

Walk the Talk: Promoting Control of Nursing Practice and a Patient-Centered Culture

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PRIME POINTS

- Control of nursing practice and a patient-centered culture promote the quality of nurses' work environments and the quality of patient care.
- Culture is the normative glue that preserves and strengthens the group and provides the healing warmth essential to quality care.
- "Walk the talk" is a best practice through which the values of unit and hospital culture are lived and control of nursing practice by nurses can be achieved.

To "walk the talk"—putting values into action, leading by example, practicing what you preach—is a best practice related to 2 of the 8 attributes or work processes identified by staff nurses as essential to a healthy work environment. These 2 attributes, *control of nursing practice* and *a culture in which concern for the patient is paramount*, are the focus of this article. Another commonality of these 2 essential attributes is that they are the only 2 of the 8 that have as many departmental/hospital-wide implications as they do unit-focused implications. Nurses cannot control practice or engage in activities

related to a patient-centered culture at the unit level unless parallel sanction and endorsement for these activities exist at the organizational level. After clarifying and illustrating the walk-the-talk metaphor and the constructs control of nursing practice and shared governance, we present the results of research that pertain to control of nursing practice and a patient-centered culture. We then suggest ways in which clinical nurses can operationalize the walk aspect of the talk, the values and beliefs inherent in control of nursing practice and a patient-centered culture.

Walk the Talk

The cultural metaphor walk the talk is not new, but its use in both popular and professional literature

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and in everyday colloquial usage is increasing.^{1,2} In the study that provided the data for this article, the term was freely used by all—staff nurses, managers, physicians, and other professionals—in all hospitals and in all regions of the United States. It was used in conjunction with 3 of the 8 essentials of a healthy work environment: nurse manager support, control of nursing practice, and a patient-centered culture. The following 2 examples illustrate use of this metaphor with respect to a patient-centered culture and control of nursing practice. The first excerpt from a 2001 staff nurse interview³ illustrates the metaphor with respect to culture.

We have a responsibility to participate in research, especially being a magnet hospital! It's part of our

culture, our norms. Nursing in this hospital is “gung ho” on research . . . But it's not enough to talk the game, there has to be action. The very least we can do to show that we value research is to fill out surveys like this.

The second example illustrates use of the walk-the-talk metaphor in the control of nursing practice. One of the study hospitals that had been invited to participate in the structure-identification studies declined because of a busy schedule of upcoming activities. A week after the invitation was declined, the investigator was informed that the administrative group had been hasty in their decision and that the request was being sent to the shared governance

research council for disposition. The council contacted the investigators, sought additional information, endorsed the study, and expedited the institutional review board's review process. The chief nursing executive explained that the council structure was still relatively new and that nurses and administrators were still learning how to make decisions together, how to walk the talk and “practice what we preach.”⁴

Source of the Data

In the spring and summer of 2006, we conducted a nationwide study^{4,7} in 8 strategically selected magnet hospitals. The purpose of the study was to ascertain the organizational structures and leadership practices that staff nurses identify as necessary for a healthy work environment, specifically, structures and practices that promote control of nursing practice and a patient-centered culture. To achieve this purpose, we needed to elicit the answers from staff nurses working in patient-centered cultural environments with confirmed control of nursing practice. The Essentials of Magnetism (EOM),⁸⁻¹⁰ a tool used to measure the extent to which staff nurses confirm that they have healthy work environments, has subscales to measure control of nursing practice and patient-centered culture as well as the other 6 essentials. It has been administered to staff nurses in hundreds of hospitals, mostly magnet hospitals, since its development in 2003. The results of these EOM evaluations were used to select the hospital sample for this study.

