difficulties is to translate existing clinical tools.

Fletcher, K., Hawkes, P., Williams-Rosenthal, S., Mariscal, C. S., & Cox, B. A. (2007). Using nurse practitioners to implement best practice care for the elderly during hospitalization: The NICHE journey at the University of Virginia Medical Center. *Critical Care Nursing Clinics of North America*, 19(3), 321-337.

The Nurses Improving Care to Health System (NICHE) program has provided a valuable framework for developing initiatives that address the needs of the elderly. Three NICHE models have been implemented within the University of Virginia Health System since 1992. These include the Geriatric Resource Nurse model, the Acute Care of the Elderly model, and, most recently, the Geriatric Consultation Service model. Nurse practitioners (NPs) with geriatric expertise have provided the leadership in implementing these initiatives to achieve the goal of improving geriatric care delivery within the health system. Each NP functions in a broad role that is tailored to meet the needs of the patients and staff and includes the role components of clinician, educator, team leader, and care coordinator. Sustainability and growth of NICHE is contingent upon demonstrating favourable outcomes that can be directly attributed to NICHE.

Gullick, J., Shepherd, M., & Ronald, T. (2004). The effect of an organisational model on the standard of care. *Nursing Times*, 100(14), 36-39.

An Australian hospital was experiencing a long-term nursing staff shortage (in common with many hospitals throughout the world). The shortage led to concerns that patient care and supervision of less-experienced staff was compromised. A survey was undertaken to ascertain which organisational modules were used in the hospital, and how well these enabled nurses to provide a high standard of care. The

findings suggest that patient allocation should be maintained where practical and that team nursing should be trialled where poor numbers and skill-mix demand a greater degree of supervision and support.

Jones, A., & Fairbrother, G. (2004). Development of a new style team nursing on an acute care ward. *Monograph, Prince Henry & Prince of Wales Hospitals*.

A series of focussed discussions was held among acute care nurses at POW's cardiology unit to discuss nursing care delivery. Following these, the staff agreed to try out a more team oriented approach than the existing model, which was centred on individual patient allocation. The care model was developed and implemented during 2001. An action research approach was utilised in the ongoing implementation of the change. Results and experience to date suggest that more collective models of care can work, as long as the team leader does not become an autocratic, task-allocating role. Under the models developed to date, some form of patient allocation usually is maintained, but it occurs within the team, and handover break and some tasks are shared. Teaming staff in a junior/senior and regular/casual manner, seems to allow for teaching, learning and quality assurance to occur more freely. A team model is assisted by the existence of a ward based clinical educator, who can float between teams and give focussed teaching assistance as required. Discussing the characteristics needed for good team nursing to occur, have to date revealed the overriding importance of flat, friendly and above all, professional communication. As well as this, leadership on the part of the team leader in specific clinical scenarios is also important, as is overall benign leadership by the NUM. This paper outlines model characteristics, implementation processes and discusses findings on nurse workplace satisfaction and views regarding models of care.

Meehan, T. (2003). Careful nursing: a model for contemporary nursing practice. *Journal of Advanced Nursing*, 44(1), 99-107.

The purpose of this study was to conduct a preliminary content analysis of the mainly primary source historical documentation of the careful nursing system and present it within the structure of a contemporary conceptual model of nursing. The results of this preliminary analysis require further verification and critical examination. However, the careful nursing model illuminates important aspects of professional nursing and could be further developed to conceptualise and guide nursing practice.

O'Rourke, M. (2003). Rebuilding a professional practice model: the return of role-based practice accountability. *Nursing Administration Quarterly*, 27(2), 95-105.

There is no patient care without clinical practice. To improve the quality of health care, organisations must build a finely tuned and resilient clinical enterprise, one founded on clear role accountability and decision authority within the team. The author views scope of practice and professional standards as the foundation for practice accountability and decision authority. A case is made that an interdisciplinary, professional practice model is an appropriate delivery model in today's health care environment; a model that places the professional role in its rightful place as decision maker and supports the roles inherent accountability to evaluate and monitor practice performance. The importance of measuring professional practice performance is seen as a key link towards better understanding ways to reduce error and ensure patient safety.

Singer, E. A. (2007). The transtheoretical model and primary care: "The Times They Are A Changin'". *Journal of the American Academy of Nurse Practitioners [NLM - MEDLINE]*, 19(1), 11.

The aim of the study was to identify the transtheoretical model and the five stages of change that assist to bring about behavioural change. A case study is presented to illustrate how the model can be applied by primary care nurse practitioners (NPs) to assist patients toward a healthier lifestyle. The transtheoretical model has implications in primary care to assist NPs in assessing what stage a patient may be in, offering encouragement to promote a healthier lifestyle change, and reassessing the patient to maintain the desired healthy behaviour. Primary care NPs can use the transtheoretical model to better advance patients into a healthy behavioural change. Documentation of the current stage a patient is in can promote continuity of care among providers, outline specific health promotion initiatives to enhance patient care, and provide documentation during regulatory inspections.

Smith, K., & Bazini-Barakat, N. (2003). A public health nursing practice model: melding public health principles with the nursing process. *Public Health Nursing*, 20(1), 42-48.

There has been a shift in emphasis in public health from the provision of personal health services for individuals to efforts targeted at improving the health of the whole community. Many in public health nursing (PHN) have welcomed this shift, recognising the important role PHN can play in promoting health and preventing disease for all. There continues to be a need to redefine PHN roles and practice so that PH nurses can participate more effectively. LA County Department of Health Services PHN has developed a practice model grounded in

nationally recognised components: the public health team; PHN standards of practice; the 10 Essential PH Services; Healthy People's 2010 ten leading health indicators and additional local indicators; and the Minnesota PHN interventions model. The LA PHN Practice model provides a conceptual framework that assists in clarifying the role of the PHN and presents a guide for PH practice applicable to all PH disciplines.

Spence, K., & Lau, C. (2006). Measuring nursing unit culture as an empirical basis for implementing a model of practice in a neonatal intensive care unit. *Journal of Neonatal Nursing*, 12(1), 20-28.

The aim of the study was to measure the culture and level of work excitement in a Neonatal Intensive Care Unit prior to and after the implementation of a new model of practice. In order for the successful implementation of a model of practice, it is imperative to understand the culture of the organization. Results indicated that behaviours that were important to the nurses before and after the introduction of the care model were similar. Measures of work excitement showed that the nurses perceived the unit was understaffed, and there was a positive change to participating in the growth and development of other nurses. Results show that the introduction and integration of a new model of practice takes time.

Tiedeman, M. E., & Lookinland, S. (2004). Traditional models of care delivery: what have we learned? *Journal of Nursing Administration*, 34(6), 291-297.

Traditional models of patient care delivery include total patient care and functional, team and primary nursing. These models differ in clinical decision making, work allocation, communication and management, with differing social and economic forces

driving the choice of model. Studies regarding quality of care, cost, and satisfaction for the models provide little evidence for determining which model of care is most effective in any given circumstance. Despite lack of evidence, newer models continue to be implemented. This article compares the advantages and disadvantages of models, critiques the existing studies, offers recommendations regarding the evidence needed to make informed decisions regarding care delivery models.

Timmins, F. (2006). Conceptual models used by nurses working in coronary care units: A discussion paper. *European Journal of Cardiovascular Nursing*, 5(4), 253-257.

In the UK, Europe and the USA conceptual models of nursing are features of many undergraduate nursing curricula. In an era of concerns about both cost and quality, together with an increased impetus towards multi-professional working patterns and role expansion, alternative models of care, such as critical pathways and care pathways are gaining increased favour in the clinical setting. The aim of this paper is to consider whether or not the traditional conceptual models of nursing are apt for today's practising coronary care nurse. Specific questions to be addressed are: what is the research evidence that informs conceptual model use in coronary care and what are the conceptual models that commonly inform contemporary practice in coronary care nursing? Suggested ways forward for conceptual model use within nursing are proposed.

Vratny, A., & Shriver, D. (2007). A conceptual model for growing evidence-based practice. *Nursing Administration Quarterly*, 31(2), 162.

Nursing administration at a small medical centre is developing and implementing an evidence-based practice (EBP) model of care to support a culture of quality care, clinical excellence, cost-effectiveness, critical thinking, empowerment of staff, and professional growth. The purpose of this article is to describe a conceptual model for EBP that addresses how to overcome barriers to implementation. Clinician expertise and values, experience, patient preference and expectation, and caring become grounded in a practice environment that must strive to become rooted in clinical research to evolve into a practice that is evidence-based. Education helps to nourish EBP, but leadership, enthusiasm, mentorship, clinical inquiry, and reflective practice make EBP thrive. The EBP ambassadors branch out to each department to grow journal clubs, EBP Web pages, EBP projects, research utilization projects, and staff-led practice reviews. The fruits are quality patient care and outcomes, clinical excellence, cost-effectiveness, critical thinking, empowerment of staff, and professional growth.

