Exemplary Professional Practice

Professional Practice Model (PPM)

**EP1**: Describe and demonstrate how nurses develop, apply, evaluate, adapt and modify the Professional Practice Model.

**Development**

In winter of 2006, a task force comprised of nurses at all levels of the organization was charged with developing and implementing a professional practice model. YH was in the process of evaluating its current infrastructure to meet Magnet Forces of Magnetism and wanted to incorporate its current nursing vision into the framework of nursing practice for its professional nursing staff. This task force performed an extensive literature review and examined a number of care models and professional practice models. The task force focused their attention on creating a PPM utilizing the current nursing vision which highlighted the components of patient centered care, safety and quality, evidence-based practice, interdisciplinary collaboration, autonomy, empowerment, accountability, professional development, and servant leaders. The literature was rich in evidence which identified key elements in any nursing professional practice model: practice, collaboration, communication and development of nurses professionally. The current vision and the information from the literature review was discussed at the SDM Practice Council, facilitating ongoing brainstorming at monthly SDM Practice Council meetings. The PPM that was designed, vetted and embraced is depicted below. Included in it are the 7 guiding principles surrounding the foundation of the Relationship Based Care Delivery Model (which will be discussed in EP4). The York Hospital Professional Practice Model was adopted on all nursing units in the summer of 2007.

Ongoing discussion to educate the nursing staff and embed the model into professional practice occurred at monthly service line meetings to hard wire the communication processes.
Application and Adaption

The development of this model has been in effect for approximately six years. However the application and adaption of the professional practice model has been ongoing. The SDM Practice Council has as one of its primary goals, to have members and individual units be responsible for submission of written documentation to the council on an annual basis, as to how it continues to apply and adapt the professional practice model at the unit level. Annually, the SDM Practice Council monitors each unit’s systems and processes and next steps to the practical application of the Professional Practice Model. Further evaluation of the model occurs through the monitoring of Nursing Sensitive Indicators, Patient Satisfaction Data, and Nurse Satisfaction. The table below represents the components of the PPM defined, and a tool which has been used to help the individual nurses discuss the model on the units.

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| 1. Patient and Family Centered Care | 1. Patients and families are the center of the health care team and the family is recognized as the constant in the patient’s life. In collaboration with patients, families are partners in the development of the plan of care.  
2. Patients and families are provided all information and education related to their care and is provided the opportunities to participate in decisions at the level of their choice.  
3. Caring is demonstrated through spiritual, physical, emotional, psychosocial, and cultural responsiveness with each individualized patient interaction. These caring practices most meaningful to the patient are integrated into the plan of care. |
<p>| 2. Evidence-Based Practice       | EBP is “a problem-solving approach to clinical decision-making within a health care organization that integrates the best available scientific evidence with the best available experiential (patient and practitioner) evidence, considers internal and external influences on practice, and encourages critical thinking in the judicious application of such evidence to the care of the individual patient, patient population or system” (Newhouse, Dearholt, Poe, Pugh and White 2005). |</p>
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| 3. Interdisciplinary Collaboration        | Mutual trust between disciplines is paramount for effective patient care  
1. The RN has responsibility, authority, accountability to coordinate communication and collaboration between the patient and family members and the health care team.  
2. Trust, respect, and accountability are the foundations of the team that guide the nurse in caring for the patient and family.  
3. Professional nursing autonomy will be ensured through a work environment that supports creativity, risk taking, constructive feedback, and collaborative practice.  
4. Interdisciplinary collaborative relationships are promoted, nurtured, and sustained.  
5. The work of all caregivers is seen as interdependent and collegial.  
6. Patient-focused care and exemplary patient outcomes are the organizing force behind creating a collaborative environment. |
2. Data motivates leaders and practitioners to change the way they work progressing toward strategic thinking or current and future needs.  
3. Continually evaluate and modify the PPM and Care Delivery Model based on changing environment.  
4. Outcomes are established through strategic planning processes and monitored through shared decision making and professional accountability. |
| 5. Patient and Staff Safety                | 1. Patient Safety is the foundation for all systems and processes.  
2. Patients, families, and staff will be engaged in ensuring safety through monitoring, evaluating, trending initiatives and outcomes not just for patients but for the nurse and work environment. |
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| 6. Shared Decision-Making for staff, patients and families. | 1. Nurses participate in system, organizational, and process decisions.  
2. Formal structures exist to support shared decision-making.  
3. Nurses have control over their practice.  
4. Patient preferences and patient’s voice at the table will become evident via patient satisfaction scores, and involving patient/patient families in system development and processes. |
| 7. Integration of Information Technology | 1. IT supports care delivery via provision of accurate, accessible clinical and financial information. |
| 8. Professional Nursing Practice | 1. Delegated practice – RNs are accountable for planning, delivery and delegating care as appropriate  
2. Interdependent practice – nurse initializes communication with other members of the healthcare team to ensure full scope of interdisciplinary expertise and services.  
3. Independent practice – nurse conducts assessments and interventions for the purpose of promoting health and healing.  
4. Practice is executed via ANA’s social policy statements, Codes of Ethics, State Nurse practice acts, Scientific theories, Research findings, Professional & regulatory standards, ANA staffing principles, Bill of Rights  
The social responsibility of nursing is demonstrated in 3 distinct realms of practice. Ongoing professional development and mentoring by Nursing Leadership will provide continuous improvement of care giver skill and knowledge, thus ensuring the highest level of quality care. |
The following narratives are excerpts from written documentation received on an annual basis from the units to describe how they are applying the PPM at the unit level and discussing it at the SDM Practice Council to reinforce and provide practical application and scenarios which foster understanding and ongoing maturity of the YH PPM.

