Nursing Professional Practice Models: Impact on Medical Nurse Empowerment and Job Satisfaction

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Background

Abstract

As the nation faces a critical nursing shortage, creating a dynamic practice environment through a professional practice model (PPM), where registered nurses (RNs) are empowered, leads to increased job satisfaction, which in turn improves quality patient care outcomes (Cicolini, Comparcini, & Simonetti, 2014).

PICOT Question

Among hospital-based medical unit RNs within a Magnet® organization (on two campuses), how does web-based learning on the organization's revised nursing PPM versus prior education on the organization's nursing PPM provided during nursing orientation impact RNs' perception of their nurse empowerment and job satisfaction over a period of three months?

Introduction

Problem description

- Nursing PPMs can act as a driver of empirical quality outcomes, cost savings, and employee engagement.
- PPM are built from the constructs of an organization's culture, mission, values and behaviors.
- Greater emphasis has been placed on how nurses are coming together to improve quality consumer care outcomes that are highly reliable and cost-effective through relevant PPMs.
- The organization lacked a universally identifiable PPM across nursing practice environments throughout the system.

Available knowledge

- Focused on current literature completed through a comprehensive electronic database search. Key search terms included professional nursing practice, nursing PPM, shared governance, nurse work environments, nurse empowerment, nurse job satisfaction, and Magnet® hospital designation.

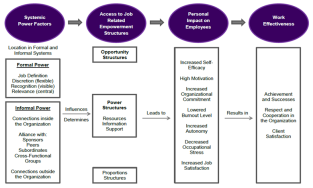
- The John Hopkins Nursing Evidence-Based Practice model was selected for application to this DNP project. This model is based on the tenets of nursing as a science and profession, nursing practice being based on the best available evidence within a hierarchy, translating research findings into nursing practice, and nursing's values of effectiveness and efficiency (Newhouse, 2007).

Rationale

- Kanter's structural empowerment theory was selected as the theoretical framework. It states that power and opportunity within organizations are essential to employee empowerment which can drive maximal organizational effectiveness and success (Kanter, 1993).
- Healthcare organizations that provide for their RNs to have access to these empowerment conditions have improved RN perceptions of patient care quality and job satisfaction (Laschinger & Fida, 2015).

THEORETICAL FRAMEWORK

Relationship of Concepts in Rosabeth Kanter's (1979) Structural Theory of Power in Organizations



Specific Aims

- Designed to further investigate nurse empowerment and job satisfaction through application of current evidence to address practice gaps
- Intended to improve the work environment and retention of RNs in a time of high demand
- Phase I -attending medical inpatient unit staff meetings to introduce the project, email communication on demographic and survey tools, releasing web-based education, following up on completion of survey tools, and completed data analysis.
- Phase 2 -project interventions, measures, analysis and ethical considerations
- Phase 3 - describing the results, interpretation, limitations and sustainability, conclusions, funding, and dissemination.

Methods

Context

- Medical RN unit-based inpatient population from seven medical units at Christiana Hospital and three at Wilmington Hospital
- Total sample 447 RNs represented approximately 26% of Christiana Care Health System's inpatient care RNs; target of 188 RNs represents approximately 42% of medicine inpatient RNs

Interventions

- Pre-survey preparations-Unit staff meetings; nurse leader education; web based learning creation; electronic survey development
- Month One -Surveys launched; web-based education released; follow up communications to nurse leaders till survey closure
- Month Two-Additional web based content released linking new PPM to Christiana Care Way and system values and behaviors
- Month Three-Relaunch surveys; follow up communications till survey closure

Measures

- Demographic tool
- Practice Environment Scale of the Nursing Work Index (PES-NWI)

Subscales: nurse participation in hospital affairs, nursing foundations for quality of care, staffing and resource adequacy, collegial nurse-physician relations, and nurse manger ability, leadership, and support of nurses

- Conditions of Work Effectiveness Questionnaire II (CWEQ II)

Six structural empowerment components: having opportunity to advance or be involved in activities beyond a person's job description; access to organizational information; access to support; access to needed resources; formal power from visible jobs central to organizational goal accomplishment; informal power from personal networks; relationships among peers and colleagues

Analysis

- Paired t-tests, regression analysis, and least squares means
- 88 participants completing both baseline and month three surveys
- 29.9% were aged 31-40; 88.3% were female; 44.1% <5 yrs of nursing experience
- 58.4% have worked on their current unit <5 yrs
- 50.6% CCHS employees <5 yrs
- 68.8% are RN IIs; 67.5% hold a BSN; 28.5% certified in medical-surgical nursing
- 89.5% identify as Caucasian
- 50.6% were involved with shared governance
- 77.9% worked at Christiana Hospital

Ethical considerations

- Demographics survey specificity had to be altered based on IRB review to address confidentiality of small groups
- Volume of groups pulled out for analysis based on subgroup n
- Influence of trust in anonymity

Results

PES-NWI Results

- No statistically significant differences for the overall PES-NWI from baseline to month three survey data
- Subscales for RNs with ADNs with significant *p* values:
  - Participation in hospital affairs (p=0.006)
  - Foundations for quality of care (p=0.03)
  - Manager ability (p=0.009)
  - Collegial nurse-physician relations (p=0.02)

CWEQ II Results

- Statistically significant difference in the CWEQ II subscale for formal power where it increased by a mean of 0.15.
- Subscales based on demographic factors with significant *p* values:

Christiana Hospital Campus

- greater access to support at CH (p=0.03)
- greater access overall to opportunity, information, support, and resources at CH (p=0.05)
- greater overall access, formal and informal power at CH (p=0.05)

Nurses with ADNs

- greater access to support (p=0.03)
- greater empowerment (p=0.04)

Nurses on the clinical ladder as RN IIIs:

- greater access to support (p=0.02)
- greater formal power (p=0.02)
- greater access overall (p=0.02)

Discussion

Summary

- New PPM and the educational instruction methods were impactful
- Project strengths: support from nursing senior leadership, CCHS Value Institute, Nursing Professional Development and Education
- Project barriers: no individual unit champions driving survey completion rates, no incentives, no contact with the DNP student during open survey periods

Interpretation

- 50.6% of month three nurses involved with shared governance and 16.8% identifying as RN IIIs with unit project responsibilities may be impacting the improved formal power in the CWEQ II
- 10% improvement on the month three survey with medical RNs' ability to describe the initial PPM

Limitations

- Three month implementation period
- Medical RNs only
- Convenience sampling of two hospital campuses in same system
- Choice of assessment tools
- No pre-assessment of valuable variables

Conclusion

- Implementation work continues based on feedback on monthly toolkits
- PPM discussions take place at multiple nursing leadership meetings and directly with clinical nurses
- Aligning the nursing practice environment to improve empowerment and JS leading to better patient care quality outcomes is daily work

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