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The Attending Nurse Caring Model[®]: integrating theory, evidence and advanced caring–healing therapeutics for transforming professional practice

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Summary

- This paper presents a proposed model: *The Attending Nursing Caring Model*[®] (ANCM) as an exemplar for advancing and transforming nursing 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 programme 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.

Keywords: *Attending Nurse Caring Model*[®], evidence, hospitalist, pain, Watson's Caring Theory.

Background

Numerous studies in the United States continue to document publicly that patient deaths are tied to lack of nurses (*New York Times*, 8 August 2002: A14). Recent crises related to safety concerns have brought new attention to nursing and physician practices and models

for how to address the shortage and crisis of care in acute care hospitals (Mustard, 2002).

These system dilemmas are compounded by the fast-paced health care delivery system of the 21st century, which has brought a nursing profession's struggle for identity and survival to a new level of public attention. Nurses are torn between the human caring model of nursing that attracted them to the profession and the task-orientated biomedical model and institutional demands that consumes their practice time. Nurses who are not able to practice within a caring context are reported to be:

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hardened, oblivious, robot-like, frightened and worn down (Swanson, 1999). In the context of a nationwide nursing shortage in the USA, if not in other Western countries worldwide, the viability of the profession is as much at stake as is the viability of care practices throughout acute care inpatient institutions.

Proposed solutions for recruitment and retention, like better compensation packages and increased numbers of under-educated nurses, or even less-prepared assistants, comprise superficial and short-term approaches to a deeper, philosophical value-based issue prevalent throughout the profession. Ultimately, the ability to resolve conflicts between what nursing is (e.g. the theories, philosophies, ethics and knowledge that guides their practices), and *what nurses do*, may be the cutting-edge difference which dictates the discipline and profession's existence and survival into this new millennium.

From a social-political lens, nursing remains invisible and externally controlled, in spite of the scientific facts and evidence that nursing care and caring are crucial variables that make a positive difference in patients' (and nurses') outcomes of health and well-being (Swanson, 1999). Meanwhile, many mainstream systems are struggling to comprehend, conform to, or catch up with the past era of hospital-centric, cure-centric approaches, which are already dissolved (Watson 2001, p. 78).

Resolution of this philosophical professional value-system-culture conflict requires renewal of the profession and the system from inside out, allowing nursing to reconnect with the foundations of professional nursing and its theoretical, knowledgeable, ethical and philosophical principles to re-vision nursing practice. However, to resolve practice dilemmas, abstract conceptualizations of what nursing is, must translate to the concrete realm of what nursing does and must guide integrative professional clinical judgement for those actions within the context of a system and culture in crises and conflict.

As institutions grope for new ways to solve the care and safety and institutional cultural dilemmas, which seem to be accelerating in Western medical institutions, new integration models of advancing caring-healing practices for inpatient acute care systems are becoming a growing trend. This movement is occurring both in nursing and medicine, as well as in hospitals themselves.

Reorientations for hospital care delivery models and patterns

There are dramatic shifts required within established patterns of care delivery that now warrant an orientation, away from traditional hospital structures and their routi-

nized, industrial practices. The traditional hospital treatment delivery model was characterized by a care delivery system driven by technology, diagnosis and treatment of acute illness, and product line management. The shifting trend is towards managed care environments, integrated with a caring-healing emphasis; this trend holds promises for transforming both practices and settings (Watson, 1999; Miller & Apker, 2002).

The new caring-healing practice environment is increasingly dependent on partnerships, negotiation, coordination, new forms of communication pattern and authentic relationships. The new emphasis is on a change of consciousness, a focused intentionality towards caring and healing relationships and modalities, a shift towards a spiritualizing of health vs. a limited medicalized view. Thus, new standards, principles, guidelines and models for advancing and sustaining professional nursing caring practice are required (Tressolini & Pew-Fetzer Task Force, 1994; Miller & Apker, 2002; Watson, 2002).

It can be argued that these complex and somewhat chaotic changes create uncertainty for medicine and nursing, but also new opportunities for leadership. However one interprets these complexities, it is clear that the responsibilities, activities and practice models of professional nursing are under fire and nursing is mandated, along with others, to re-think conventional industrial models of care delivery. It is also clear that responsibilities of nursing will continue to be substantially transformed (Miller & Apker, 2002) whether we agree with the changes or not.

