Being and Creating Caring Change in a Healthcare System

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VA Eastern Colorado Health Care System

Abstract

Nursing leaders from the VA Eastern Colorado Health Care System (VAECHCS) developed an evolving model of caring theory-guided practice. As leaders and administrators with multiple roles, functions, and perspectives in a large healthcare system, the authors create and hold space for human caring and relationship-centered care within a clinical practice setting. This article contributes an overview of their action research framework and how they use this framework to link practice, theory, and inquiry in the delivery of healthcare services.

Key Words: Caring, practice model, theory-guided practice

Never doubt that a small group of thoughtful people could change the world. Indeed, it is the only thing that ever has (Margaret Mead)

Introduction

Do you believe nursing is plagued by a theory-practice gap? In our work exploring the theory of human caring as foundation for nursing practice, we at VA Eastern Colorado Health Care System have experienced the embeddedness of caring in who we are and what we do when providing care for veteran patients. Thus, for us, the question of the "gap" is not about individual values or behaviors but, rather, it is about the environments we create for our caring practices. In this article, we share exemplars of our evolving caring theory-guided practice model. This model is inductive, dynamic, and ecological, which is to say that we focus on relationships between and among persons, systems, and experiences (Bent, 1999). As leaders and administrators with multiple roles, functions, and perspectives in a large healthcare system, we continue to work at creating and holding space for human caring and relationship-centered care within a clinical practice setting. Our perspective is not singular nor is it prescriptive. We welcome response and ongoing feedback about our efforts to sustain theory-guided practice as a system. This article contributes an overview of our action research framework and how we use this framework to link practice, theory, and inquiry in the delivery of healthcare services.

Background

Veterans Health Administration

The Veterans Health Administration (VA) is the largest integrated health system in the United States (Perlin, Kolodner, & Roswell, 2004). VA operates a network of 163 hospitals, 137 nursing homes, and over 800 clinics. Within these VA healthcare facilities, 39,000 registered nurses (RNs), 10,500 licensed practical/vocational nurses (LPNs), and 9,400 nursing assistants

(NAs) provide care to our country's veteran population (VA Office of Nursing Services, 2004). Nationally, 49% of VA patients are over 65 years of age. Seventy percent of patients have annual incomes less than $26,000. When compared to age-matched non-VA patients, those who receive VA healthcare have three additional non-mental health diagnoses and one additional mental health diagnosis.

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Over 78,000 veterans receive care from the VAECHCS, which comprises an acute care hospital, multiple hospital-based specialty and primary care clinics, two nursing homes, eight community-based primary care clinics, and home-based primary care provided by nurse practitioners (NPs) throughout Southern and Eastern Colorado (CARES Commission). The Nurse Executive at VAECHCS is a member of the Executive Leadership team who has responsibility for other patient-focused care areas (such as social work, psychology, and pastoral care). Nursing remains a distinct professional service within the organization and has not been administratively organized into disease or condition defined "service-lines."

Caring Theory-Guided Practice Model

Why?

Our journey toward theory-guided practice began after we recruited a PhD Nurse Researcher. This was a position that for several years had been held vacant in response to economic strain. We realized this was shortsighted and that filling this fundamental position needed to be a priority to advance professional practice in our environment. Nursing leaders within VAECHCS sought a way for nurses to communicate shared commitments, practices, and values in caring for veteran patients and their families. We were looking for language and process to illuminate, guide, and support nursing practice as it complements the practice of other disciplines in the healthcare setting. We were seeking a voice and a structure for caring within our healthcare system. We selected Watson's theory of human science and human care (Watson, 1979, 1985, 1999).

Additionally, theory-guided practice was recognized as an important way to communicate nursing roles, values, and knowledge to patients and interdisciplinary colleagues. As the hallmark of a professional discipline, a theory-guided practice model has great potential to advance professional practices to better meet patients' needs and inform the development of nursing-sensitive indicators for quality outcome assessment and evaluation of nursing care. Finally, a theory-guided practice model offers context for reflecting and pursuing nursing excellence.

How?

In addition to caring theory as the conceptual framework for our evolving ecological model, specific theories informed our processes. Lewin's model of individual and organizational change (Misshauck, 1979) informed our understanding of the way change occurs in an organization. In Lewin's classic model, change begins when people in an organization desire an alternative to the current situation within the organization. Change begins when people desire change. Committed individuals begin to "unfreeze" values, ideas, and philosophies that contribute to the existing organizational situation and follow with efforts to instill new values, ideas, and philosophies that will bring about a change of behavior in individuals and the organization. Finally, individuals

and groups within the organization “refreeze” the newly acquired values, ideas, and philosophies so that they become internalized by the individual and form the basis for future behavior.