**Patient and Family Centered Care (RBC foundation at the center)**

A recent admission to the YH Behavioral Health unit was a patient who had schizoaffective disorder, depression and anxiety. The patient had been living many years in a group home and had multiple admissions to the YH BHS unit, so the staff had developed a relationship with the patient. During one admission on BHS, she lost one of her uncles who she was very close to. The patient received permission to attend the funeral and asked the staff “What would she wear?”. This mobilized the staff to action where they brought in clothes for the patient as well as did a makeover, curling her hair and doing her make up for the event. The patient looked like a kid on Christmas and was beaming ear to ear throughout the process. The patient was glowing and when staff accompanied her to the funeral, her family admired and complimented her on her new look. The patient continued to do her hair like she was shown each day, even after being discharged from the unit. Staff realized that such a small task/gesture could make such a significant impact on a patient and become one of the most rewarding of a nurse’s career. This example demonstrates how caring is demonstrated through meeting the physical, emotional, and psychosocial responsiveness with each individualized patient interaction. The nursing staff assisted this patient to develop a sense of self and confidence with their support. This patient became more stable and compliant with her medications, and was seen less frequently on the unit in the months that followed. The staff on BHS demonstrated that the PPM in this domain is meaningful to the patient, and are integrated into the plan of care.

**Interdisciplinary Collaboration**

The example which follows was part of the submission from our Emergency Department, written by Daniel Bledsoe MD, HP, FACEP, FAAEM and submitted by Phillip Rogers RN, CEN, BHCM, one of the emergency department staff members. On July 4, 2012 as Dr. Bledsoe was leaving the hospital something told him to walk through the other side of the ED. There he found a tiny baby in cardiac arrest and saw controlled chaos of the department as the unit responded and cared for this infant. The patient had recently been discharged from Hershey Medical Center Pediatric Intensive Care Unit for a history of rapid atrial fibrillation and was taking multiple antiarrhythmics. Urgent transfer was being coordinated back to Hershey between medical command, nursing and the Pediatric Intensivists at the Medical Center. The infant was responsive with CPR and unresponsive without it. Ground transport needed to be arranged as they could not fly the infant while CPR needed to be initiated and in this case sustained during transport. Dr. Bledsoe and the patient’s nurse joined the ALS ambulance crew and began a road trip to Hershey. They had a smooth ride and delivered the infant directly to the PICU staff. It was a long ride back to the hospital as the team watched the sun rise knowing they had done all they could for this tiny patient. Later the team learned all their efforts had not been in vain, as the child had survived and was doing very well developmentally and was being followed by neurology for the risk for developmental delays due to the events early in her life.

Dr. Bledsoe spoke of the interdisciplinary and inter-hospital collaboration between the two Magnet hospitals. During the council meeting, it was evident there was trust, respect, and accountability
that guided the nursing staff in caring for the patient and family. Professional nursing autonomy was ensured through the work environment that supported the collaborative practice that exists between nurse and physician in the ED, but throughout the emergency department and other hospitals when the outcomes of the patient are top of mind when decisions of transfer and plan of care is taken into account. The emergency room, works with a multitude of interdisciplinary collaborative relationships that need to be nurtured and fostered so that patient care is promoted, nurtured, and sustained. When any member of the group takes the time to acknowledge that work, it helps to sustain a healthy work environment, especially to those staff who were personally involved. Patient-focused care and exemplary patient outcomes are the organizing force behind creating a collaborative environment and the example submitted by the ED certain demonstrates how the ED fosters that example.