We selected the 8 magnet hospitals, according to the 8 census-tract regions of the United States, that

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had the highest or second-highest EOM scores. To obtain the interview sample, we selected the clinical units with the highest EOM scores within each hospital. The “experts” that we interviewed on these units consisted of 244 staff nurses nominated by their peers and managers, 105 nurse managers, and 97 physicians nominated by staff nurses or managers. The number of staff nurses interviewed varied by the size of the unit but usually consisted of 2 or 3 staff nurses, 1 nurse manager, and 1 physician per unit. We interviewed the chief operating officer, the chief nursing officer, and 4 to 6 representatives from professional departments such as respiratory therapy, physical therapy, dietary, and pharmacy in each hospital to obtain the perspectives of these personnel of the nursing department and the degree of interdepartmental collaboration. We also conducted “participant-observation,” a qualitative research technique,^{11,12} in all central and unit council meetings during the 4-day on-site visit.

Control of Practice

The American Nurses Credentialing Center, which governs magnet designation, refers to control of nursing practice as “shared” or “unit-based” decision making related to an environment in which administrators use a participative management style.¹³ The Institute of Medicine,¹⁴ in the institute’s delineation of 5 evidence-based management practices needed for a healthy work environment, define it as “involving workers in decision making pertaining to work design and work flow.” Staff nurses in magnet hospitals define control of nursing practice as a work process through

which nurses at all levels in the organization have input and make decisions on issues of importance that affect nurses, the context of nursing practice at unit, departmental, and hospital levels, and the quality of patient care provided.¹⁵ The input includes access to power and exchange of information, views, and judgments; the decision making is interdependent and shared; and the issues of importance include practices, standards, policies, and selection of equipment.

Nurses wrote of control of nursing practice as follows:

Control of nursing practice means two things to me.

On the unit, it means that I determine the order and sequence of my work, interventions, and functions.

What works best for most of my patients. It means that I have a “say-so” in how the unit is run, how we float, and do self-scheduling. . . Control of nursing practice also means that

nurses as a group, all of us in this hospital, the managers and administrators, well they’ve always been responsible for making the decisions, what is new [is] that now staff nurses are involved. We are responsible and accountable for group decisions. Together, with the administrators, we control our practice and the practice environment. We are responsible and accountable for the quality of nursing in this hospital. And those aren’t just empty words. . . . We not only

have “a say,” we make decisions about policies and issues and equipment. . . . Sometimes when a problem or issue is presented, it is made clear from the “get-go” that we are being asked for input only, that administration will make the decision. And that’s OK as long as we know “up front.” When you make the decision, you are accountable for the outcomes.

Staff nurses in both the United States^{15,16} and Canada,¹⁷ now^{4,18,19} and in the past,²⁰ concur with well-established precepts of a profession in distinguishing between clinical autonomy and control of nursing practice. Clinical autonomy is individual, patient-centered decision making with the patient as the primary and often sole beneficiary. In much of the nursing literature,^{18,19} clinical autonomy and control of nursing practice are combined, referred to simply as decision making, and are discussed as though they were the same attribute. The American Association of Critical-Care Nurses standards for maintaining and sustaining a healthy work environment²¹ group the 2 dimensions of autonomy under a single standard, effective decision making, but particularly note the principle of unique and combined spheres of practice that is so critical in selecting the appropriate type of decision making: independent or interdependent. Control of practice, articulated by Flexner²² almost 100 years ago in his characteristics of a profession, is the self-regulation and self-determination of professional

issues, practices, and standards by professionals. The following excerpt from an interview with a staff nurse illustrates the application of this definition to nursing. (All excerpts in this article are from interviews with staff nurses unless noted otherwise. NM indicates excerpts from interviews with nurse managers; MD, excerpts from interviews with physicians.)

centrally but you need input from all units. But, then, there are some issues that are unit-specific and these we take care of in Unit Council.

Shared Governance

As in any form of self-regulation or self-determination, a structure is needed to facilitate smooth and

implementation of principles such as partnership, ownership, accountability, and equity.⁴ Investigators and experts have noted or empirically shown that shared governance structures that are not practical and are not accompanied by best management practices will not enable nurses to control practice. Laschinger and Wong²⁴ state that

What makes shared governance structures viable and what best practices make shared governance structures effective in enabling nurses to control nursing practices?