Watson, J., & Foster, R. (2003). The attending nurse caring model : integrating theory, evidence and advanced caring-healing therapeutics for transforming professional practice. *Journal of Clinical Nursing*, 12, 360-365.

This paper presents a proposed model, the Attending Nurse Caring Model (ANCM), as an exemplar for advancing and transforming practice within a reflective, theoretical and evidence-based context. Watson's theory of human caring is used as a guide

for integrating theory, evidence and advanced therapeutics in the area of children's pain. The ANCM is offered as a program for renewing the profession and its professional-practices of caring-healing arts and science, during an era of decline, shortages, and crises in care, safety and hospital and health reform. The ANCM elevates contemporary nursing's caring values, relationships, therapeutics and responsibilities to a higher/deeper order of caring science and professionalism. intersecting with other professions, while sustaining the finest of its heritage and traditions of healing.

Wolf, G., Hayden, M., & Bradle, J., (2004). The transformational model for professional practice: a system integration focus. *Journal of Nursing Administration*, 34(4), 180-187.

Health care organisations face the increasingly difficult challenge of providing services that are of high quality, reasonable cost and easy accessibility for their constituents. Mergers and acquisitions are one strategy for accomplishing this, but in doing so it is critical to have a "road map" to create an integrated system, rather than merely a consortium of hospitals. The University of Pittsburgh medical centre has successfully created an integrated healthcare system of 19 hospitals. The authors describe the professional practice model used as a framework for success in integrating patient care.

Dunbar, B., Bonnie, P., Berger-Wesley, M., Cameron, T., Lorenz, B., Mayes, D., Ashby, R. (2007). Shared governance: making the transition in practice and perception. *Journal of Nursing Administration*, 37(4), 177.

The shared governance literature contains numerous examples of how to design and implement nursing shared governance models. However, there is a major gap between design/implementation and a change in culture. A change in nursing culture will support viability of this governance model. The authors detail the steps taken by a shared governance transition team to help a large nursing organisation make changes in the governance process and perception as well as to incorporate a maintenance plan.

Fitzgerald, M., & Solman, A. (2003). Clinical practice development in Central Coast Health. *Collegian*, 10(3), 8-12.

Engagement in clinical practice development (CPD) may be achieved in a range of ways. In this paper we describe the formation of a strategic plan for CPD in Central Coast Area Health Service (CCAHS). The plan specifically builds on work that has already been achieved by clinicians and is inclusive of the multidisciplinary team. In order to clarify the strategic direction, three levels of CPD are offered as examples of increasingly intensive CPD. In the strategic plan, senior personnel are recruited to support area-wide developments. At the same time clinicians are supported to work on specific local projects creating a simultaneous top down and bottom up approach. Preparation of clinicians for the challenges of team building and change in practice ensures that people choosing to engage in CPD have realistic expectations of the commitments and rewards that may be expected.

Gerrish, K. (2001). A pluralistic evaluation of nursing/practice development units. *Journal of Clinical Nursing*, 10(1), 109-118.

Nursing/practice development units (N/PDU) are perceived as centres for pioneering, evaluating and disseminating innovative practice developments and for facilitating the professional development of practitioners. This paper reported a pluralistic evaluation of the NPDU accreditation program provided by the University of Leeds, UK. Stakeholder perceptions of what constituted a successful NPDU were achieving optimum practice, providing a patient-oriented service; disseminating innovative practice, team working, enabling practitioners to develop their full potential, adopting a strategic approach to change and autonomous functioning. The findings highlighted differences between the rhetoric of a successful NPDU and the reality in which they function. Whereas all the units were actively involved in innovative practice development, evaluation, dissemination and networking activities, several factors influenced the success of the units, in particular, the role of the clinical leader, the motivation and commitment of NPDU members, financial resources and the nature of support from managers, medical staff and education institutions. Although the NPDUs had made significant progress in developing both health care practice and practitioners, there is still a need to consider how the claim that NPDUs benefit patients can be substantiated.

Bissell, P., May, C. R., & Noyce, P. R. (2004). From compliance to concordance: barriers to accomplishing a re-framed model of health care interactions. *Social Science & Medicine*, 58(4), 851-862.

As a framework for organising health care interactions, compliance and adherence have come in for increasing criticism in recent years. It has been suggested that interactions with patients should not be viewed simply as opportunities to reinforce instructions around treatment; rather, they should be seen as a space where the expertise of patients and health professionals can be pooled to arrive at mutually agreed goals. This concept known as concordance is attracting increasing interest in health services research within the UK. In this paper, we seek to empirically explore the relevance of a re-framed consultation through qualitative interviews with a small group of English speaking patients of Pakistani origin with a diagnosis of type 2 diabetes. We suggest that the focus of many respondents in this study on material and structural factors limiting diabetic regimen integration and the emphasis on a 'doctor-centred' model of health care interactions, represent distinct problems for the accomplishment of the concordance project. However, given that some patients sought greater understanding and appreciation by health professionals of the subjective aspects of living with diabetes, if it is evaluated at the level of health care relationships, rather than health outcomes (such as improved compliance) concordance may well be a significant development for those who suggest that respect for the patients agenda is a fundamental aspect of health care.

Capitman, J. (2003). Effective coordination of medical and supportive services. *Journal of Aging Health*, 15(1), 124-164.

For at least the past quarter century, tension between "medical/allied health" and

"social" models of care have characterised much of the home-care policy debate. There has also emerged a growing body of research and boundary-bending care models based on a holistic view of care recipients and care-giving. Such models coordinate between medical care and expanded supportive community services (SCS) that range from assistance with lifestyle modification, self-care, and informal care to adult-day services and home-health care. This article presents a new rationale for these models based on disablement theory and recent accounts of fairness in health policy. This approach is contrasted with the efficiency and efficacy policy perspectives that have received the most attention. The implications of an equal-opportunity approach to home-care policy for performance indicators are explored. Six basic models of coordination and current evidence on their impacts are described from this new perspective. Using qualitative data from two recent projects, five dimensions of care recipient and caregiver experiences that may be relevant to performance measurement are described. Suggestions for further service innovations and research are offered.

Denberg, T. D., Ross, S. E., & Steiner, J. F. (2007). Patient acceptance of a novel preventive care delivery system. *Preventive Medicine*, 44(6), 543-546.

Reports research to determine patient acceptance of a preventive care model employing outreach by non-physician experts outside of clinic visits. Questionnaires were completed by patients in the waiting room of an academic general medicine practice. Topics included the role of primary care providers in coordinating health care; interest in being contacted by non-PCPs between visits; and willingness to communicate with such experts by phone, e-mail, and internet. Results indicated that either that requiring primary care provider

involvement in preventive health care is not always necessary, is inconvenient, or represents an unnecessary expense. Most were open to a non-PCP-centred method of receiving preventive services. Socioeconomically disadvantaged patients and those with poorer self-rated health, however, were less likely to express interest in the concept.

Gask, L. (2005). Overt and covert barriers to the integration of primary and specialist mental health care. *Social Science & Medicine*, 61(8), 1785-1794.

This paper is concerned with the historical attempt over the last 20 years to improve integration between primary and specialist mental health care. Semi-structured interviews were carried out during the period December 2000 - March 2001 with primary care workers, specialist medical and nursing staff, managers and other key informants in one large group model Health Maintenance Organization in the USA. Both overt (financial) and covert (attitudinal and conceptual) barriers to the integration of mental health and primary care were identified and the impact of these barriers on organizational development is discussed with reference to Activity Theory. The nature and quality of interprofessional conversation in an organization may be important mediating factors in addressing covert barriers to integration between primary and specialist mental health services. There may be insufficient actual contact between different groups of workers in primary and specialist care to enable these professionals to share ideas, challenge mutual assumptions and understand each others' viewpoints about the nature of their work, the covert barriers to integration. Workers may differ in the conceptual models of mental health care they utilize, their views about access to services, and the amount of information they require.

In order to integrate services effectively, these issues will require discussion. Financial pressures in the system may lead to failure on the part of management to sanction and encourage opportunities for interprofessional conversation and the geographical distance between places of work may also limit opportunities for contact. However, an alternative explanation might be that attitudinal and other covert barriers to integration effectively prevent, in the first place, the development of such a shared space in which these covert barriers might actually be addressed.

Gask, L., Ludman, E., & Schaefer, J. (2006). Qualitative study of an intervention for depression among patients with diabetes: how can we optimize patient professional interaction? *Chronic Illness*, 2(3), 231-242.

