Hallmarks of success in nursing practice

Four hallmarks of success in nursing practice are identified and discussed. The hallmarks are the use of conceptual models to guide nursing practice, the development of classification systems, the establishment of formal linkages between nursing education and nursing service, and the recognition of clinical scholars and clinical scholarship. Two innovations in nursing practice are identified that could become future hallmarks of success: alternative nursing care delivery systems and collaborative practice.

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NURSE HISTORIANS have for many years presented chronicles of the trials and tribulations undergone by nurses in their attempts to provide excellent patient care. Readers are familiar, for example, with the terrible conditions Florence Nightingale encountered at Scutari and the "miraculous" changes she was able to make in the care of the soldiers there.[1] Contemporary histories of nursing explore the social, political, and economic forces that helped or hindered nurses' constant efforts to push back the frontiers of nursing practice and create conditions conducive to high-quality nursing care. For example, Baer[2] placed the development of modern nursing in the social and political context of post-Civil War society. Although historians have facilitated our understanding of how and why nursing has developed since the 1850s, they have focused primarily on the problems of nurs-

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ing practice, past and present, rather than on the successes. The purpose of this article is to present a more optimistic view of nursing practice by outlining four hallmarks of success in the evolution toward excellence. Identification of these hallmarks was the result of a continuing dialogue between the authors about the innovations in contemporary nursing practice that have resulted in considerable change in the content of nursing education programs and in the organization and administration of nursing services. The hallmarks are

1. the use of conceptual models to guide nursing practice;
2. the development of classification systems;
3. the establishment of formal linkages between nursing education and nursing service; and
4. the recognition of clinical scholarship as a professional imperative, followed by the emergence of nurse clinicians as clinical scholars.

The authors firmly believe that these innovations have had and will continue to have a substantial and significant impact on the quality of patient care.

CONCEPTUAL MODELS AND NURSING PRACTICE

The first hallmark identified was the use of explicit conceptual models of nursing to guide practice. A conceptual model comprises abstract, general concepts and statements that describe and link the concepts. Each conceptual model of nursing represents a particular frame of reference within which patients, their environments and health states, and nursing activities are viewed, and thus it presents a comprehensive, holistic view of nursing care. Roy's Adaptation Model, Levine's Conservation Model, Neuman's Systems Model, Orem's Self-Care Framework, and Rogers's Science of Unitary Human Beings are but a few of the conceptual models used in nursing practice today.[3-7]

The special utility of a conceptual model comes from the systematic structure it provides for thinking, for observing, and for interpreting what is seen. More specifically, conceptual models of nursing provide general guidelines for all aspects of clinical practice; they identify the general nature of the clinical problems to be considered, the purposes to be fulfilled by nursing practice, the settings in which nursing practice occurs, and the characteristics of legitimate recipients of nursing care. Each model also identifies the nursing process to be employed and the technologies to be used, including indices of patient assessment, a diagnostic taxonomy, a strategy for planning, a typology of interventions, and criteria for the evaluation of intervention outcomes. Thus the general nursing process of assessment, diagnosis, planning, intervention, and evaluation is given a distinctive context and format by each conceptual model.

Most conceptual models may be adapted to various clinical specialties by linkage of the general guidelines for practice provided by the model with the more specific and concrete theoretical knowledge of the clinical specialty. In critical care nursing, for example, substantive information about the physiologic and psychosocial responses of patients to life-

threatening problems, as well as a knowledge of the available technology, amplifies the guidelines for practice provided by a model. In a specific case, Levine's Conservation Model was linked with information about responses to cardiac disease to develop nursing diagnoses, referred to by Levine as trophicognoses, for a 57-year-old man who was hospitalized with the medical diagnosis of end-stage heart disease.[8] And Orem's Self-Care Framework, coupled with data on the physiologic and psychosocial impact of hemodialysis, was used to develop a comprehensive nursing care plan for a 62-year-old man admitted to the hospital for evaluation of postadrenalectomy complications.[8]

Conceptual models help to distinguish between the practice of nursing and that of other health professions. For example, some models assert that nursing focuses on a holistic view of patients' responses to actual or potential health problems, whereas medicine focuses only on patients' diseases. Anecdotal reports support the contention that the use of an explicit conceptual model increases nurses' confidence that they are practicing nursing rather than medicine, social work, physical therapy, or some other health profession; this sense of professional identity leads to professional autonomy and therefore enhances nursing as a career choice.[9] Furthermore, clinical studies have demonstrated the benefits to patients of the use of an explicit conceptual model of nursing. Hoch,[10] for example, found that nursing care based on protocols derived from either Roy's or Neuman's conceptual models resulted in lower depression scores and higher life satisfaction scores in groups of retirees than did nursing care based on no explicit conceptualization of nursing. Additional evidence of the benefits of explicit conceptual models as guides to nursing practice is accumulating as the result of major clinical projects being conducted in the United States and Canada.[11,12]

Conceptual models, then, clearly facilitate the identification of nursing-specific problems. Therefore, nurses are less likely to expend energy trying to deal with problems that belong to another profession.[13] The use of a conceptual model may be especially helpful in clarifying and justifying the nurse's role and activities, inasmuch as claims are sometimes made that nursing practice, especially in high-tech acute care settings, looks a great deal like medical practice. Use of a conceptual model also draws the individual nurse into a network of other nurses whose practice is based on that same conceptual model. This networking, in turn, permits the fulfillment of some women's special developmental goal of "weav[ing] themselves zestfully into a web of strong relationships that they experience as empowering, activating, honest, and close" (*Boston Globe Magazine*, October 16, 1988, p 46).