Additionally, Gladwell’s (2000) work in how “little things can make a big difference” was influential as we started to unfreeze current organizational culture and its manifestations in nursing. Gladwell suggested that a change process begins, or “tips,” by focusing and concentrating resources on a key area, that it continues through trusting and deliberately testing intuitions and believing that change is possible. We set to “testing” our instincts about a caring framework for theory-guided practice through verifying personal experiences and acquiring experientially based knowledge and reinforcing dimensions of personal knowing among nurses (Carper, 1978).

Our work took shape through a critical mass of people, all of whom have strong professional commitment, interest in theory, and openness to processes of inquiry, growth, and change. We sought consensus among nursing leaders on the importance and value of theory-guided practice models in nursing generally and using one in our setting specifically. Nursing staff were asked to participate in a research study about Evidence Based Practice in nursing; one item on the research tool asked nurses to rate the extent to which the institution “promotes a specific nursing theory as a basis for nursing care” (Thompson, 1997). We moved to open focused discussions of specific theories and frameworks and by consensus we selected Watson’s theory of human science and human care (Watson, 1985)This consensus decision was based on many factors—some value driven (e.g., as an integrated healthcare system, VAECHCS nurses see patients over a lifetime and develop important relationships with patients and families—the fit with caring theory was a natural) and others more practical (e.g., VAECHCS as an organization and many individuals within the system enjoy a strong, collaborative relationship with the University of Colorado Denver/Health Sciences Center where Jean Watson holds an Endowed Chair in the School of Nursing). The internal working group, comprised of nurses in administration, management, staff, clinical nurse specialist, and research roles, formed and identified financial resources and articulated goals (Table1). Finally, we formalized a partnership with Jean Watson who had offered encouragement and support throughout development processes.

Diffusion and reflective demonstration. We have pursued our work through diffusion and demonstration, two modes of growth that are simultaneous and not mutually exclusive. By diffusion, we mean activities designed to have an influence on individuals within the system. These could include, for example, participation in internal or external educational offerings about the theory of human caring, conduct multiple nursing studies that reference the theory of human caring as part of the conceptual framework or that focus on caring relationships, creating documentation templates that reference elements of the theory for use in the electronic medical record, and changes in the physical environments that patients and nursing staff encounter when in the system.

Our demonstration projects, called Nightingale Units, are group-level unfreezing and refreezing efforts to which we committed financial and other system resources. In these units, we offered intensive, purposeful support to staff to translate the theory of human caring into daily clinical nursing practice. We did this by contracting with a registered nurse massage therapist who is known for her work in this area. Marilyn was present in the units 1 or 2 days per week for a year and through role modeling and teaching she has helped individuals and each unit as a whole advance their unique caring-healing models.

The Nightingale unit. As has been the experience among many nursing units across the country, one of the clinical practice settings on which we focused attention and resources had high turnover, poor morale, and high dissatisfaction among patients, their families, and physician partners. This particular unit lacked a sense of self-definition or identification and similarly lacked something in which they could have pride. Daily activity on the unit has been described by one "insider" as a factory where nursing staff checked in, robotically accomplished the tasks of the day, and went home, only taking time perhaps to ridicule the nurse from whom they had assumed care because he/she had forgotten to empty the Foley catheter bag at the end of the preceding shift. This dark environment was reinforced by a 91% bed occupancy rate that encouraged chaos and frenzied behavior.

Although nursing leaders were seeking a way for nurses to communicate shared commitments, practices, and values in caring for veteran patients and their families, staff on this unit were wary of the prospect of a motivational "gimmick." The concept of being a demonstration unit in which theory-guided practice was developed and evaluated was introduced slowly and gently by the unit-based manager rather than as a mandate from higher levels of nursing administration. It was presented with sensitivity to concerns of adding "something else to do" into nurses' day. Early, in efforts to introduce caring-theory guided practice to this unit, a few champions emerged who wanted to know and do more and from there, energy quickly spread among other nurses and staff on the unit. With support from the education department in the medical center, the majority of the staff was able to attend intimate classes with Jean Watson to learn concepts of the theory in an experiential way. Many nurses returned inspired from opportunities for reflection although a few continued to find it challenging to make—or want to make—a connection with this work. The unit-based manager focused on a course that included both highly visible and "behind-the-scenes" implementation strategies to facilitate momentum and sustainability of the work in the unit. What appeared to staff as a very natural journey was, in fact, an intentional, purposeful progression through every staff meeting, every proficiency/evaluation, and every interaction. The unit manager was challenged to "walk the walk" in visible ways, a sometimes daunting prospect in the bureaucratic, complex environment of healthcare delivery.