The study aimed to describe the communication between the depression care specialist (DCS) nurses and patients with both depression and diabetes in an intervention study. Our aims were to inform both the quantitative findings of the present trial and the design of future primary care intervention studies. The DCS nurses employed a range of interventions in addition to the problem-solving and case-management skills that formed the basis of this intervention. Patients sometimes posed difficulties in being unable to understand the treatment, unprepared to engage with a new treatment and unready (or even unable) to acquire new skills. To optimize the interaction between patient and professional in the case management of depression and diabetes, training should provide guidance in the use of different models of care (medical and psychological), help case managers to identify and negotiate problem scenarios and combine an active model of therapy such as problem-solving treatment for primary care (PST-PC) with elements from motivational interviewing, ensure effective engagement

in treatment, and specifically explore how interaction between depression and diabetes might result in adverse outcomes.

Grace, L. (2007). What determines a patient's treatment? Evidence from out of hours primary care co-op data in the Republic of Ireland. *Health Care Management Science*, 10(3), 283.

This study explores consistency in healthcare. It investigates whether vulnerable groups in the population receive the most appropriate care. This is achieved by considering the case study of individuals who present to out of hours (OOH) primary care services in the Republic of Ireland with gastroenteritis. Specifically an individual can potentially receive four services; nurse advice, doctor advice, a treatment centre consultation or a home visit. Results show that service choice is influenced by patient, call and seasonal characteristics to varying degrees. Patient symptoms are the primary driver of the type of service the patients receives. Results also indicate that the OOH primary care facilities individual characteristics do not affect service choice. This suggests a degree of consistent care across these organisations. It also provides evidence that service choice is exogenous to the organisation.

Halcomb, E., Davidson, P., Daly, J., Yallop, J., & Toftler, G. (2004). Australian nurses in general practice based heart failure management: implications for innovative collaborative practice. *European Journal of Cardiovascular Nursing*, 3, 135-147.

The growing global burden of heart failure (HF) necessitates the investigation of alternate methods of providing coordinated, integrated and client-focussed primary care. Currently, the models of nurse-coordinated care demonstrated to be effective in RCTs

are only available to a relative minority of clients and their families with HF. This current gap in service provision could provide fertile ground for the expansion of practice nursing. This paper nurse in HF management in Australia. There is a paucity of data evaluating the potential role for practice nurses in a reconfigured, collaborative health care system. Those studies that were identified were largely of a descriptive nature. In addition to identifying the practice nurse as a largely unexplored resource, key themes that emerged from the review included: 1 current GP services face significant barriers to the implementation of evidence-based HF practice; 2 there is considerable variation in the practice nurse role between practices; 3 there are significant barriers to the expansion of the practice nurse role; 4 multidisciplinary interventions can effectively deliver secondary prevention strategies; 5 practice nurses can potentially facilitate these multidisciplinary interventions; and 6 practice nurses are favourably perceived by consumers although there is some confusion about their role. On the basis of the literature review, practice nurses represent a potentially useful adjunct to current models of service provision in HF management. reviewed the published literature describing the current and potential role of the practice.

Hjelmgren, J., & Anell, A. (2007). Population preferences and choice of primary care models: A discrete choice experiment in Sweden. *Health Policy*, 83(2-3), 314-322.

The aim of the study was to examine which attributes are important when individuals choose between primary care models. In particular, we studied whether individuals that were given a choice preferred individual family physicians (GP) or a primary care team consisting of physicians and nurses (PCT). Waiting time, user charges, ability to choose provider, and degree of influence over

the care received were each statistically significant discriminants. Subgroup analysis showed that older individuals and individuals in poor health preferred the option to register with a GP whereas working individuals and individuals living at a greater distance from a hospital preferred the option to register with a primary care team.

Jonsdottir, H., Litchfield, M., & Pharris, MD. (2004). The relational core of nursing practice as partnership. *Journal of Advanced Nursing*, 47(3), 241-248.

Consideration of the relational core of nursing has gained significance in today's health systems, where the work of nurses is dominated by technologically-driven, prescriptive, and outcome-oriented approaches. This has led to disregard for individual experiences of living life with diverse health conditions. Aim: the aim of this paper is to articulate the relational core of nursing practice as partnership. Discussion; the relational core of nursing practice is explicated as a process of professional partnership, focussing on the evolving dialogue between nurse and patient. In partnership, the dialogue is open, caring, mutually responsive and non-directive. The nurse attends to that which is of concern to patients in relation to their health predicaments and the meaning in the health experience unfolds. The nurse and the patient reach insight that represents more useful ways of comprehending and acting on their health predicaments. Partnership represents theoretically-driven practice that invites nurses to meet patients where they are in understanding their health predicaments and what can be done about then. As such, partnership strengthens the resolve of nurses to resist the pressures of contemporary health service delivery to provide a technical form of practice and it protects the relational core of a fully professional practice.

Lapidos, S., Christiansen, K., Rothschild, S. K., & Halstead, L. (2002). Creating interdisciplinary training for health care professionals: the challenges and opportunities for home health care. *Home Health Care Management Practice*, 14(5), 338-343.

Training health care professionals to work together in managing the problems of elderly patients is an area where the home health care industry can make a crucial and substantial contribution. Since 1996, Rush Home Care Network, an affiliate agency of Rush-Presbyterian-St. Luke's Medical Centre in Chicago, has served as a clinical training site for an interdisciplinary education program. This program, the Rush Geriatric Interdisciplinary Team Training Program, was initially funded in 1996 through a grant from the John A. Hartford Foundation. Trainees from medicine, nursing, social work, pharmacy, occupational therapy, physical therapy, and clinical nutrition observe and work with Rush home care teams. They participate in team meetings, home visits, patient assessment and counselling, and in-service training. The Rush home care experience in interdisciplinary team training can be viewed as a model for other home health care organizations interested in becoming clinical training sites for team care.

MacLeod, R. (2000). Learning to care: a medical perspective. *Palliative Medicine*, 14(3), 209-216.

The development of palliative care as a recognizable specialty has been supported by an acknowledgment of palliative medicine as a discrete discipline within the medical profession. While the knowledge and skills required for training in palliative medicine are well defined, there are elements of the medical care of people at the end of life that are more difficult to outline. Nursing practitioners and academics in particular

have made important contributions in defining caring as an entity, and published work in the field of nursing, bio-ethics and philosophy has encouraged an understanding of what caring is and how it is practised. However, it has rarely been addressed specifically in the medical literature. Undergraduate and postgraduate curricula outline some of the attitudes required to practise palliative medicine but the way in which doctors learn to care and indeed should care has not been clearly detailed. This paper reviews some of the literature pertinent to this aspect of palliative care, with particular reference to some of the elements that may influence how and why doctors learn to care in the way that they do in their practice of medicine.

Marinescu, L. G. (2007). Integrated approach for managing health risks at work - the role of occupational health nurses. *AAOHN Journal [NLM - MEDLINE]*, 55(2), 75.

Currently, many organizations are using a department-centred approach to manage health risks at work. In such a model, segregated departments are providing employee benefits such as health insurance, workers' compensation, and short- and long-term disability or benefits addressing work-life issues. In recent years, a new model has emerged: health and productivity management (HPM). This is an employee-centred, integrated approach, designed to increase efficiency, reduce competition for scarce resources, and increase employee participation in prevention activities. Evidence suggests that corporations using integrated HPM programs achieve better health outcomes for their employees, with consequent increased productivity and decreased absenteeism. Occupational health nurses are well positioned to assume leadership roles in their organizations by coordinating efforts and programs across departments that offer health, wellness,

and safety benefits. To assume their role as change agents to improve employees' health, nurses should start using the language of business more often by improving their communication skills, computer skills, and ability to quantify and articulate results of programs and services to senior management.

McGeehan, S. K., & Applebaum, R. (2007). The evolving role of care management in integrated models of care. *Care Management Journals [NLM - MEDLINE]*, 8(2), 64.

The purpose of this study is to better understand care management in integrated models of service delivery. Semi structured interviews were conducted with state and program level administrators and care managers from nursing and social work disciplines in eight programs providing integrated care. The professionals interviewed discussed the benefits and difficulties associated with providing care management to a population with a wide range of needs, issues related to interfacing with different health care professionals, and the overall purpose of the care manager role. The findings suggest a need to unify the purpose of care management in programs, that educational and training efforts for care managers need to be examined more closely, and that there is a need for future research to focus on the value of comprehensive care management in a medical model of care.

Nolan, M., Ryan, T., Enderby, P., & Reid, D. (2002). Towards a more inclusive vision of dementia care practice and research. *Dementia*, 1(2), 193-211.

Drawing on recent literature this article explores the development of research with family carers and people with dementia and identifies a number of themes that have emerged over time. It raises fundamental questions about the nature and purpose of research and the balance of power between researchers, family carers and people with dementia. Existing notions of expertise and knowledge are called into question and the article concludes with a call for a more empowering and inclusive model of research and practice based upon a relationship-centred approach to care.