CLASSIFICATION SYSTEMS

The second identified hallmark of success in nursing practice was the development of classification systems. Nursing classification systems label patient problems, the acuity of the illness, the nursing care needs, or the level and intensity of nursing care required by each patient. They represent nursing's version of medicine's diagnosis related groups (DRGs) and, as

such, go beyond the specification of medical diagnosis and demographic data to provide information that can be used on a regular basis by nurses concerned with the delivery of nursing care.[14]

Virtually every clinical agency now has or is developing a classification system for use by nurses. Although most of these systems represent isolated efforts, some have received considerable attention. The alphabetically arranged list of nursing diagnoses issued by the North American Nursing Diagnosis Association (NANDA)[15] is perhaps the best-known of these classification systems and, in fact, is so pervasive that textbooks have been written on the basis of its diagnoses. Some, such as the book by Doenges, Jeffries, and Moorhouse[16] on nursing care plans for many nursing diagnoses, are in heavy demand. Interest in nursing diagnosis has developed from the understanding that the identification of a patient's nursing diagnosis enhances the formulation of nursing goals and interventions and facilitates the development of benchmarks for quality assurance reviews.

The NANDA nursing diagnoses have recently been expanded by Loomis and associates,[17,18] who have demonstrated the relationship between the NANDA system and a psychiatric nursing classification system. They also have suggested a linkage of their work with the *Diagnostic and Statistical Manual* (DSM-III-R) used in psychiatry.

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Another example of a classification system is the Ambulatory Care Client Classification Instrument (ACCCI).[19] Verran explained that the ACCCI "reflects the domain of ambulatory care nursing practice or the range of responsibilities and activities that may be used by nursing staff to serve outpatients."[19(p280)] A distinctive feature of this classification system is its focus on the amount and type of nursing knowledge needed to deliver care.

The work of Auger and Dee represents another approach to classification.[20,21] Their system is based on Johnson's Behavioral System Model of Nursing[22] and therefore addresses the relationship between specific patient behaviors and the corresponding nursing interventions required. Auger and Dee operationalized their classification system for use in the psychiatric setting, but they also explained how it can be applied in all nursing practice settings through the development of specific patient criteria.

NURSING EDUCATION AND NURSING SERVICE

The third hallmark identified was the establishment of formal linkages between nursing education and nursing service. These linkages take several forms, including partnerships and joint appointments. Partnerships, such as the formal mechanism used to link the University of Pennsylvania (Penn) School of Nursing and the Division of Nursing of the Hospital of the

University of Pennsylvania, seem to capture the best of the academic and clinical worlds. At Penn, selected faculty members have responsibilities related to both education and practice. One faculty member, for example, is both a clinical director at the university hospital and a division chairperson in the School of Nursing. As such, she directs patient care activities at the departmental level in the hospital, provides leadership in her division in the school (eg, overseeing faculty development and curriculum activities), and teaches students. Another faculty member is a clinical specialist in the Department of Obstetric and Neonatal Nursing at the hospital and an educator in the Health Care of Women and the Childbearing Family Division of the nursing school. Individuals who hold such appointments at Penn are designated clinician educators; they are full members of the faculty and employees of the university rather than of the clinical agency.

Another example of a partnership between nursing education and service is the Regional Project to Improve Nursing Services and Nursing Education in Maternal and Child Health Care.[23] The purpose of this federally funded project was to improve the quality of care for mothers and children through the collaborative efforts of teams of nurse educators and nurse clinicians.

Another way to link nursing education and service is through joint appointments.[24] These appointments frequently involve the employment by both a school of nursing and a clinical agency of an individual whose teaching and clinical practice responsibilites are divided according to the employment conditions in the two institutions. Joint appointments are especially effective when the essential nature of the relationship between practice and educational activities is fully specified.

These linkages between nursing education and nursing service tend to be characterized as "faculty practice." The idea of nurse educators as clinicians is certainly not new, but it was lost during the time of deliberate and virtually complete separation of nursing education from nursing service. The current enthusiasm for and value accorded to faculty practice are evident in the well-attended conferences on faculty practice sponsored by the American Academy of Nursing. A distinctive innovation in faculty practice is being implemented at the Vanderbilt University School of Nursing, where faculty members are becoming health care entrepreneurs. One faculty member, for example, established an independent practice at the Center for Sexual Health Care, and three others have established a fee-for-service program to guide breast feeding. This form of faculty practice has been studied by Maurin, who found that several schools of nursing now sponsor clinical projects involving faculty members in direct patient care.[25,26] Another successful nursing faculty practice was established at Creighton University.[27] This practice is distinguished by the establishment of a financial affairs office that monitors the budget and evaluates faculty participation in a formal practice plan.