What MDs do in Medical Council, we do in Nursing Council. We solve practice issues like what kind of dressing is best for the hospital to buy for PICC lines, we establish standards of practice, review quality indicators, and are responsible and accountable for the general practice of nursing in this hospital. We also have a hand in deciding skill mix and how many positions and what kind of positions go where. We worked out all the procedures for how to get flu shots to the patients and staff that needed them. . . . We decide on what should be done with new graduates who don't pass boards . . . It doesn't work unless there is communication and follow-through between central and unit councils. If it's an issue affecting nurses or patients on all units, then it's decided

accountable operation. In nursing, control of nursing practice is operationalized through shared governance or similar structures. Born on the heels of the participative management and decentralization themes of the early 1980s, shared governance is a nursing management innovation that legitimizes nurses' control of nursing practice while extending the influence (input and decision making) of nurses at all levels, to administrative areas previously controlled by management.²³ Shared governance is a structural configuration of councils and committees that provide formal mechanisms that ensure nurses' responsibility, right, and power to make decisions and to control nursing practice.

Whether termed shared leadership, clinical governance, collaborative governance, shared decision making, or simply the nursing council, the structure alone will not "bake the cake." The structure must be accompanied by best management practices that make shared governance possible through

"most shared governance efforts are seen by staff as chiefly structural, with staff nurses on councils and committees but without the authority to have significant control over professional practice, thus leading to cynicism and unwillingness to assume accountability for client outcomes." Cynicism, unwillingness to be accountable, and lack of decision making were also reported in a nationwide survey²⁵ of staff nurses working in hospitals that supposedly had shared governance systems in place.

Although shared governance is not identified as a force of magnetism or listed as a source of evidence,²⁶ it is commonly understood that shared governance or a similar structure is required for designation as a magnet hospital. However, staff nurses in some magnet hospitals did not confirm the existence of workable shared governance structures. In 3 of 34 magnet hospitals participating in 2 different studies,^{8,10} staff nurses reported that shared governance structures were not

viable and workable and did not enable the nurses to control nursing practice. So, the question becomes as follows: What makes shared governance structures viable and what best practices make shared governance structures effective in enabling nurses to control nursing practice? Those are the questions we posed to the 500 experts we interviewed in the study reported here.

What Was Learned

Structures That Enable Control of Nursing Practice

The experts interviewed identified 2 structures, shared governance and career ladders, and 5 practices that enabled nurses to control nursing practice within the organization.

Shared Governance. Many shared governance formats, varieties, and names were described. Most of the structures were labeled something other than shared governance. The structures followed different models^{4,23}; the councilor model was by far the one most frequently used. Councils were usually organized according to different functions, such as practice, quality improvement, research, evidence-based practice, education, and informatics. In some hospitals, the councils were organized according to professional role, such as staff nurse, charge nurse, nurse manager, educator, and advanced practice nurse.

In smaller organizations, functions were grouped into fewer types of councils, and not all central councils were replicated at the unit level. Compared with smaller organizations, larger hospitals had more councils, sometimes with a double focus such as charge nurse practice council or staff nurse evidence-based practice

council, and central councils were more often replicated at the unit level.

Career Ladder Programs. Career ladder programs, specifically the criteria delineating participation and/or leadership in council activities were frequently cited as enabling and promoting nurses' control of practice. Movement through the steps of the career ladder was usually associated with salary increases or bonuses. Although important and much appreciated, increases in salary and bonuses were not the only or necessarily the chief motivating factors for participation in control of nursing practice, but they were a facilitator. Many nurses stated that they participated in a career ladder program because they had a professional responsibility to do so.

Best Practices That Promote Control of Nursing Practice

The 5 best practices that promoted control of nursing practice were specific behaviors demonstrating the walk aspect of walk the talk—managers' and leaders' actions that made shared governance structures workable, thus facilitating nurses' control of nursing practice. Nurses in one hospital described walk the talk as follows:

We believe that the success of our organization, which we define as the highest quality of patient care possible, high patient satisfaction, professionals who are job satisfied as well as professionals who judge that they are contributing, are making a difference in the quality

of care a patient is receiving—the success of such an organization is dependent upon a “professional democracy” form of government. Professional departments being run by professionals and decisions made by professionals who are knowledgeable about clinical issues and close to the frontline application of solutions. This is our talk, our beliefs, one of our cultural values. If we, everybody, truly believe that, then we must walk the talk and put our beliefs into action.