Pearson, A. (2003). Multidisciplinary nursing: rethinking role boundaries. *Journal of Clinical Nursing*, 12(5), 625-629.

The ambiguous role of nurses within the health care team has been a subject of much debate, evident in current practice and the study of the early development of nursing in Australia. Early nursing work was broad and uncontested. Debates about nursing and non-nursing tasks are thought to have emerged after the establishment of "Nightingale reforms" in the 1870s. Nursing role conflicts may be due in part to the rise in technology and medical intervention, the demise of generalist doctors, nurses and patient-centred care, the creation of nursing specialists who moved to other community care positions and nursing's drive for professionalisation. Nurses' roles in meal times provides an example of the ambiguous and contentious issues of nursing and non-nursing work. Health services need a generic worker who is client-focussed, possesses multidisciplinary skills, manages the care environment, humanises the system at the point of contact and acts therapeutically.

The broad and flexible role ascribed to nurses is threatened by cost containment and the scramble for new occupations within the broad field of health services, which is plagued with increasingly rigid role boundaries. The examination of nursing workforce planning arrangements is needed to ensure greater coherence and clearer lines of nurses' roles and responsibilities.

Rothstein, W. G., & Hannum, S. (2007). Profession and gender in relationships between advanced practice nurses and physicians. *Journal of Professional Nursing*, 23(4), 235-240.

Relationships between registered nurses and physicians have often been described in terms of two models; one based on interactions between two health professions and one based on the patriarchy of male physicians and the deference of female nurses. To evaluate nurses' perceptions of the two models, 125 advanced practice nurses at a state-wide professional conference completed a closed-ended self-administered questionnaire that asked about their relations with male and female physicians. Nurses rated male and female physicians very similarly; both groups were rated most favourably on their confidence in the nurse's expertise and least favourably on their recognition of the nurse's responsibilities unrelated to the care of individual patients. Nurses rated female physicians under the age of 50 more favourably than older female physicians and rated male physicians of all ages similarly. These findings provide greater support for the professional than for the gender model of nurse-physician relations.

Seek, A., & Hogle, W. P. (2007). Modeling a better way: navigating the healthcare system for patients with lung cancer. *Clinical Journal of Oncology Nursing [NLM - MEDLINE]*, 11(1), 81.

The coordination of services for patients with suspected or newly diagnosed lung cancer produces improved patient outcomes, particularly in their quality of life. Evidence-based practice demonstrates improved outcomes from the multimodality therapies offered today, especially for patients with lung cancer; however, navigating through the healthcare system is especially challenging for patients. In developing the Multidisciplinary Lung Cancer Clinic at Frederick Memorial Hospital, navigation challenges in the healthcare system have been addressed. Patients are receptive and pleased with the approach, in which a nurse practitioner coordinates services and provides guidance and support for patients. The program offers benefits to patients with lung cancer in the community hospital setting. A similar program can be implemented in community cancer centres for patients with other diagnoses to improve outcomes and satisfaction with the healthcare system.

Sicotte, C., D'Amour, D., & Moreault, M. P. (2002). Interdisciplinary collaboration within Quebec community health care centres. *Social Science & Medicine*, 55(6), 991-1003.

Central to the success of many recent health system reforms is the implementation of new primary health care delivery models. The central characteristic common to these new models usually emphasises interdisciplinary collaboration. This paper studied interdisciplinary collaboration among various groups of professionals

within an original Canadian primary health care delivery model. The results showed modest results in achieving interdisciplinary collaboration especially since interdisciplinary collaboration is a central objective that has been pursued for more than 25 years. This study demonstrates that the main factors associated with interdisciplinary collaboration are closely linked to work group internal dynamics. Interdisciplinary collaboration is linked to the simultaneous and antagonistic effect of some central intragroup process factors. Conflicting values and beliefs are present that both enhance and limit interdisciplinary collaboration. The presence of conflicting stimuli seriously undermines the strength of the CHCC work group's shared beliefs and strongly limits interdisciplinary collaboration. The results also stress the importance of administrative formalisation initiatives to enhance collaboration among different professions. The efficacy of formalisation in this context is based on its capacity to offer an articulated and operative interdisciplinary framework that can generate a counteractive effect to the traditional professional framework. It offers concrete rules that help align the work group beliefs with interdisciplinary values.

Tosh, K. (2007). Nineteenth century handmaids or twenty-first century partners? *Journal of Health Organization and Management [NLM - MEDLINE]*, 21(1), 68.

The purpose of this paper is to consider the processes influencing the nature of the relationship between hospital medical and nursing staff since the influential Briggs Report of the 1970s declared that the nineteenth-century handmaid model remained a powerful concept. The paper discusses how three doctor-nurse relationship models have attempted to account for the way these two groups interact. A fourth perspective is put forward as a potentially revealing way of viewing group relations, taking from the social psychology-based theory of social identification. The paper maintains that a frank and open discussion of the problems that may be encountered in developing the doctor-nurse relationship is a vitally important ingredient for modern health care. By employing a polemic style the key aim of this paper is to stimulate debate between the relevant parties in this area and to attempt to highlight some of the less obvious factors that may represent tangible barriers to effective partnership.

Anthony, M., & Hudson-Barr, D. (2004). A patient-centred model of hospital discharge. *Clinical Nursing Research*, 13(2), 117-136.

Patient-centred care is a key characteristic of quality health care in the 21st century. Three patient processes of care, characteristic of patient-centred models of care may be related to improved readiness for discharge: patients' knowledge of their home-going needs, their relative importance, and their active involvement in the discharge process. 44 patients having planned abdominal surgery were interviewed at three time points to determine their information needs and preference for involvement. Patients indicated 4.74 needs prior to admission, 5.05 needs prior to discharge and 5.35 needs after discharge. Patients expressed a desire for information and preference to be involved. These findings provide initial evidence for the efficacy of future intervention is designing care as seen through the eyes of the patient.

Dewing, J., & Reid, B. (2003). A model for clinical practice within the consultant nurse role. *Nursing Times*, 99(9), 30-32.

This article discusses how the clinical, or practice element, of the consultant nurse role can best be delivered and how consultant nurses can enable others to develop their practice. The model for the clinical practice of a consultant nurse outlined in this paper is continually being reviewed. However, it is clear that consultant nurses should not work in isolation to provide care or services and must work alongside others to both inform their role and enable others to apply research evidence to nursing care.

Dontje, K., Corser, W., Kreulen, G., Teitelman, A. (2004). A unique set of interactions: the MSU sustained partnership model of nurse practitioner primary care. *Journal of the American Academy of Nurse Practice*, 16(2), 63-69.

Presents a unified conceptual model that identifies the integral processes of nurse practitioner (NP) care delivery and that integrates major structural influences and potential outcomes. The model is further characterised to delineate the unique and value-added nature of NP primary care and to describe how this nature may be correlated with specific clinical outcomes.

Fawcett, J., Newman, D., & McAllister, M. (2004). Advanced practice nursing and conceptual models. *Nursing Science Quarterly*, 17(2), 135-138.

This article focussed on advanced practice nursing. A definition and central competency of advanced practice are given and four roles assumed by advanced practice nurses are identified. Questions related primarily to the advanced practice role of nurse practitioner are raised. Two nurse scholars who teach and practice discuss their experiences as advanced practice nurses, with an emphasis on using a conceptual model of nursing as a guide for their practice.

Garfield, S., Smith, F., Francis, S. A., & Chalmers, C. (2007). Can patients' preferences for involvement in decision-making regarding the use of medicines be predicted? *Patient Education and Counseling*, 66(3), 361-367.

The study aimed to develop a model of patients' preferences for involvement in decision-making concerning the use of medicines for chronic conditions in the UK and test it in a large representative sample of patients with one of two clinical

conditions. Multivariate analysis revealed that age, social class and clinical condition were associated with preferences for involvement in decision-making concerning the use of medicines for chronic illness; but gender, ethnic group, concerns about medicines, beliefs about necessity of medicines, health status, quality of life and time since diagnosis were not. This study has demonstrated that current research does not provide a basis for predicting patients' preferences for involvement in decision-making. Building concordant relationships may depend on practitioners developing strategies to establish individuals' preferences for involvement in decision-making as part of the ongoing prescriber-patient relationship.

Kelleher, S. (2006). Providing patient-centred care in an intensive care unit. *Nursing Standard [NLM - MEDLINE]*, 21(13), 35.

This article examines the provision of patient-centred care in an intensive care unit where patients' autonomy may be compromised. It discusses the Synergy Model as a framework for encouraging nurses to transform a technical and potentially dehumanising environment into a humane and healing place.