A major benefit of the linkage between nursing education and nursing service is the refinement of nursing curricula. Those faculty members who hold appointments in clinical agencies are especially sensitive to the need for an appropriate balance of

content relating to technology and content relating to biopsychosocial responses to actual and potential health problems.

CLINICAL SCHOLARSHIP

The fourth identified hallmark of success in nursing practice was the recognition of clinical scholarship as a professional imperative and the consequent emergence of nurse clinicians as clinical scholars. In the words of Palmer, clinical scholarship "(1) is rooted in observations of the health-sickness phenomena of people, (2) mandates extensive knowledge in those sciences used in the practice of nursing as well as knowledge of nursing itself, (3) requires significant extensive experiences in the clinical practice of nursing, and (4) demands intellectual activity: thinking, analysis, and synthesis."[28(p318)] Its purpose is "the discovery, organization, analysis, synthesis, and transmission of knowledge resulting from client-oriented nursing practice."[28(p318)] Clinical scholarship takes many forms, ranging from the development and testing of new nursing care plan components, such as assessment formats and intervention protocols, to application of the findings of nursing research to daily clinical practice.

As nurses become clinical scholars, they practice nursing in an increasingly thoughtful manner. They think more about what they see and what they do in the clinical arena. They continually contemplate situations and stretch their minds toward insights into nursing practice and helping people to improve their health. Nurses who are true clinical scholars are noted for their ability to make novel connections between things or ideas—mental leaps and intuitive lunges that improve nursing practice and therefore enhance the well-being of their patients.[29,30]

A key feature of the clinical scholar is the ability and willingness to transmit the knowledge derived from the analysis and synthesis of clinical observations through presentations at local, regional, national, and international conferences as well as through publication in the major clinical nursing journals. Clinical scholars are not content to keep their discoveries to themselves or to limit transmission to their immediate coworkers.

It is important to underscore the fact that clinical scholars are not ivory tower academicians but nurses who are working at the cutting edge of innovative nursing practice. Evidence of the recognition accorded to the value of clinical scholarship as a major and legitimate form of scholarly work in nursing includes, but is not limited to, the election of clinical scholars to the American Academy of Nursing, selection of clinical scholars for the Sigma Theta Tau Founders' Award for Nursing Practice, and funding of the Clinical Nurse Scholars Program by the Robert Wood Johnson Foundation.

FUTURE HALLMARKS OF SUCCESS IN NURSING PRACTICE

Innovations have emerged in nursing practice that, if widely implemented, should become future hallmarks of success. Two such innovations require attention now and in the future.

Nursing care delivery systems

One of these innovations has to do with the development of alternative systems of

nursing care delivery. The current nursing shortage has provided a unique opportunity for the development and testing of various ways to deliver nursing care, and funding is becoming available from major private foundations for pilot tests. For example, case management is being studied to determine its cost-effectiveness, its influence on desired patient outcomes (especially patient satisfaction), and its effect on nurse job satisfaction. The effectiveness of derivatives of primary nursing is also being explored.

Other designs for the safe, satisfying, and cost-effective delivery of nursing care based on comprehensive conceptual models of nursing need to be explored. In particular, the coordinating role of nurses that follows logically from the use of a conceptual model of nursing needs to be more fully emphasized.

Collaborative practice

The second innovation in nursing practice has to do with the further development and refinement of collaborative nurse-physician practices. Major groups, such as the President's Commission on Nursing and the Institute of Medicine, have recommended that formal partnerships be established between nurses and physicians.[31] These partnerships may be based in a variety of settings, including ambulatory clinics, health maintenance organizations, private offices, and hospitals. It is believed that these collaborative practices will have a substantial impact on the larger health care delivery system.

The development in nursing of clinical ladders that are similar to those in medicine and other health professions is enhancing the readiness of nurses for collaborative practice, because clinical ladders facilitate the identification across professional lines of true peers. This development of peer relationships is the sine qua non of collaborative practice. Furthermore, peer relationships in collaborative practice will help nurses to achieve the autonomy we have desired for so long within the appropriate structure of shared governance rather than self-governance.

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The identification of four hallmarks of success provides evidence of the evolution of excellence in nursing practice, and the identification of two innovations in nursing practice that should attain the status of hallmarks in the future indicates that nursing practice is becoming even more excellent. It is noteworthy that this article completes a trilogy of discussions of hallmarks of success in nursing. The first article, published in 1983, focused on nursing theory development,[32] and the second, published in 1987, dealt with nursing research.[33] This third article is in many ways the most important, because it represents the collaborative effort of a seasoned academician and a seasoned clinician to transcend their individual interests and biases in order to identify nursing innovations that are relevant to all nurses, regardless of work setting, as they strive to provide the best possible care to patients. Another reason for the singular importance of this third article is that it focuses on the real world and underscores how far we have come since Nightingale founded modern nursing in the artillery barracks at Scutari.

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