Evidence Based Practice

The 4 Main practice council stated in their “operationalizing the tenets” grid that as a unit they will incorporate evidence based practice changes into daily practice and incorporate using the work of the clinical effectiveness team to assist them to care for patients. The clinical effectiveness teams as described throughout this submission provide evidence based recommendations to impact patient care outcomes. As nurses, sometimes we need to be the receivers of other groups work, and disseminate those findings and act upon the recommendations. The structure for the CET’s is to bring those items which require action, to the SDM practice council. In the council, the nursing staff discusses the recommendations and decides how they can integrate them into practice. The Pneumonia and CHF pathways from the CET have provided a framework for the evidence. In collaboration with the informatics department, these pathways have been embedded into the EMR, where nurses can follow and integrate the recommendations and orders to each patient as necessary.

In addition to the CET recommendation, also come those practice changes as discussed in NK6, where the evidence from our forum activities is discussed and staff put them into practice. In some cases this is as simple as discussion in an email, and in others more comprehensive programs and education are required. On 4 Main, the staff who have attended EBP Forum will mentor the staff in completing literature searches on topics of interest to the staff in caring for a specific disease processes. Due to increasing full time support from the previously part time Director EBP/NR, we have

EP1.3 4 Main using Palliative care journal club site to participate in activities
increased the opportunities for staff to participate in journal club to impact the ability for the nursing staff to review. As screen shot above (EP1.3) demonstrates a site on the palliative care portal that staff can go to participate in these activities. Our palliative care program has an open invitation to attend the palliative care journal club, so that those nurses who may want to increase their knowledge in this population, can freely do so and be supported for attending this program.

**Outcomes Measurement/Outcomes focused**

The outcomes can be broken into two separate categories. One category is clinical outcomes of the patient, and the other is the outcomes we achieve for patients on behalf of the nursing care as nurses our patients achieve. The first example was discussed by the nursing staff on 3 North A. A patient who was being cared for by the staff was admitted in a sustained supra-ventricular ventricular tachycardia (SVT). When the cardiologist was consulted to see the patient he ordered a dose of Adenosine not commonly used on the unit, and that many staff had not even administered. The nurse caring for the patient was hesitant but embraced the opportunity to learn something new and provide care in a timely manner. A year earlier the staff would have advocated transferring the patient to the next level of care, but now as the Cardiologist offered his assistance, the staff took on the challenge. With support and education regarding the condition, as well as the medication they were administering they began the procedure. The medication and treatment was a success! The staff appreciated the confidence the physician had shown in them, and the physician appreciated the staff professionalism and timely actions. The collaboration between the nursing staff and physician led to a positive outcome for this patient as each worked synergistically for both the physiological and psychosocial successful results. The patient had her SVT converted to NSR, remained calm and was grateful she could stay on the unit where she had developed a trusting relationship with the staff.

Outcome measurement has been a strong focus of the SDM structure, as NSI’s are linked to the Quality Council, RN Satisfaction is linked to Leadership Council and Patient Satisfaction linked to Practice Council. With the councils aligned to discuss, monitor and be accountable for outcomes, the work to improve practice is where it should be, with the staff that provides the care. The pictures below (EP1.4) demonstrate the content presented at the quality council, practice council and leadership council on key nursing outcome metrics.

**Hospital CMS/JC/DOH Indicators**

- Falls – CMS NSI
- Restraints - DOH
- HAPUs – CMS NSI
- Pain Management – JC NPSG, Pt. SAT
- Med. Errors – JC NPSG
- CaUTIs – CMS NSI

**Quality Council Outcomes**

**Hospital Wide Indicators**

**SDM Nursing Quality (Pl) Council FY-12, Report 4: January 17, 2012**
Over the next several months, the councils will focus on hardwiring and assisting in making this work more meaningful and easier for the direct care nurse to understand. Much of the decision surrounding our change from a council model for SDM, to a Congressional Model, is due in part to driving the outcomes and measurement to the staff at the unit level where they will work through the professional practice model to focus on their nursing practice to collaborate with others to meet the needs of patients as the primary coordinators of their care.
**Patient and Staff Safety**

For the past two years 2011 and 2012, YH nursing staff has been focused on the improvements to patient/staff safety based on the responses of the staff through the AHRQ patient safety survey.