Knox, S., & Gharrity, J. (2004). Creating a centre for nursing excellence. *JONA's Healthcare Law, Ethics and Regulation*, 6(2), 44 - 51.

A centre for nursing excellence provides a structure for organising professional nursing within an organisation. It gives nursing leadership a method of explaining, demonstrating and showcasing nursing. A centre for nursing excellence provides a method of interpreting the primary and multiple roles of nursing, including patient care delivery, education, research, leadership and management. A centre for

nursing excellence can be used as a basis for the development of practice models, education and development programs, nurse recruitment strategies and retention, and leadership and management programs

Kaplow, R. (2003). AACN synergy model for patient care: a framework to optimise outcomes. *Critical Care Nurse (supplement)*, 27-30.

Synergy is an evolving concept that occurs when individuals act in mutually engaging ways to promote positive outcomes for patients. The AACN synergy model for patient care links practice and outcomes. The premise is that positive patient outcomes will occur when patient characteristics and nurse characteristics work in mutually enhancing ways and that these outcomes will occur if the nurse demonstrates the competencies in relation to patient's needs. The AACN synergy model for patient care takes a comprehensive look at the patient and puts the patient at the centre of nursing practice. A major tenet of this model is that patient characteristics are important to nurses, and nurse characteristics are important to patients.

Latter, S., & Courtenay M. (2004). Effectiveness of nurse prescribing: a review of the literature. *Journal of Clinical Nursing*, 13(1), 26-32.

In the UK, the number of nurses able to prescribe medicines is rapidly increasing in line with Government policy directives. Whilst a number of research studies have been conducted on nurse prescribing, review and synthesis of findings from these studies had not been undertaken. A literature review was conducted to identify key findings about the impact and effectiveness of nursing prescribing as well as under-researched issues, in order to inform future

research, education and practice in this area. Findings indicate that patients are generally satisfied with district nurses' and health visitors' prescribing in the first phase of nurse prescribing. Nurses who prescribe are also generally satisfied with their role, although some concerns about the adequacy of their pharmacological knowledge have been raised. There is some variation on the prescribing patterns of district nurses, health visitors and practice nurses, and the limitation of the original Nurse Prescribers' Formulary (NPF) have been highlighted. Some preconditions for good nurse prescribing practice have begun to be identified. Some nurse prescribing outcomes e.g. its impact on the prescribing practices of doctors, and the perspectives of certain patient groups - remain un-evaluated.

Lein, C., & Wills, C. E. (2007). Using patient-centred interviewing skills to manage complex patient encounters in primary care. *Journal of the American Academy of Nurse Practitioners [NLM - MEDLINE]*, 19(5), 215.

The aim was to describe effective and efficient patient-centred interviewing strategies to enhance the management of complex primary care patient encounters. Patient-centred interviewing can enhance effectiveness of care in complex patient encounters. A relatively small investment of time and energy has positive yields in regard to improvements in longer term physiological status, treatment adherence, quality of life, patient-provider working relationship, and patient and nurse practitioner satisfaction. Use of patient-centred interviewing strategies can enhance effectiveness of patient care processes and outcomes while retaining efficiency of patient management.

Lyth, G. (2000). Clinical supervision: a concept analysis. *Journal of Advanced Nursing*, 31(3), 722-729.

Clinical supervision is a commonly discussed concept within nursing. There appears to be a belief that it is a good thing for nursing. Many practitioners, however, are still unsure what clinical supervision is and what is expected of them. A number of definitions and models of supervision have been developed but it remains ill-defined. This paper develops a conceptual analysis of clinical supervision using the method developed by Rodgers (1989). A review of the literature precedes the description of the attributes, antecedents, consequences and references. A model case is outlined prior to a proposed definition of supervision being given. It is hoped that this paper will stimulate further exploration and study of this concept.

Mick, D., & Ackerman, M. (2000). Advanced practice nursing role delineation in acute and critical care: application of the strong model of advanced practice. *Heart & Lung: The Journal of Acute and Critical Care*, 29(3), 210-221.

This purpose of this study was to differentiate between the roles of clinical nurse specialists and acute care nurse practitioners. Hypothesized blending of the clinical nurse specialist and acute care nurse practitioner roles is thought to result in an acute care clinician who integrates the clinical skills of the nurse practitioner with the systems knowledge, educational commitment, and leadership ability of the clinical nurse specialist. Ideally, this role blending would facilitate excellence in

both direct and indirect patient care. The Strong Model of Advanced Practice, which incorporates practice domains of direct comprehensive care, support of systems, education, research, and publication and professional leadership, was tested to search for practical evidence of role blending. Levels of self-assessed clinical expertise as well as valuing of role-related tasks differed among this sample of clinical nurse specialists and acute care nurse practitioners. Groundwork has been laid for continuing exploration into differentiation in advanced practice nursing roles. As the clinical nurse specialist role changes and the acute care nurse practitioner role emerges, it is imperative that advanced practice nurses describe their contribution to health care.

Naden, D., & Eriksson, K. (2004).

Understanding the importance of values and moral attitudes in nursing care in preserving human dignity. *Nursing Science Quarterly*, 17(1), 86-91.

The purpose of this investigation was to explore when nursing becomes an art, and to develop a theory/model of nursing as art. The overall design of the investigation was qualitative and phenomenological-hermeneutic. The five substantial categories in the theory/model are: invitation and confirmation, encounter, values, moral attitude and demeanour, the act of good will, and aesthetic communication. One main finding of this nursing investigation based on the caring perspective was that values and a thoroughly moral attitude and demeanour are central when nursing becomes an art.

Ponte, P., Connor, M., DeMarco, R., & Price, J. (2004). Linking patient and family-centred care and patient safety: the next leap. *Nursing Economics*, 22(4), 211.

The Dana-Farber Cancer Institute (DFCI), Boston Massachusetts, has been on a road of self-reflection, learning, and innovation in the area of patient safety since 1995 when the institute was propelled into the public eye because of two medication errors. Ponte et al highlight DFCI's evolving understanding of creating cultures of safety in health care organizations.

Suhonen, R., Valimaki, M., Katajisto, J., & Leino-Kilpi, H. (2007). Provision of individualised care improves hospital patient outcomes: an explanatory model using LISREL. *International Journal of Nursing Studies*, 44(2), 197-207.

Previous studies propose the efficacy of individualised care for hospital patients. The aim of this study is to examine predicted relationships between individualised care and patient satisfaction, patient autonomy and health-related quality of life. This study was carried out in six acute hospitals in Southern Finland. The findings support the proposed model linking individualised nursing care directly to the positive patient outcomes defined. Individualised care explained the variance on patient satisfaction and patient autonomy. A low but significant association was also found between individualised care and perceived health-related quality of life. Not only clinically important, this model also has implications for further research into individualised care and its relationship with positive patient outcomes.

Adams, A., & Bond, S. (2003a). Staffing in acute hospital wards: part 1. The relationship between the number of nurses and ward organisational environment. *Journal of Nursing Management*, 11(5), 287-292.

This paper is one of two that explores relationships between nursing staff resources, ward organisational practice and nurses' perceptions of ward environments. Findings show that the number of nurses is not only associated with ward organisational systems but also with a range of care processes and staff outcomes which hitherto have been linked only to ward organisational systems. The latter have been identified as providing different opportunities for developing multidisciplinary working and nurses' autonomy but the central importance of having an adequate number of staff to achieve these aims has been largely overlooked in research. Having fewer nurses was associated with both hierarchical and organisational attitudes to care provision, denoting lower standards of nursing practice. A larger nursing complement was significantly associated with devolved organisational structures but no link was established between more staff and higher standards of nursing practice. When there was more staff there was a positive association with nurses' perceptions of multidisciplinary collaboration, their ability to cope with workload and job satisfaction. Employing an adequate number of nurses to provide care is clearly beneficial for nurses themselves. Patients are likely to benefit from a lower incidence of hierarchical practice associated with having a low nurse/bed ratio within a ward.

Adams, A., & Bond, S. (2003b). Staffing in acute hospital wards: part 2. Relationships between grade mix, staff stability and features of ward organizational environment. *Journal of Nursing Management*, 11(5), 287-292.

This paper explores relationships between grade mix, staff stability, care organization and nursing practice. Hypotheses about ward clinical grade mix were not well supported. Where there was rich grade mix, nurses reported better collaborative working with other disciplines and greater influence. However, it was expected that wards practising 'devolved' nursing would have a richer grade mix and that the latter would lead to more innovative practice and nurses experiencing greater job satisfaction. A link between poor grade mix, unprogressive practice and perceived lower standards of care - was supported. Wards practising the 'devolved' system rely on adequate numbers of nurses rather than a rich grade mix, and do not necessarily provide a more stable, retentive work environment for nurses. A strong link between staff stability and standards of professional nursing practice was found, indicating that staff stability is more important than a rich grade mix for achieving innovative, research-based practice. However, staff instability undermined cohesion with nurse colleagues, collaborative working with doctors, and nurses' ability to cope with the workload. Higher standards of nursing practice are achieved where stability is high, independently of staffing characteristics.