The dynamics of relational, human-to-human caring practices and comprehensive therapeutic modalities for caring-healing seem to be eclipsed by the daily routines, mechanics and demands of economic, management, physical and technological aspects of care. The heart of the necessary changes needed for renewal and transformation seem to be dependent on human dimensions and skills that result in transforming patterns and depths of communication, relationships and healing modalities. These human caring-healing dimensions transcend profession, system and institutional structures.

Miller & Apker (2002) have identified some of the key pattern shifts in communication and in the roles of nursing that move us beyond conventional systems. While the nurse has traditionally served as caregiver, educator, and emotional support for patients, families and so on, the new demands and responsibilities extend into new dynamics and relational aspects of care delivery. They identify several key new areas for new relationships and communication expectations. They include, for example (Miller & Apker 2002, p. 155, author's parentheses):

- More interaction with nursing assistants (and technicians);
- Increased (change in nature and patterns of) communication with physicians, medical residents (and other professional health practitioners, e.g. PharmDs);
- Liaison with increasing numbers of hospital-specific personnel (chaplains, massage therapists, complementary practitioners) which are an increasing discipline;
- Interaction (and cooperation) with insurance companies and outside agencies charged with coordinating care across the care continuum.

They characterized these new communication patterns within managed care hospitals as the four Cs of nurse communication. The four Cs include:

- Collaboration with wide range of hospital personnel;
- Conflict resolution around costs and care issues;
- Change management leadership roles and communication experts;
- Construction of new nursing identity, personally and professionally.

These changing communication and relationship patterns and expectations have generated new visions of nursing and medicine. Likewise, efforts to revision leadership initiatives to address the shifting patterns in hospital structures are beginning to emerge. Growing public scrutiny around issues of safety and mortality rates in hospital systems is also contributing to the call for dramatic changes in professional nursing and physician practice models.

Physician *hospitalist* model

A growing physician practice model, termed the *hospitalist* movement in the USA, has been underway for the past 5 years or so. The *hospitalist* is structured as a daily on-site practitioner (usually a physician) who is an inpatient generalist (or specialist on cardiac intensive care units) who is employed by the hospital to oversee direct care protocols and care regimes for hospitalized patients (Cram, 2002). The physician hospitalist mediates treatment programmes and clinical care issues between and among the interdisciplinary treatment team. The goal is to facilitate total quality improvement prospectively, rather than retrospectively. The hospitalists are generally accountable to the hospital administration and tend to see themselves as practitioners 'who run hospitals and have an ethical and moral obligation to make sure that when people come into our (systems) we treat them as guests who come into our home' (Cram, 2002).

Nurse *hospitalist* as emerging model?

The recent work of Mustard (2002) has connected issues of caring and competency to address current attention and concerns with patient safety and day-to-day examples of substandard patient care. He proposes a new model of the *nurse hospitalist*, as a daily teacher and facilitator for hospital nurses based on living examples of substandard care that have been documented within the institution. He envisions the inpatient generalist advanced practice hospitalist nurse as one who is employed by the hospital, but who reports to the Chief Nurse Executive. This role of hospitalist nurse, proposed by Mustard, would be 'devoted entirely to collaborating with nurse leaders, educators, charge nurses, and floor nurses in advancing the competency of nursing' (Mustard 2002, p. 36).

Mustard's model requires no structural change in the institution, but introduces an educational agenda with the nursing staff, with nursing and hospital administration, to assist in creating a new learning environment, thus changing the culture of care practices, helping to increase oversight, decrease injury, accidents, deaths and improve overall safety standards. In Mustard's model, the nurse hospitalist becomes an expert in both caring and competency as a means to improve the performance of the acute care nurse. In this model, there is more emphasis on critical thinking and interpersonal skill, rather than just clinical and technical skill. The attributes required for the hospitalist nurse, in Mustard's model, are related to attributes of our humanness and stress the humanities of nursing practice (Mustard, 2002, p. 38). He reports some of the necessary attributes that have been identified for such a nurse, for example:

- Coordinating care among different disciplines of the clinical team;
- Informing the patient on the level of detail of care being rendered, including prognosis based upon the patient's preference or desire to know;
- Respecting the patient's values, privacy and dignity, especially in decision making; making the patient comfortable in the hospital environment;
- Providing emotional support and reducing fears and anxieties;
- Involving family and friends in patient support and decision making; and
- Addressing the patient's anxieties in discharge planning and providing support for successful recovery after discharge.