**What should you do?**

- Review & discuss results with your staff
- Find root causes of problems
- Develop specific action plans
- Monitor results
- Focus on communication
- Other areas of focus?

**Patient Safety Update**

- The Final Check
- Daily Safety Brief
- Post-fall Huddles – RCA
- Delayed Diagnosis Task Force
- Culture, culture, culture...and......
- Just Culture and High Reliability

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Our collaborative relationship with our colleagues in Patient Safety including director Gary Merica, RPh, and associate director Kelly Gipson BSN, RN, allow nursing to have a strong and powerful voice at the patient safety table. The YH nursing staff participate in RCA’s and other patient safety analyses, in which the goal is to create and promote the safest environment out patients can have. The PPM seeks to bring this quality and patient safety metric even closer to the forefront, which is why it is part of the infrastructure of the YH PPM and nursing vision. The newest developments in the patient safety domain are the implementation of post fall huddles. Implemented to help decrease the total fall rate on the inpatient nursing units, the post fall huddles are implemented within one hour of a patient fall, with all members of the healthcare team present, including the NM and/or the house supervisor. The goal, is to reinforce and establish the safety patient care environment for a patient who has recently fallen. Instituting additional fall prevention recommendations such as bed alarms, low beds, mattresses and toileting schedules helped to mitigate future risk to a patient who has already fallen. In doing so, YH nursing staff has outperformed the NDNQI benchmark related to falls with injury for the past two years. For example, our step down unit 4 SW sees a high acuity patient population with chronic illness and patients who are at highest risk for falling according to the staff’s use of the ABCS tool (EP1.7). Using this information, while the staff work to achieve the NDNQI benchmark for total falls, they have continued to meet the falls with injury benchmark, so that those who may fall, have no or minimal injuries. Keeping their patients safe and following these outcomes continues to fuel the 4 SW nurses journey to meet the benchmark for total falls since they already do so for falls with injury.
When the falls task force met in June 2012, Nancy Bowling MBA, RN, NM 4SW wanted to be able to participate so that she could help to assist/participate on behalf of the unit to achieve their benchmark. She, along with patient care assistant who was in charge of reviewing all fall patients each morning, attended the all day Kaizen event coordinated by the patient safety office and nursing to impact the hospitals opportunity to meet the fall benchmarks the majority of the time. Our comprehensive work to address total patient falls will be discussed in detail in EP32 and EP32EO.

**Shared Decision-Making for staff, patients and families**

We will continue to support unit-based shared decision making committees for performance improvement, clinical practice, education, patient satisfaction, evidence based practice/nursing research and recruitment and retention. One example that the 6 Main nurses discussed during a practice council meeting was, that many units have made the autonomous decision that all staff must participate in at least one council. While it is not mandatory that staff participate on a council per se, they must make the decision to support SDM in whatever means they had possible. Here are some of the recommendations they implemented:

- As a group will review monthly staff meetings with specific detail regarding pt satisfaction data.
- NM supports staff input and staff RNs to participate in hospital-wide councils and committees.
- Continue to support staff involvement in committees and councils by providing necessary education and time away from bedside for meetings.
- Continue to participate in NDNQI RN Satisfaction Survey and use data to enhance staff involvement.

The NICU works in a close environment with patients and families in a continual basis. According to NICU staff member Kelly Poole RN and Stacey Warfel RN, YH NICU is unfortunately following in the increasing trend of newborn babies addicted to prescription pain killers. There have been several weeks when the NICU census has included 5-7 NAS (Neonatal Abstinence Syndrome) babies. In response to this increasing trend, the NICU has developed a core group of nurses to discuss NAS. The NAS group has also added a neonatologist to this group. The NICU nurses recognize they only have to deal with the NAS baby for 12 hours max per day. So what happens when these babies go home?? Many go home with their parents, but some go to foster care or are adopted. What support is available for these families? Not much. The NICU has integrated into their PPM that staff that cared for the infant during early admission and intervention works with the family for several days prior to time of discharge.

Fortunately for the York Hospital NICU, one of their fellow NICU nurses had adopted a drug addicted baby (before being employed at YH). Families adopting or fostering these infants are often at a loss for support. Luckily Lori has volunteered to call these families after their consent has been obtained, to be a resource and support person. The relief seen on the mom’s faces has been reassuring that this is the right thing to do. The NICU is lucky to have such a wonderful resource for this NAS population.