Bojtor, A. (2003). The importance of social and cultural factors to nursing status. *International Journal of Nursing Practice*, 9, 328-335.

The objective of the author was to examine nursing staff workload. The examination is based on the workload model of Ropbert Karasek and on the status integration theory of P. Gibbs and Walter T. Martin. As a means of examination, an open questionnaire consisting of 55 items and 76 variables was given to nurses working in different fields of health care, studying in higher education instead, or to persons with a degree in

nursing (n =465). The main concern of the authors was to attempt to identify the inconsistencies in nursing status which might come from limited decision-making freedom and high workplace requirements. In the process of statistical analysis of the data, considerable variation was observed regarding some scales of the questionnaire. The authors emphasise the reasons for the inconsistencies in nursing status might originate either from traditional cultural elements or from increased workload based on unclear competencies which are focussed on the nurses.

Clarke, S. P., & Aiken, L. H. (2003). Registered nurse staffing and patient and nurse outcomes in hospitals: a commentary. *Policy Politics Nursing Practice*, 4(2), 104-111.

The authors' research group published a major article in October 2002 showing a strong effect of nurse staffing on both patient outcomes and factors related to nurse turnover in 168 Pennsylvania hospitals. This article reviews major design elements and findings of the study and discusses policy implications of this research. Even though evidence is mounting that hospital staffing is a public health issue, regulation of staffing levels remains controversial. Higher quality staffing data that incorporate information about patients' needs for nursing care are required for better administrative decision-making and research purposes. That the current nurse shortage is occurring in an era of renewed concerns about safety in hospitals offers unique opportunities for developing public policy to remedy problems with staffing and other long-standing workplace environment issues in hospital nursing.

Fitzgerald, M., Pearson, A., Walsh, K., Long, L., & Heinrich, N. (2003). Patterns of nursing: a review of nursing in a large metropolitan hospital. *Journal of Clinical Nursing*, 12(3), 326-332.

In this Clinical Practice Development (CPD) project we set out to identify and describe the current approaches to the management and delivery of nursing care in an Australian metropolitan teaching hospital. Using a simple descriptive design, data were collected to elicit patterns of care provided by nursing teams. We sought to demonstrate patterns described by nursing teams (interviews) and actual patterns of care (observation). As expected there was a degree of incongruence between the espoused and actual patterns of care. Interview data revealed that most study wards had a view of nursing that emphasised meeting the total care needs of patients and their families through offering bio psychosocial and educative care. The observational data revealed that a relatively large proportion of time was expended on activities that were not regarded as important by staff when interviewed (e.g. documentation) while relatively small amounts of time were observed to be spent educating patients or communicating with relatives of patients. The identification of this type of gap creates a dissonance in clinicians that can be used to stimulate change through CPD. Clinicians used the information to stimulate discussion and to rewrite team value statements.

McGillis-Hall, L., & Doran, D. (2004). Nurse staffing, care delivery model and patient care quality. *Journal of Nursing Care Quarterly*, 19(1), 27-33.

Little research has been conducted examining the linkages between nurse staffing and care delivery models in relation to patient care quality. Nurses in this study perceive that an all RN staffing model is associated with better quality outcomes for patients, and that staffing models that include professional and unregulated staff may pose a challenge for unit-based communication and the coordination of care. Patient care delivery models were also important predictors of the quality outcomes studied.

McGillis Hall, L. (2003). Nursing intellectual capital: a theoretical approach for analysing nursing productivity. *Nursing Economics*, 21(1), 14-19.

The pressure for increasing productivity in the context of nursing shortage has surfaced the need to measure nursing productivity with more sophisticated tools. The author has outlined a framework for assessing nursing productivity that includes the contribution of nursing knowledge and skill, and factors such as organisational trust and commitment. The framework includes nursing knowledge indicators such as educational preparation, experience, career development, autonomy, organisational trust and commitment and employee satisfaction. The model also includes nursing productivity indicators such as direct care hours, turnover, absenteeism, orientation and education, nursing errors, and patient satisfaction. Results of this study are expected to assist organisations in refining their ability to recruit, develop and maintain the most effective nursing workforce.

Needleman, J., Buerhaus, P., Mattke, S., Stewart, M., & Zelevinsky, K. (2002). Nurse-staffing levels and the quality of care in hospitals. *The New England Journal of Medicine*, 346(22), 1715-1722.

It is uncertain whether lower levels of staffing by nurses at hospitals are associated with an increased risk that patients will have complication or die. The mean number of nursing hours per patient day was 11.4, of which 7.8 hours were provided by RNs, 1.3 hours by LPNs, and 2.4 hours by nurses' aides. Among medical patients, a higher proportion of hours per day provided by RNs and a greater absolute number of hours per day provided by RNs were associated with a shorter length of stay ($p = 0.01$ and $p < 0.001$ respectively), lower rates of both UTI and upper GI bleeds. A higher proportion of hours of care provided by RNs was also associated with lower rates of pneumonia, shock or cardiac arrest, and failure to rescue. Among surgical patients, a higher proportion of care provided by RNs was also associated with lower rates of UTI, and a greater number of hours of care per day provided by RNs was associated with lower rates of failure to rescue. We found no association between increased level of staffing by RNs and the rates of in-hospital death or between increased staffing by LPNs or nurses' aides and the rate of adverse outcomes.

Needleman, J., Kurtzman, E., & Kizer, K. (2007). Performance measurement of nursing care. *Medical Care Research and Review*, 64, 10S.

Concerns about nurse staffing in hospitals, nursing's influence on patient safety and health care outcomes, and nurses' work environment (e.g. equipment failures, documentation burden) have led to increased interest in measuring and reporting nursing's

performance. This article reviews recent efforts and issues involved in identifying a set of nursing-sensitive performance measures. Sustaining and strengthening current efforts requires developing measures that address all the domains of nursing, addressing technical issues needed to analyse the impact of nursing on patient safety and health care outcomes, developing data systems that provide the information needed to implement the model system, regularly improving the set of endorsed standards to reflect the most current science and empirical evidence, and persuading all health care stakeholders that measurement and reporting nursing-sensitive standards make a difference in the care and quality that are delivered. Each of these tasks requires substantial development work and construction and maintenance of the infrastructure to sustain the performance measurement efforts.

Sexton, A., Chan, C., Elliott, M., Stuart, J., Jayasuriya, R & Crookes, P. (2004). Nursing handovers: do we really need them? *Journal of Nursing Management*, 12(1), 37-42.

This study attempts to address the content of the nursing handover when compared with formal documentation sources. The nursing handover has attracted criticism in the literature in relation to its continuing role in modern nursing. Criticisms include those related to time expenditure, content, accuracy and the derogatory terms in which patients are sometimes being discussed. Twenty three handovers, covering all shifts, from one general medical ward were audio-taped. Their content was analysed and classified according to where, within a ward's documentation systems, the information conveyed could be located. Results showed that almost 84.6% of information discussed could be located within existing ward documentation structures and 9.5% of information discussed was not relevant to

ongoing patient care. Only 5.9% of handover content involved discussions related to ongoing care or ward management issues that could not be recorded in an existing documentation source. The results of this study are representative of only one ward in one Australian hospital.

Walker, K., Donoghue, J., & Mitten-Lewis, S. (2007). Measuring the impact of a team model of nursing practice using work sampling. *Australian Health Review [NLM - MEDLINE]*, 31(1), 98.

The increasing number of inexperienced graduates, as well as other levels of nurse such as the enrolled nurse and assistant-in-nursing, requires health service and nursing managers in the acute care sector to rethink the long-preferred "patient allocation" model of care provision. As well, the escalating shortage of registered nurses and subsequent low morale among those remaining in the workforce require hospitals to re-examine skills mix and staffing ratios. This paper presents the results of two work-sampling studies conducted in a major metropolitan private hospital, the first of which was to provide a rationale for changing from the patient allocation model to a team model of care. The second study aimed to evaluate and provide data on the impact of the change. Staff were heavily involved in both studies as well as the change process. The findings highlight how effective the new model has been in redistributing certain aspects of care to make better use of each nurse levels knowledge and skills.

Harrison, J. P., & Lee, A. (2006). The role of e-Health in the changing health care environment. *Nursing Economics [NLM - MEDLINE]*, 24(6), 283.