While we agree that all these attributes are congruent with professional nursing care, there is no theory, or overarching disciplinary foundation for Mustard's

hospitalist nurse model. The hospitalist nurse model is not responsible for direct patient care, nor advanced practice approaches that are explicitly guided by theory; but rather is designed more as a staff educator role.

While the hospitalist nurse model is posited as a proactive and prospective model for improving nursing performance in a facilitative manner, in contrast with the retrospective model of quality control, it can be enhanced if created more explicitly within a professional collegial cooperative model, that is discipline specific, while simultaneously transcending any disciplinary myopia. If nursing is to be renewed for mature caring practices, any model must be grounded both in time-honoured values of caring and be guided by an explicit disciplinary perspective. It is true that proactive, prospective approaches and solutions to competency and caring issues are preferred, and we concur that true total quality improvement, practiced retroactively, is ineffective. However, acknowledging, and building upon, the intellectual, theoretical and moral grounding of the model, along with an implementation approach that endorses and facilitates nurses advancing in their caring practices (informed by congruent theories, values and knowledge/evidence), will significantly improve the hospitalist nurse concept. Offering new structures, patterns and possibilities for nurses' unity and self-renewal from within hold promise for nurses actively to cocreate the very caring-healing models they envision for their patients, the public and their profession.

Extending *hospitalist nurse*: turn towards caring theory-guided, evidence-based practice model

The proposed nurse hospitalist model, its general premises and directions, are consistent, to a large extent, with a proposed advanced professional nursing caring model. A process termed 'theory-guided, evidence-based, reflective practice' offers a promising approach to this hospitalist concept, but frames it within a new professional practice model that is grounded in a disciplinary foundation. Therefore, offering hope to improve and advance nursing's time-honoured caring-healing practices in both inpatient and community settings (Fawcett *et al.*, 2001).

***Attending Nurse Caring Model*® (operationalizing theory-guided, evidence-based reflective practice)**

The Attending Nurse Caring Model (ANCM) can incorporate some, if not most, of Mustard's hospitalist notions, while extending it, allowing more actualization of nursing as a mature caring and healing profession.

The ANCM, in some ways, parallels, but expands, Mustard's nurse hospitalist model. For example, the ANCM is designed to deliver and oversee a programme of collaborative, comprehensive, continuous caring-healing nursing therapeutic practices, for a group of identified patients/families, all within the context of relationship-centred care (Tressolini & Pew-Fetzer Task Force, 1994). Whereby in the hospitalist nurse model, the advanced nurse oversees other nurses, rather than having the direct opportunity for developing, practicing and overseeing a comprehensive plan of theory-guided care for patients/families.

The ANCM incorporates a caring theory as a philosophical-ethical base that grounds nurses in a shared world view and culture. It allows the emergence of a collective vision, whereby shared knowledge, values, goals and advanced caring therapeutics can extend practices. This process, in turn, can generate a new pattern and structure for care delivery. A culture of shared knowledge and values guide heart-felt caring practices that are grounded in both theory and evidence. This approach helps to translate theory and evidence into advanced nursing therapeutic practices. Thus, the ANCM extends and advances professional caring practices and patterns, while expanding, supporting, and simultaneously sustaining independent and interdependent care goals. The ANCM is both discipline-specific and trans-disciplinary.

Defining The Attending Caring Nurse (ACN)

The Attending Caring Nurse (ACN) within the ANCM is responsible for:

- Establishing and sustaining a continuous, caring relationship with patients/families; this relationship may begin before hospital admission, or on hospital admission, and continue after discharge with follow-up;
- Comprehensive assessment of caring needs and concerns, from patient's frame of reference – using caring theory as a guide for caring needs;
- Assessing meaning of the subjective as well as objective concerns;
- Co-creating with the patient/family a plan for comprehensive caring and healing that intersects with and is coordinated with the medical plan of care;
- Overseeing and assuring comprehensive care planning and in some instances directly carrying out the therapeutic regime plan related to the caring-healing modalities of nursing;
- Creating plans for direct communication with other nurses, physicians and team members to assure continuity.

Moreover, the ACN is responsible for writing comprehensive nursing directions for continuous care. This plan includes assuring caring theory-guided, evidence-based caring and healing therapeutic modalities. The ACN is responsible for oversight of this comprehensive plan of caring and healing, 24 hours a day. The ANC practitioner is considered an independent-interdependent professional nurse, who works collaboratively in full partnership with other nurses, physicians, and other health disciplines within the hospital and community.