Although part of the vision in building a model of caring theory-guided practice was for nursing staff to have the courage to embrace and highlight their contributions to health and healthcare, this demonstration unit demonstrated that staff first needed support to explicitly identify the unique and valuable contributions nurses make to healthcare. Nurses were working in a task-oriented culture and needed support to reflect on the ways they support health and healing for patients. The nursing department contracted with an outside, clinically focused nurse with expertise in translating concepts of caring theory into daily practice. At first, staff in the unit did not understand why this nurse had appeared in their midst but by the end of only one week they were drawn to her light. She was invaluable in demonstrating patient and staff outcomes of advanced caring healing modalities such as aromatherapy or reflexology. She also modeled appreciating the moments spent with patients and how to genuinely care for the patient as well as honoring the profession and each other. Most important, her approach had a protective effect against any tendency to focus exclusively on the "doing" or task-related aspects of caring-healing modalities by emphasizing the relational aspects of caring for patients.

As momentum for understanding and embracing a caring-theory-guided practice model grew within the unit, some staff members chose to move to other units within the medical center. However, the number of applicants for those positions far exceeded the number of vacancies. Two staff became Reiki practitioners and developed a medical center competency evaluation for Reiki. Several used reflexology skills, documenting the experience in the medical record and sharing the outcomes with other disciplines. Still others worked quietly journaling and taking time to ground themselves before entering a patient's room. Staff nurse leaders developed a nursing focused change of shift report that engaged the patients and supported their healing. Another group painted and decorated the staff break room so that it served as a retreat and a place to refocus. Others worked on creating an environment for patients where lights were dimmed after lunch and where soft music was played. We instituted a computerized documentation template with Jean Watson's carative factors to encourage staff to think about their care in caring ways as well as aid in later data retrieval for evaluation projects. This unit piloted a caring visitor program in collaboration with the medical center volunteers where caring theory was integrated into the volunteer's orientation when visiting patients on this unit. As the work continues, nurses from this unit are becoming resources in advanced caring-healing processes.

The Action Research Umbrella

Our diffusion and demonstration activities are unified under an umbrella of participatory action research; the Colorado Multiple Institutional Review Board has approved the project. Known by various names, action research is a constellation of research approaches with shared assumptions, definitions, and methodologies (Reason, 1998; Stringer, 1999). Commonly, action research proceeds from and honors lived experience. Often, action research aims to illuminate the experiences of those who have been marginalized. As a mode of inquiry, action research designs and methods are systematic, participatory, and democratic and thus make important contributions to science and social change. Practitioners, such as nurses, social workers, or educators, apply action research designs and methods to improve the activities of work, solve problems, develop projects, or resolve crises. Thus, the aims of any action research project include producing knowledge and action that are directly useful to a group of people as well as empowering people through the process of using their own knowledge. Notably, action research is itself a group activity in which participants explicitly value collaborative process.

Inquiry using an action research approach may employ diverse and otherwise nontraditional methods of generating data. In our work to support and advance theory-guided nursing practice, we consider multiple sources of data because they promote reflection and inform the interpretation of our efforts and the outwardly observable results of our efforts. Our data include journals, field notes, meeting minutes, observation of meeting activities themselves, ceremonies and recognitions, contracts, formal planning and documentation of care in the medical record, patient and staff experiences and preferences, surveys, observed changes in the care giving environment, feedback from other disciplines and departments within VAECHCS, feedback from nursing faculty who instruct students in our setting, tape recordings, photographs and video recordings, clinical and administrative policies, hiring and turnover data, and more. Our data are primarily verbal because words often offer a richer representation of human experiences but we value the communicative properties of a chart or graph when data support their use.