Providing Access to Power. In the literature, providing access to power is usually referred to as “empowerment.” The experts described it as “leaders and managers who made you feel that you had something to contribute and that you had the power to make decisions that affect nursing practice, and that you were not only *allowed* to use that power, but were *expected* to do so.” Shared governance structures “that worked” were perceived as a source of formal power.

Shared governance structures and control of nursing practice are about authority, power, and influence. Staff nurse interviewees did not appear to be afraid of or shy away from the concept of power. They had clearly adopted the newer meaning of this word. Rather than power meaning “to impose your will upon another,” power is the capacity to cause change, influence events, initiate action, and control outcomes.^{4,27} Traditionally, power was

conceptualized as a fixed mass, a finite quality; if one person had power, someone else had lost it. Power was described this way by a speaker at the September 2006 magnet hospital conference in Denver. A newer concept and one used in all 8 hospitals, is that power is infinite;

perceive that they are empowered. In this tool, empowerment is defined as access to power. The tool is used to measure 4 specific lines of power—information, opportunity, support, and resources—and access to both formal and informal power. Staff nurses in these 8 mag-

other hospitals, nurses in these 3 hospitals had significantly higher empowerment scores, particularly with respect to the informal power generated through collaborative interactions with colleagues as noted earlier. The integrated model was also reported as being far more effi-

Pride in and acknowledgment of outcomes, accomplishments, and actions of shared governance councils is both self and professionally reinforcing.

power has an exponential quality that can be released, distributed, and shared to the mutual benefit and growth of all involved.²⁸ A staff nurse remarked as follows:

Just because administration shares some of their power with us doesn't mean that they lose their authority and power. The rule is that decisions are made by the people "in the know," those who have the most experience and knowledge about the issue or problem, and who are most affected by the outcomes. And for most clinical issues, that's the staff nurse, or educator, or clinical specialist.

On the basis of research by Laschinger and Wong,²⁴ we anticipated that "access to power" would be a possible indication of viable shared governance structures. Thus, we tested all staff nurses (not just those on the units with high EOM scores) in the 8-hospital sample by using the Conditions of Work Effectiveness Questionnaire II, a tool used to measure the extent to which nurses

net hospitals scored quite high in empowerment, higher than any other sample of staff nurses reported in the literature and within a percentage point of nurses in advanced practice positions.²⁹

Information, opportunities, and support were the chief sources of power. The chief source of informal power in the majority of the 8 hospitals was the opportunity and expectation that staff nurses would collaborate with physicians and other professionals in events such as regularly scheduled interdisciplinary patient care rounds.^{30,31} The interdependent decision-making characteristic of these kinds of rounds had the force and power of all participating professional disciplines.⁴

Another source of informal power was an "integrated" shared governance model rather than the usual "silo" model (ie, shared governance structures housed in and operated out of individual departments).³² Integrated models in which the shared governance structure was housed in the hospital, not in any single department, were described by interviewees in 3 of the 8 hospitals. Compared with nurses in the

cient than the silo model: "When all disciplines are represented in council, you can discuss the impact and implications and make decisions without having to go back and check with each separate department."

Promoting Widespread Participation. "Time and opportunity to participate" and "individual differences in contributions" were 2 of the major factors cited by interviewees that will "make or break" the viability and workability of a shared governance structure and the effectiveness of the structure in enabling control of nursing practice. The first factor, time and opportunity to participate, is largely a best management practice issue of having enough staff members so that nurses can get off the unit to attend meetings and paid time off to attend when day-long meetings are held. The second factor, recognizing the contribution of different nurses and making it possible for them to contribute in different ways, not only increases the workability of the shared governance structure but also results in a wider scope of participation with the benefits of participation accruing to a larger group of people.