In 2005 health care organizations spent 2.3% of total operating expenses on information technology and are slowly developing the infrastructure necessary to expand e-Health capabilities. E-Health is being recognized as a method to improve the overall health status of the population. It is important to build partnerships among health care providers, local community organizations, and national health care associations to ensure the continued development of e-Health initiatives. This study has managerial implications associated with the strategic application of e-Health systems and policy implications on future resource allocation.

Malin, B. (2007). A computational model to protect patient data from location-based re-identification. *Artificial Intelligence in Medicine*, 40(3), 223-239.

Health care organizations must preserve a patient's anonymity when disclosing personal data. Traditionally, patient identity has been protected by stripping identifiers from sensitive data such as DNA. However, simple automated methods can re-identify patient data using public information. This research demonstrates that patient anonymity can be formally protected in shared databases. Our findings illustrate that significant quantities of patient-specific data can be disclosed with provable protection from trail re-identification. The configurability of our methods allows health care administrators to quantify the effects of different levels of privacy protection and formulate policy accordingly.

Pinna, G. D., Maestri, R., Andrews, D., Witkowski, T., Capomolla, S., Scanferlato, J. L., et al. (2007). Home telemonitoring of vital signs and cardiorespiratory signals in heart failure patients: system architecture and feasibility of the HHH model. *International Journal of Cardiology*, 120(3), 371-379.

The Home or Hospital in Heart Failure Study (HHH) is a European Community funded trial (QLGA-CT-2001-02424) which compares usual care of heart failure (HF) with three home-based interventions in a multicentre, multicountry (Italy, Poland and UK), randomized controlled clinical trial. Home telemonitoring (HT) of clinical parameters represents a potential alternative (or addition) to traditional home care models. Nocturnal respiratory disorders (periodic breathing, sleep apnoea) are very common in HF, and are associated with increased morbidity and mortality. We developed an integrated HT system for monitoring of both vital signs and respiration. All measurements were patient-managed. This paper describes the architecture of this system, and assesses its feasibility. This study, the largest so far, demonstrates that self-managed home telemonitoring of both vital signs and respiration is feasible in HF patients, with surprisingly high compliance. We found an excellent rate of acceptable nocturnal respiratory recordings, which are those with the greatest clinical relevance.

Roberts, D., Tayler, C., MacCormack, D., & Barwich, D. (2007). Telenursing in hospice palliative care. *The Canadian Nurse : Infirmiere Canadienne [NLM - MEDLINE]*, 103(5), 24.

During the last months of life, many people with advanced illness will be living in their homes. Coping with changing symptoms, and ultimately preparing for death, becomes part of daily life. Whether the ill person is at home for days or for months, they depend on family or friends to be primary caregivers, supported by home-based services. However, after physician and home health offices close, many patients and their caregivers are left to cope alone. The authors describe an innovative partnership between B.C. NurseLine (a provincial tele-triage and health information call centre), the British Columbia Ministry of Health and Fraser Health Hospice Palliative Care program that created after-hours access to care for dying patients and their families in one of Canada's largest health authorities. The article outlines how information and communications technology enabled merging the capacity and expertise of B.C. NurseLine with the expertise of specialized community-based palliative care services to achieve outcomes of improved symptom management, decreased visits to emergency rooms and enhanced support for families who are caring for loved ones at home. For nurses caring for home-based patients, there are lessons to be learned about how to maximize technology to create systems that both improve access to care and are sustainable in the future.

Buchan, J., & Dal Poz, M. (2002). Skill mix in the health care workforce: reviewing the evidence. *Bulletin of the World Health Organization*, 80(7), 575-580.

Reviews the evidence related to skill mix in the health care workforce.

Buerhaus, P., Staiger, D., Auerbach, D. (2000). Implications of an aging registered nurse workforce. *Journal of the American Medical Association*, 283(22), 2948-2954.

The average age of registered nurses (RNs), the largest group of health care professionals in the United States, increased substantially from 1983 to 1998. The average age of working RNs increased by 4.5 years between 1983 and 1998. The number of full-time equivalent RNs observed in recent cohorts has been approximately 35% lower than that observed at similar ages for cohorts that entered the labour market 20 years earlier. Over the next 2 decades, this trend will lead to a further aging of the RN workforce because the largest cohorts of RNs will be between age 50 and 69 years. Within the next 10 years, the average age of RNs is forecast to be 45.4 years, an increase of 3.5 years over the current age, with more than 40% of the RN workforce expected to be older than 50 years. The total number of full-time equivalent RNs per capita is forecast to peak around the year 2007 and decline steadily thereafter as the largest cohorts of RNs retire. By the year 2020, the RN workforce is forecast to be roughly the same size as it is today, declining nearly 20% below projected RN workforce requirements. The primary factor that has led to the aging of the RN workforce appears to be the decline in younger women choosing nursing as a career during the last 2 decades. Unless this trend is reversed, the RN workforce will continue to age, and eventually shrink, and will not meet projected long-term workforce requirements

Buerhaus, P. I., & Needleman, J. (2000). Policy Implications of research on nurse staffing and quality of patient care. *Policy Politics Nursing Practice*, 1(1), 5-15.

This article provides a comprehensive overview of nursing workforce studies, examines current efforts to investigate the relationship between hospital nurse staffing and patient outcomes that are sensitive to nursing, and discusses the implications for public and private policy making. Although the impact of hospital restructuring on nurses is generally well known, public policy making in this area has not resulted in significant changes. The lack of substantial policy is attributed to insufficient empirical evidence linking changes in hospital nurse staffing to adverse patient outcomes. Even though new studies are providing a rapidly expanding body of knowledge, readers are urged to use caution when using these findings to support mandated hospital nurse staffing levels. The level of sophistication that would allow precise estimates of minimal acceptable staffing levels and ratios will not be achieved.

Kenney, P. A. (2001). Maintaining quality care during a nursing shortage using licensed practical nurses in acute care. *Journal of Nursing Care Quality [NLM - MEDLINE]*, 15(4), 60.

Implications of an aging registered nurse workforce, coupled with an inadequate supply of new nurses, presented a unique challenge for the nurse executive in an acute care hospital. This article presents one possible solution: reintroduction of licensed practical nurses to the patient care setting. It describes a pilot project initiated to answer the following question: Is there a change in quality of patient care or staff satisfaction when the nursing care delivery system adds a licensed practical nurse to the registered nurse and patient

care assistant care pairs? It also describes the driving forces behind this practice change and presents focus group discussions, the implementation process, and conclusions and recommendations.

Netten, A., Jones, K., & Sandhu, S. (2007). Provider and care workforce influences on quality of home-care services in England. *Journal of Aging & Social Policy, 19*(3), 81.

A key trend in home care in recent years in England has been movement away from “in-house” service provision by local government authorities (e.g. counties) towards models of service commissioning from independent providers. A national survey in 2003 identified that there were lower levels of satisfaction and perceptions of quality of care among older users of independent providers compared with in-house providers. This paper reports the results of a study that related service users’ views of 121 providers with the characteristics of these providers. For the most part, characteristics associated with positive perceptions of quality were more prevalent among in-house providers. Multivariate analyses of independent providers suggested that aspects of the workforce itself, in terms of age and experience, provider perceptions of staff turnover, and allowance of travel time, were the most critical influences on service user experiences of service quality.

Smadu, M. (2007). Collaboration and innovation needed to address shortage. *The Canadian Nurse, 103*(4), 3.

While this question raises eyebrows and, understandably, makes us cringe, the reality is that despite increases in nursing education seats, new nursing graduates alone will not address the gaps created by an aging nursing workforce and increased demands for nursing services. Since the early 2000s,

CNA has been projecting a shortage of 78,000 registered nurses by 2011 and 113,000 by 2016. What we heard at the conference is that optimizing nursing skills begins with careful scrutiny of the work of nurses and the need to look at the efficient use of nursing skills and knowledge. For example, increasing the availability of patient care support technologies, such as bed lifts, can reduce the physical demands on nurses and the amount of sick time due to injury, thus enabling nurses to spend more quality time with patients. Making efficient use of the nursing workforce must also be centred on innovative models of care delivery, including, for example, a team-based approach to care and telehealth.

Smith, A., & Lichtveld, M. (2007). A competency-based approach to expanding the cancer care workforce. *Nursing Economics, 25*(2), 110.

Like nursing, many health care professions are experiencing significant workforce shortages including social work, public health, pharmacy, medicine, basic science, and other allied health disciplines. The following observations were made: (a) the cancer health workforce needs are universal and widespread across discipline, continuum of care, and geography; (b) recruitment and retention needs are often very local or regional in nature; (c) ongoing quality management and continuing education is a prerequisite to keep pace with scientific developments and social complexity of cancer; (d) the work-force development pipeline spans issues of education, training, licensing, recruitment, and retention; and (e) health workforce problems and solutions are not unique to cancer, but are felt more intensely in the context of an aging population. Specifically, the Cancer Core Competencies are intended for health care professionals who have the generalized knowledge of cancer and are able to

initiate the continuum of cancer care from prevention and screening through palliative care, to assure the continuum of services to cancer patients and their families.