Organizational Synthesis

How will those who come after us know that we were here? (Dean Peter Eaton)

The following clinical exemplar holds within it multiple stories of the value of intentional, relationship-centered clinical caring. This exemplar is not unusual nor is it an extraordinary example of relationship-centered care. We share it, because it illustrates the potential we have as nurses and clinical leaders to facilitate space for meaning, discovery, and healing in our systems. Often, healing moments in our busy practices go unnoticed or are not recognized for their significance and influence on the healing environment. Honoring these moments fuels the heart with the energy to care.

This exemplar sheds light on the potential for shifting from disease guided practice where patients and caregivers are objects, leading to a pattern of dissonance to a caring, healing-guided practice that demonstrates patient/family centered care resulting in a more harmonious pattern (Table 2). Although most practice settings in the United States hold a combination of both happening simultaneously, the caring, healing-guided practice offers more moments that foster safety and trust.

Mr. A. was a 62-year-old Hispanic man in the Medical Intensive Care Unit (MICU) who was experiencing multiple and worsening medical diagnoses. He had been married for 36 years and had one adult son and two adult stepsons. He was an Army Vietnam veteran and now worked for a woodworking company, providing the only source of income for his household. He had been diagnosed with pancreatic cancer and had sought medical attention for vague symptoms over 2 months, after which he was also diagnosed with early-stage prostate cancer. He also had medical diagnoses of post-traumatic stress disorder, aspiration pneumonia, hepatic abscesses, portal vein thrombosis, diabetes, and bacterial and fungal sepsis. He had multiple high intensity medications and high tech supports for his care and was no longer able to advocate for himself, leaving his wife to be his proxy healthcare decision maker. Caring for this very ill man in the MICU posed ethical dilemmas for the team of nurses and physicians, for as they explored their sense that further interventions were “futile,” his family was pursuing treatment and survival.

The predominant emotion among members of the healthcare team was frustration, expressed as impatience with what they believed was the family’s “denial” of his terminal condition and imminent death. The medical team communicated authoritatively that the family was contributing to the dying man’s suffering, which, not surprisingly, further angered and alienated the family, who threatened litigation. An ethics team recommended changing the medical team, though the family continued to be angry, untrusting, and accusatory and the new team was also uncomfortable with the level of aggressive care provided. Finally, all agreed to a “comfort care approach” with all current interventions to continue until death. The family was finally able to voice their sense that he was going to die and was close to dying now.

During the initial palliative care assessment, time was spent truly listening and being present for the wife and sons. As part of the wife’s grieving process she was facing life without her husband and surviving in a world without his income. Through actively listening, the palliative care certified nurse specialist (CNS) identified the fear, pain, and distress that centered on the loss of income when her husband died. Knowing that a normal part of grieving is imagining life without the person, the CNS knew the patient’s wife was trying to plan for her survival. After realizing this, the CNS discussed with the physician whether or not the patient’s newly diagnosed pancreatic cancer could be related to the patient’s service in the military. Through an identified service connection additional benefits could be approved to perhaps cover the patient’s

memorial/burial and a small pension for the wife. The social worker was also involved in looking for assistance in helping relieve the financial burden.

To help remove the anger and shouting that had been taking place among the family and staff members, soft voices, active listening, and touch were promoted. The caring/healing nursing therapeutics consultant and the registered nurse case manager set about further changing the environment physically, emotionally, and spiritually for the patient, family, and staff involved with the patient. Aromatherapy, music, and hand/foot massage helped to soften the environment and decrease hostility among the family and staff. During these interactions the wife was able to reminisce about her husband and their life together. Through this sharing of memories, love was felt in the room and a greater love was witnessed when the wife massaged his feet. Touch and music made the wife feel that the staff truly cared for her husband. She no longer wanted words but wanted to see acts of love and kindness. During the last 12 hours of his life, the family was able to communicate openly and honestly with staff regarding their fears, concerns, and feelings to ultimately give permission for the patient "to go."

This exemplar illuminates the strength of authentic presence in meeting family needs. Although the process was uncomfortable for all, a patient and family focus led to amazing experiences for the patient, his family, and for staff. Amazing experiences can occur. Love and kindness go a long way to create trust and a truly caring environment for patients, families, and staff to heal.

In reflecting on this challenging situation in which many people experienced pain, we cannot help but wonder how family healing may have been affected had additional staff members known how and been able to be present and offer caring and healing practice and intention. Further, institutional resources may have been more effectively applied to healing had more caring been integrated earlier in this man's care.