Using Recognition to Reinforce Participation. Using recognition to reinforce participation refers to recognition of the shared governance structure and of the decision-making outcomes, not the individuals involved. When physicians, administrators, and professionals from other departments recognize the worth and value of nurses controlling the context of the practice of nursing in an organization, these nonnurse professionals will use the structure, thus making it more workable and effective. In addition, the act of “working together” generates more informal power.

Taking Pride in and Acknowledging Outcomes, Accomplishments, and Actions of the Shared Governance Councils. Pride in and acknowledgment of outcomes, accomplishments, and actions of shared governance councils is both self and professionally reinforcing. Nothing succeeds like success. Acknowledgment is also a way in which the work of “less visible” participants can be recognized and appreciated. One nurse remarked as follows:

I know that I had a part in that decision. And that’s fine. The credit goes to the group, not to any one individual. And I’ll check with Sue again to see if there is something else I can do to help. I’m a whiz on the computer and I’m happy to go onto the Web at home after I get the kids to bed.

Having Evidence-Based Practice Teams. Evidence-based practice teams and their activities are often attractive to a frontline nurse who

shuns large group meetings or group decision making. Output from the efforts of these teams provides the moral, ethical, and scientific guidance and authority for the decision making essential to improving quality of patient care.

What Clinical Nurses Can Do

Setting up a shared governance structure and a clinical ladder program and implementing many of the best practices associated with control of nursing practice are leadership functions and responsibilities. But there is much that staff nurses can do to put their beliefs about professional behavior and responsibilities into action.

Walk the Talk. If you believe in the “Professional Democracy” form of self-regulation and self-determination for your profession, if you believe that nurses have not only the ability but the professional right, responsibility, and accountability to control the context of nursing practice in the organization in which they work, you demonstrate this talk by getting involved. Although high expectations are laudable, a new shared governance structure may not work perfectly from the beginning. Self-determination and self-regulation are processes that must be learned. Democracy isn’t easy.

Best Practices That Promote Control of Nursing Practice

- 1 Providing Access to Power
- 2 Promoting Widespread Participation
- 3 Using Recognition to Reinforce Participation
- 4 Taking Pride in and Acknowledging Outcomes, Accomplishments, and Actions of the Shared Governance
- 5 Having Evidence-Based Practice Teams

Participate. Participation means identifying and presenting issues, participating in council meetings, providing input on issues, canvassing peers, communicating results of decisions, and ascertaining the progress and disposition of problems and issues. Only 1 of the 8 hospitals we visited had a formal system for keeping track of issues and their disposition. Any nurse who identified a problem or had a question or a “why can’t we?” completed a half-page form and submitted it to the nurse’s council representative. In this system, it was mandatory that the nurse receive a written reply as to the disposition or decision related to the query within 2 weeks.

Recognize Contributions of All. For workable shared governance structures to positively affect nurses’ control of nursing practice, enthusiastic and spirited participation by nurses at all levels is a must. But we are all different. Some nurses may recognize

participation as a professional responsibility, but family obligations inhibit full participation. For others, participation is a matter of differences in interests and abilities:

I prefer giving direct patient care to sitting in a meeting. I'm not interested in the big meeting stuff. You're talking to a guy on the front line with a rifle; my interests don't lie in that direction. I'm a meat and potatoes kind of guy.

Some nurses will want to serve as unit representatives and/or to lead councils. Others, like this meat and potatoes kind of guy, can participate by offering suggestions and recommendations in their unit council, by doing investigative work such as determining the best equipment for various patient procedures, by formulating standards, or by conducting best practice searches on the Internet and evaluating current practices. What is important is that the contributions of all are recognized, respected, and appreciated; that lines of communication are kept open; and that both the problem or issue and the solution or decision are "owned" by all.