Winter, A., & Teare, J. (2002). Workforce planning and community children's nurses: it's all in the advertisements. *Journal of Child Health Care*, 6(2), 84-95.

This paper outlines a study exploring job advertisements for community children's nurses (CCNs). A post-structural approach was taken to illuminate the development of community children's nursing services (CCNS) and the profile of characteristics, skills and caseload within a workforce-planning context. An analysis of 100 advertisements looked at title, skills, caseload, qualifications and evolving roles. The analysis comprised an initial quantitative descriptive account of data, followed by further analysis of the text using thematic analysis and coding. The skills identified were compared to those identified by Proctor et al. (1999). The most commonly occurring skills were interpersonal (35%), multi-professional team working (33%), clinical (28%), management (18%) and leadership (16%). The analysis was limited, but provides a unique insight into employers' perceived needs in providing CCN services, evolving titles and roles and could inform practitioners, contribute to service evaluation, future service provision and workforce planning.

Aust, B., Rugulies, R., Skakon, J., Scherzer, T., & Jensen, C. (2007). Psychosocial work environment of hospital workers: validation of a comprehensive assessment scale. *International Journal of Nursing Studies*, 44(5), 814-825.

Studies have shown that adverse workplace factors can increase the risk of ill-health in hospital workers, but more comprehensive measures of the psychosocial work environment are needed. The aim of this research was to test a comprehensive and theory-based psychosocial work environment questionnaire and analyse associations with mental health. The sample included patient care workers (nurses, nurse assistants, midwives) and laboratory technicians. Patient care workers had more quantitative, emotional and cognitive demands, higher work pace and more role conflicts than laboratory technicians, but also better work organization, including more influence at work, better possibilities for development and a higher meaning of work. Both patient care workers and laboratory technicians had substantially higher scores on the demand scales and lower scores on the influence at work scale than the general working population. Further analyses showed that high levels of demands at work and low levels of work organization and problematic interpersonal relations at work were associated with lower self-rated mental health.

Brown, R. B., & Brooks, I. (2002). Emotion at work: identifying the emotional climate of night nursing. *Journal of Management in Medicine*, 16(4/5), 327.

This paper introduces the concept of the emotional climate of the workplace and explores how it both shapes and is shaped by the emotions experienced, expressed and redefined by nurses. It extracts emotional aspects of an organizational climate framework developed by Litwin and

Stringer and examines these with respect to nurse's experiences. The primary research was carried out at a general hospital NHS Trust in the East Midlands of the UK using a grounded theory methodology. The research methods included semi-structured interviews and observation. The themes identified include many of those found by Litwin and Stringer, others which represent variations upon these, and a new set, which, when combined, identify the emotional climate of the organization. The findings have confirmed that the experiment of using a 33-year-old positivistic framework to investigate aspects of qualitative research has enabled a robust contribution to the conceptual area of emotional climate.

Ekedahl, M., & Wengstrom, Y. (2007). Nurses in cancer care: stress when encountering existential issues. *European Journal of Oncology Nursing*, 11(3), 228-237.

Previous research related to stress among health care staff has highlighted several complex issues; however, a deeper analysis of the existential components has been lacking. The purpose of this paper is to study the stress of registered nurses who work with terminally ill and dying cancer patients. The material analysed are based on a life story approach and interviews carried out with 15 Swedish nurses working in hospices, oncology wards, and outpatient services for patients with advanced cancer. The nurses' stress levels ranged from low to severe, including multifaceted stress with existential dimensions. Different types of stress appear to be related with the individual, group, institutional, and cultural level.

Elbright, P. R., Paterson E.S., Chalko, B.A., & Render, M.L. (2003). Understanding the complexity of registered nurse work in acute care settings. *Journal of Nursing Administration*, 33(12), 630-638.

Nursing shortages and patient safety mandates require nursing managers and administrators to consider new ways of understanding the complexity of healthcare provider work in actual situations. The authors report findings from a study guided by an innovative research approach to explore factors affecting registered nurse performance during real work on acute care medical-surgical units. Our findings suggest beginning targets for interventions to improve patient safety, as well as recruitment and retention, through support for registered nurse work.

Hall, D. (2007). The relationship between supervisor support and registered nurse outcomes in nursing care units. *Nursing Administration Quarterly*, 31(1), 68.

Workplace social support is a major characteristic related to the Job Demand-Control model of job stress. Organizational and managerial supports have an effect on nurse satisfaction and burnout. The relationships between perceived supervisor support and measures of nurse occupation-related outcomes were investigated in 3 nursing units within an academic medical centre. Nurses with greater levels of perceived supervisor support experienced more positive job outcomes and less negative outcomes, including less occupational stress, than nurses with less perceived supervisor support. Implications for refocusing the role of the nurse supervisor and its effect on multiple nursing occupation-related outcomes are discussed.

Hendry, C., & Walker, A. (2004). Priority setting in clinical nursing practice. *Journal of Advanced Nursing*, 47(4), 427-436.

Priority setting is an important skill in nursing, and a skill deficit can have serious consequences for patients. Recent studies have suggested that it is a difficult skill for newly qualified nurses to acquire and may not be given sufficient attention in nurse education. Priority setting can be defined as the ordering of nursing problems using notions of urgency and/or importance, in order to establish a preferential order for nursing actions. A number of factors that may impact on priority setting have been identified in the literature. These include: the expertise of the nurse, the patient's condition, the availability of resources, ward organisation, philosophies and models of care, the nurse-patient relationship and the cognitive strategy used by the nurse to set priorities. However, very little empirical work has been conducted in this area.

Manion, J. (2003). Joy at work!: creating a positive workplace. *Journal of Nursing Administration*, 33(12), 652-659.

How can we regain a sense of joy through our work? Many nurses feel disconnected from their organisations, morale is plummeting and employee mistrust and cynicism are growing. Reversing these trends is crucial in the face of current and future labour shortages. The author shares recent information on health care workers who experience joy through their work and the implications for today's nurse leaders.

Ponte, P. R., Kruger, N., DeMarco, R., Hanley, D., & Conlin, G. (2004). Reshaping the practice environment: the importance of coherence. *Journal of Nursing Administration, 34*(4), 173-179.

Today's nurse leader is challenged to create a practice environment that fosters multidisciplinary collaboration, professional development, and a culture of safety. Fostering a sense of coherence among staff nurses about their place within the nursing department and the nursing department's place within the broader organisation is essential to the development of such environments. When nurses have a sense of coherence about their work setting, they are more likely to feel confident that the care of patients and families is fully supported by the organisation in which they work. The authors describe the concept of coherence; discuss findings from a preliminary study regarding attributes that may contribute to coherence in individual nurses, and describe systems and programs that have been implemented in a large academic medical centre to foster a sense of coherence in individual nurses, the nursing department and the institution as a whole.

Stone, P. W., Tourangeau, A. E., Duffield, C. M., Hughes, F., Jones, C. B., O'Brien-Pallas, L., et al. (2003). Evidence of nurse working conditions: a global perspective. *Policy Politics Nursing Practice, 4*(2), 120-130.

There is a global nursing shortage. Few health services decision makers have made the critical link between the number of human resources, the characteristics of the work environment and the impact on patients, nurses and the system as a whole. The purpose of this article is to review evidence about nurse workload, staffing, skill mix, turnover and organizational characteristics' effect on outcomes;

discuss methodological considerations in this research, discuss research initiatives currently under way, review policy initiatives in different countries and make recommendations where more research is needed. Overall, an understanding of the relationships among nurse staffing and organizational climate to patient safety and health outcomes is beginning to emerge in the literature. Little is known about nursing turnover and more evidence is needed with consistent definitions and control of underlying patient characteristics. Research and policy initiatives in Australia, Canada, New Zealand and the United States are summarized.

Sumner, J., & Townsend-Rocchiccioli, J. (2003). Why are nurses leaving nursing? *Nursing Administration Quarterly, 27*(2), 164-171.

The causes of nurses exodus from acute health care delivery practice may lie more in intrinsic factors rather than the heretofore overtly expressed reasons. This article examines bureaucratic factors, issues related to the medical profession and medical/scientific discourse, and factors within the nursing profession itself that may contribute to nurses dissatisfaction and unhappiness and cause him or her to leave. Nursing has emotional work and the implications for the individual nurse and nursing as moral work and moral distress are discussed. Suggestions to facilitate retention are made for changing the work environment to feel valued for their skilfully applied humanness.