**Integration of Information Technology**

In the PPM tenets, the nursing informatics team as well as WSH IT department supports care delivery and the PPM itself via provision of accurate, accessible clinical and financial information. The
Tower 2 nursing staff supports electronic health care record (CareCom) initiative with a representative, who attends monthly meetings. Nurse Managers and staff work directly with Nursing Informatics and Information Technology Staff. Staff attends planning meetings for Computerized Physician Order Entry (CPOE). Work flow is enhanced by Computer on Wheels (COWs) and dolphins. Each POD has access to one dolphin, several COWs, and two work terminals. Introduction of vital sign machines that communicate with power charts is continuing and staff are represented with the team associated with the implementation of Hospira smart pumps.

NK9 and NK9 EO demonstrate the significant work the YH nursing staff have done to integrate information technology into their daily practice. The integration of IT also helps to support the other component so of the PPM such as patient safety and outcomes measurement. The following screen shot (EP1.8) from the EMR is an example of nursing practice changes our nursing informatics staff send to the nurses to inform them when changes are coming or have been decided by their peers in the NIC and need to be integrated into their practice. Not all practice changes occur in an email, as each unit has a designated super user which also helps to disseminate useful IT related information. Our
SDM council structure assists the nursing staff to discuss and vet the nursing workflow and practice implications prior to the implementation phase of many projects.

**Professional Nursing Practice**

Professional nursing practice is identified by the hallmarks of collaboration, professional development, communication and practice. One example submitted by Sharon Donley NM and Marissa Lagna RN, BSN from the surgical unit 6 Main, illustrates this in a simple example: During a particularly busy day a situation arose on another surgical unit, where two nurses were working together (practice) and had a patient that came back from the OR with a 3-way bladder irrigation system. Both of them had not cared for a patient with an irrigation system before and were not sure what to do. The doctor told the nurses to call 6 Main if they had any questions. One of the nurses from the other unit called and asked them about the system. The charge nurse Michelle, took time to come down to the floor and spent about 20 minutes explaining everything that the RNs needed to know and showed them how to irrigate and change the bag (professional development). The staff member, not knowing the nurse manager of 6M, forwarded this email to the Director, CNEI Paula Coe, to see if there was any way to let the manager know how much the two nurses appreciated the help. Additionally, the fact that Michelle took time to walk down to the unit and show the two nurses what to do (collaboration) was deeply appreciated.

In addition to the examples above, the following link represents an example of the Operationalizing the Tenets grid template and a completed grid which reflect the nursing staff's application, adaption, modification and evaluation of the PPM on 6 South during the past year.

YH nurses continually embrace the PPM and use it for each patient, each and every time every day; to provide care to the patients they care for. Registered nurses are the primary coordinators of the patients care as seen in the center of the PPM schematic. As such, have the responsibility, authority and accountability to delegate and coordinate practice to the meet the needs of the patients and families in the domains of the PPM.

**Modification and Evaluation**

Over the past several years YH nursing staff has continued to mature their practice with the PPM. While compliant with sending the annual operationalizing the tenet grid to the Practice Council, the staff still has difficulty speaking to their nursing practice and care of patients within the domains and guiding principles of the model. With the reorganization within the nursing structure, it has given the nursing staff the opportunity to re-evaluate the PPM schematic and picture. At the writing of this document, the staff is participating in a hospital wide recognition event labeled Pride, Passion & Professionalism, where displays which represent the PPM on the unit level will be developed. The goal of this event is to have the staff reflect upon their nursing practice and be able to provide an opportunity to showcase to their peers, colleague's families and visitors the care that is represented on the units through the PPM. It also allows staff to demonstrate their creativity and assist them in showcasing the model in easy to understand terms and examples which are meaningful to them in their teaching and learning style to support and sustain their understanding of why it is essential that this model exists. We have plans to begin a formal evaluation of the PPM, and its schematic in the spring of 2013 which we hope to share with the appraisers during site visit.
Summary

The YH PPM has been alive and integrated into nursing practice since its development in 2007. The model is applied to the nursing practice on the unit through shared decision making and practice council, where the staff operationalizes the guiding principles on a daily basis. Modifications to the PPM and its evaluation have begun as the recent organizational change to a centralized model of nursing and new CNO, have created an opportunity for staff to redefine themselves and create passion and vision within a new framework of practice which will allow communication, collaboration and nurses to continue to develop professionally.