Use Power Wisely. It is difficult for staff nurses to demand access to power, but they can avail themselves of the lines of power offered: "If you don't use the power presented; you'll lose it." There is nothing wrong with feeling powerful and being responsible and accountable for decisions that reflect that power. One nurse remarked as follows:

When a physician's research project is going to involve nursing, they come to

research council, present it, and have to have our approval before it can go ahead. That's a biggie! And when you feel that power and responsibility, you make doggone sure that you make the right decision. . . . The doc came up to me after the meeting and said that he figured out a way that he could improve his proposal by a question I had asked. Wow, that makes me feel good and professional.

Take Pride in Achievements. "By your actions they will know you." Take pride in your accomplishments; know what they are even if you were not involved in every initiative. Recognize the achievements of peers and the group. Accept responsibility and demonstrate a willingness to be held accountable for decisions made. Nurses in one hospital explained the following:

If, in spite of everyone doing their homework, the council makes a wrong or perhaps not the very best decision about the best antipressure mattresses for the hospital to purchase, we must own our mistake and figure out ways to "live with it" until the mattresses wear out.

Culture in Which Concern for the Patient Is Paramount

Culture is the combination of symbols, language, beliefs, assumptions, and behaviors that manifest people's or society's artifacts, values, and norms, the 3 components or levels of culture.³³ When applied to an organization, hospital, or clinical

unit, the culture is referred to as a corporate culture, the focus of this article. Artifacts are the visible creations of the culture, the image of the unit, status symbols, rites, rituals, ceremonies, and "sacred cows" (persons, things, or beliefs that cannot be attacked but are revered and protected). An example of an artifact on one of the units in our study was that all professionals who achieved specialty certification were the subject of a "toast and roast" ritual enthusiastically attended by all physicians and nurses on the unit. Values are the time-honored, deep-seated, pervasive beliefs of what "ought to be." They are the standards by which we make decisions that influence every aspect of our lives. Walking the talk is how we make our vision and values tangible.¹ Values are the concerns and goals ascribed to by most people in a work group that shape the group's behavior. Norms are the agreed upon ways of doing things. Norms guide performance and include both the implicit and the explicit shared meanings of behavior and the rewards and sanctions associated with compliance or non-compliance.

Cultures can be located anywhere along a continuum from rich, dynamic, and powerful to weak or static, depending on how overt and pervasive the norms and values are. In weak cultures, norms are subtle, difficult to discern, or not ascribed to by all. The dynamism of the culture depends on the strength and pervasiveness of values, the longevity of the work group, the attention given to transmitting the culture to new people, and on how well taught and reinforced the values and

norms are by group members. The vitality, strength, dynamism, and adaptability of the culture depend on the degree of communication among members and on the degree of acceptance of the values among subgroup members. Three processes need attention to ensure a dynamic culture: establishing values and norms, transmitting the values and norms to new team members, and changing and updating values and norms when necessary.

History of a Patient-Centered Culture of Excellence in Magnet Hospitals

A culture of excellence was associated with the original 1984 Magnet designation and was described as “something almost palpable; you can feel it when you walk into a hospital.”³⁴ Designation as a magnet hospital by the American Nurses Credentialing Center is based on the structures (called the Forces of Magnetism) associated with an excellent work environment that were derived from results of the original study and on the criteria for certification of nursing service administrators.¹³

Although the 14 Forces of Magnetism and the sources of evidence for the forces have no references to culture,²⁶ since our first study in the mid-1980s, staff nurses in magnet hospitals have consistently reported the presence of a patient-centered culture in their work environment. In 1988, a total of 88% of the 1634 staff nurses in 16 magnet hospitals and 75% of the 2336 staff nurses in 8 nonmagnet hospitals reported that they worked in a culture of excellence in which “concern for the patient was paramount.”^{35,36} In 2003, in a study¹⁰ of 4320 nurses in 26

magnet and nonmagnet hospitals, 90% of the nurses in magnet hospitals and 67% of those in nonmagnet hospitals gave affirmative answers for the same item. In 2006, in a study⁸ of 10 483 nurses in 18 magnet and 16 nonmagnet hospitals, 88% of nurses in the magnet hospitals and 74% of those in nonmagnet hospitals reported that concern for the patient was paramount.