The ANCM parallels an Attending Physician model, except the ACN is 'attending to' comprehensive nursing care-healing practices and therapeutics, and their integration with medical treatments. The ACN is informed and guided by an ethic and theory of caring, a caring relationship and evidence. In summary, the ANCM seeks to make explicit the caring relationship, the knowledge, values, philosophy, theory and therapeutics that guide advanced professional caring-healing practices. Finally, the ACN creates a new pattern and structure for delivery of professional nursing that transforms conventional approaches, while activating and renewing nursing caring paradigm.

Pilot project: The Attending Nurse Caring Model: integrating theory and evidence to transform practice

The ANCM is currently underway as a pilot project on one unit at The Children's Hospital in Denver, Colorado. It is constructed as a Nursing-Caring Science, theory-guided, evidence-based, collaborative practice model by applying it to the conduct and oversight of pain management on a 37-bed, postsurgical unit. The ANCM is designed to operationalize a disciplinary focus for advancing nursing practice in collaboration with physicians and other members of the team. This caring science initiative is informed by values, theory and knowledgeable caring practices. It becomes both nursing specific and trans-disciplinary, in that the ANCM model guides a comprehensive, continuous caring-healing programme and pain management for children/parents.

Caring theory and pain

The construct of pain is particularly well suited to this approach because effective pain management has historically been constrained by lack of a common theoretical/philosophical perspective (biological vs. a comprehensive unitary, whole person approach) and by limitations in

accessibility and utility of the sizeable literature on assessment and management. The urgency to define effective practice models in the USA has recently been heightened by the need to implement the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for pain management. Caring theory and pain theory are congruent in their contemporary focus on the subjective human experience, the inner life processes and meaning of the experience. Pain theory describes the pain experience as a dynamic interaction among biological, physiological, psychosocial, cultural and spiritual influences. The human caring process requires knowledge of human behaviour including the unity of mind, body and spirit, one's strengths and limitations, and responses, and knowledge of how to comfort, offer compassion and empathy within the context of a caring relationship (Watson, 1985, p. 227).

ANCM: proposed theory-guided evidence programme

In the pilot project, nurses who self-select to apply and participate in the ANCM are being introduced to a series of educational sessions of caring theory, including the 10 Carative Factors (Watson, 1979) in order to understand the structure of the caring process. More recent work related to caring theory incorporates notions of caring consciousness, intentionality, and caring-healing modalities that are being incorporated into 'caring moments' in direct care situations. In addition to manifesting caring into practice, the model of care simultaneously assists professionals with their own caring-healing practices for self-care. Another aspect of knowledge is that available through clinical evidence and clinical judgements. Sackett *et al.* (1997, p. 2) defined evidence-based practice as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'. Evidence encompasses not only the empirical and theoretical literature, but also clinical expertise and feedback from patients and families. In the ANCM pilot project, participants are initiating the search for evidence, as they define clinical problems in pain management. The nurses participating in the project are learning how the ANCM can increase their caring consciousness and intentionality to use knowledge and evidence, as well as to help increase autonomy, enhance interdisciplinary teamwork and reduce suffering in children. Reflective activities, such as focus group discussions and individual recordings of caring moments help participants integrate the theoretical knowledge into their day-to-day practices

with children in pain. Nurses are also writing nursing directions on the order sheet in the medical record for use of caring–healing modalities and nursing therapeutics for comfort measures, pain control, creating a sense of well-being, relaxation, etc. These nursing modalities complement the physician's orders for analgesics. To date, collaborative practices among interdisciplinary participants are changing, with enhanced patterns of communication and dialogue between nurses and physicians and other members of the team.

Finally, the ANCM elevates contemporary nursing 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. In summary, the proposed ANCM offers new options for addressing the dissonance between nursing theory and practice; between nursing caring philosophy, knowledge and values and system constraints. The ANCM seeks to transcend conventional problematic practice patterns, generating new possibilities for self-renewal of time-honoured values of nursing, combined with the most contemporary knowledge and advanced modalities of nursing. As such, it offers hope for transforming both nurse self and system, while working within the context of the most contemporary crises and challenges facing today's health care structures, systems and society, at this point in human history.

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