Discussion

Be the change you want to see (M. Gandhi)

Within our changing system, we have learned that (a) caring is sustainable and contagious, (b) change can be planned and still be dynamic, and (c) there are steps you can take while awaiting your "critical mass." It is important to meet people where they are, organizational or system change starts with personal commitment, and personal empowerment fuels community empowerment and success, which supports organizational environments conducive to personal empowerment. Yet we continue to ask many questions as the work ebbs and flows within our system. For example, how do nurses' personal understandings of spirituality influence our ability to engage with caring theory-guided practice? How do we speak about the difficult economic choices we make when we begin to "tip" by focusing resources on selected needs but not on other equally good causes? Can a relational practice model change the patterns of interacting with professional and nonprofessional unions? How much is possible from a position of diffusion alone if there are no dedicated personnel to support demonstration of a new idea? How do we begin the dialectic among nursing taxonomies, nursing outcomes, and a caring-healing nursing practice? Once embraced as ethic and moral ideal within a system, can "participation" by nurses who care for patients remain voluntary? We can say it no better than did the German philosopher Johann Wolfgang von Goethe who described all that is possible:

> The moment one definitely commits oneself, then providence moves too. All sorts of things occur to help one that would never otherwise have occurred. A whole stream of

events issues from the decision, raising in one's favor all manner of unforeseen incidents and meetings and material assistance which no man could have dreamed would have come his way. Whatever you can do or dream you can, begin it. Boldness has genius, power and magic in it. Begin it now. (Goethe) (Table 3)

We certainly continue to face challenges but our successes illuminate the following attributes. Our work reflects the intersection of bottom-up and top-down approaches through which individuals and groups are able to develop ownership of caring practice at new levels. Leaders in the process emerge from among managers and clinicians who have an interest in being a more formal part of the process. Our ecological, theory-guided practice model supports a caring community in which individuals, groups, and systems relate in ways that reproduce the caring whole (Davis, 2000). Leaders support these models by creating vision and articulating the importance of caring to elicit support for the vision. Because our system leaders participate in the process through intentionally cultivating a caring consciousness, the relationships and partnerships that develop are strong and sustainable.

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Table 1

Goals for Caring Theory-Guided Practice Model in Nursing at VAECHCS

As nurses committed to advancing a caring theoretical foundation for nursing practice we share the following goals, hopes, and reasons for committing to this work:

- To honor the caring practice of nurses
- To promote intention and attending to veteran patients and their unique experiences and contributions to our world
- To provide a reference/framework for strengthening practice
- To define how we value caring practice
- To define and describe the ethical foundations of nursing
- To develop nursing knowledge within a caring framework
- To improve our ability to articulate to patients, families, professional colleagues, and ourselves the nursing contribution to health and healthcare
- To unite nursing through a culture and ethic of caring for self and other

Table 2

Patterns of Practice

Disease-guided practice Dissonance	Caring/healing-guided practice Harmonious
• Paternalistic • Agenda of providers vs. family • One dimensional • Limited • Practice focused care • Breakdown in communication • Escalating physical, emotional, social, cultural, spiritual, crisis • Anger predominant emotion • Multisystem (negative) effects	• Relationship and connectedness • Open to discovery • Patient/family-centered care • Unfolding dynamic dimensions • Clarity • Authentic presence • Holistic assessment of physical, emotional, social, cultural, spiritual being • Holistic therapeutic interventions • Love predominant emotion • Multisystem positive efffects

Table 3

Definition, Philosophy, Theoretical Foundation of Nursing at VAECHCS

- Nursing is the art and science of professional caring in the human health and healing experience. As a distinct caring-healing health profession, nursing provides holistic care in collaboration with other disciplines. Nursing promotes healthy and healing environments and provides disease prevention, health education and restoration, rehabilitation services, palliative care, and end-of-life care.
- The goal of nursing throughout the Eastern Colorado Health Care System (ECHCS) is to cultivate knowledgeable and intentional caring and healing relationships and practices. These caring practices honor human, clinical, and community concerns of the veteran population and their families, facilitating self-efficacy through enhancement of self-knowledge, self-care, and self-healing approaches, optimizing health and wellness.
- Our values of relational caring lay the ethical foundation for applying clinical and empirical evidence to improve nursing practice and patient-centered health and healing outcomes. Relationship-centered caring is the context for applying the art and science of nursing to formulate, evaluate, and modify plans of care that embrace a mind-body-spirit perspective. Relationship-centered nursing care integrates the physical, psychosocial, cultural, developmental, and spiritual needs of the veteran population and their families.