These consistent findings in large samples in different magnet hospitals would seem to indicate that the emphasis and valuation of culture from the original magnet hospital criteria as an attribute of excellence have survived and withstood the test of time. And even though identified in the original study, culture was not included as a Force of Magnetism, perhaps because culture is an exceedingly difficult construct to measure. In a recent study³⁷ designed to differentiate intensive care unit cultures associated with end-of-life decision making in 4 adult medical and surgical intensive care units, a 6-member research team conducted participant observations and collected data for 5 hours a day, 5 to 7 days a week, for 7 months on each of the 4 units studied before judging that the team had identified the different intensive care unit cultures.

Most quantitative tools used to measure culture measure only the value dimension of culture.^{38,39} Sometimes the dominance of one value over another is measured by presenting competing aspects. In 1985, we used the work of Peters

and Waterman⁴⁰ on a culture of excellence to measure cultural values in hospitals. Because the competition between cost and quality care was, and continues to be, a nagging reality, we constructed the following item: Cost (money) is important, but quality patient care comes first in this organization. In 1988, a total of 77% of nurses in magnet hospitals and 65% of nurses in nonmagnet hospitals responded affirmatively to this item. In 2003, the percentages were 78% and 57%; in 2006, they were 76% and 63%. Unquestionably, in both magnet and nonmagnet hospitals, the percentage of nurses who report a patient-centered culture decreases when respondents are specifically requested to factor in the competing value of cost. But what is truly remarkable is that for all 3 periods, the decrease in percentages remained the same, between 12.5% and 13%. This finding reflects remarkable stability in these competing values over an 18-year period, again showing that in hospitals with a culture of excellence, the value of a patient-centered

What Clinical Nurses Can Do



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Recognize
Contributions of All
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Achievements

culture has survived despite the tremendous competing value of “cost” in recent years.

In 2001, after staff nurses in 14 magnet hospitals identified the 8 work processes or attributes (1 of which was a culture in which concern for the patient is paramount) essential for a healthy work environment,⁴¹ we constructed the EOM tool to measure all 8 attributes. We included the values of a culture of excellence⁴⁰ as well as the competing cost–patient care item.¹⁰ The patient-centered culture subscale of the EOM tool does not measure all 3 aspects or levels of culture; it measures only values and the 3 value processes.

In the study reported here, 446 staff nurses, nurse managers, and physicians from the 101 patient care units on which staff nurses had previously confirmed a patient-centered culture were asked, “What are the 5 dominant cultural values of the unit on which you work.” (Readers may find it beneficial to respond to this question before reading the results, thus allowing comparison of the readers’ work situation with that of these interviewees working on excellent units in excellent hospitals.) We followed the suggestion of Cammann et al³⁷ for eliciting norms, the behavioral aspect of walk the talk, by requesting interviewees to “describe a nurse who ‘fits into’ the work group on this unit.” Sometimes the prompt “What does he or she do that tells you that they fit in” was used. Answers to these questions were descriptions of behaviors. Because norms are agreed-upon ways of doing things, these behaviors should reflect the norms of the unit related to the core cultural values.

The total number of responses was 1989 because some interviewees cited fewer than 5. Using thematic and categorical analysis,^{11,12} we grouped the 1989 value responses into 9 categories on the basis of the explanations and descriptions provided by the interviewees. A total of 57 responses did not fit the 9 categories and were dropped, leaving a total of 1932 identified core values in 9 categories. Normative behaviors described in response to the nurse-who-fits-in question were grouped by value categories and will be used to provide descriptions of behaviors related to the values. In this article, we have used a large number of verbatim excerpts to illustrate both the walk (norms) and the talk (core values) in order to adequately represent the range from this large number of responses.

Hospital values were gathered from in-house documents, on-site coinvestigators, chief nursing officers, and the hospitals’ official Web sites. Although obtained at the time of the on-site visit, information was not tabulated until interviews from all units had been transcribed and analyzed in order to avoid presetting the categorical analysis of the unit core values.

Unit Core Values and Normative Behaviors

Table 1 displays the core values in 8 magnet hospitals as described by staff nurses, nurse managers, and/or physicians on 101 units previously confirmed by staff nurses to have a patient-centered culture of excellence. The values are presented in order of the frequency that the response was cited. The analysis is based on 1932 responses. Table 1

also presents the hospital core values as cited in hospital documents, by on-site coinvestigators and chief nursing officers, and/or on the official Web sites of the hospitals. The table allows a comparison of similarities and differences between unit and hospital core values.

Patient/Family Centered—Patient First

A total of 60% of the staff nurses and managers and 49% of the physicians cited the value patient/family centered—patient first. It was cited by interviewees on all units in all hospitals. Descriptors of this value included doing the “right thing” for the patient; genuine caring and doing one’s best. The patient is the first and priority concern.

A nurse who “fits in” on this unit is one who, at the end of the day, feels comfortable saying as we are walking out: “I really feel good; I did a good job, I made a difference in the lives of my patients. If I hadn’t picked up that groin bleed when I did, Joe would have been in serious trouble.”

Three adjectives were used to describe this value: *Safe* care is the minimum, but we aim for *excellence* and *quality* care. Customer orientation was also used, but not as often as safe, excellent, or quality care. A feeling of professional pride in being able to give that level of care on a consistent basis was sometimes mentioned as a component of quality care.

This hospital has received many awards, both formal and informal, for quality patient care. The EMTs and ambulance drivers have told us that they will say to the patient, “It will take a little longer, but I’m going

Table 1 Unit and hospital core values in 8 magnet hospitals

Unit core values	Responses (n = 1932)		Hospital core values
	No.	%	
Patient/family centered—patient first	1120	58	Quality care
Teamwork	1024	53	Collaboration, teamwork
Competent performance	754	39	Continual improvement
Family orientation and camaraderie	715	37	
Respect, trust, and equality	676	35	Respect
Integrity and honesty	483	25	Integrity
Autonomy and patient advocacy	483	25	
Stewardship	154	8	Stewardship
Compassion and justice	115	6	Compassion Justice Hospitality Community

to take you to ____ hospital because they give the best care in the city.”

Quality care means consistently good outcomes and patients who are satisfied; being attentive to the needs of patient and family; giving family-centered, holistic care; keeping patient and family informed.

Teamwork

Teamwork was cited as a core unit value on all units in all hospitals. For the total group, 57% of the nurses and managers and 37% of the physicians identified this as a core value.

On this unit, you never have to ask for help; we answer others’ call lights; we work together to get the job done. Nobody leaves till all patients are cared for.

The end goal is more important than the prominence of any one person or group.

The “team” owns the quality of care and the process of providing it.

We work together well, no cliques. We cover for each other so that all nurses can go on interdisciplinary rounds for their patients.

We don’t complain or bitch—cheerful, helpful. Smile; don’t let the small things get you down.

With the teamwork they have going, the nurses on this unit can handle very complex patients that no one nurse could handle alone. (MD)

References in this category were to the “unit-based” team that consisted primarily of nurses and other nursing personnel, but also secretaries and housekeeping. However, the team also included the medical director, the residents, pharmacists,

and unit-based therapists, such as the physical therapist in orthopedics. Pride in what the team could accomplish was also frequently cited.

Competent Performance

Competent performance was cited as a core value by 39% of all interviewees, slightly more so by physicians (41%) than by nurses (39%) and managers (36%).

High-quality, caring people who are incredibly competent is the major value of this unit. We have the best nurses, therapists, and doctors in this hospital on this unit. (MD)

Everyone functions at a very high level. It’s performance, not just head knowledge, although you can tell that they have the knowledge base by the questions they ask—very organized; they give you the relevant information and offer suggestions and recommendations. (MD)

The quality of the nurses equals competence plus personal attributes and characteristics such as kindness, caring, compassion. (MD)

There is a big emphasis here on education—keeping self constantly up-to-date. Always try and look to improve yourself. There is a big push on establishing evidence-based practice and getting certified.

Sharing information, the results of decisions, and learning from one another is as important as an individual's own competence. (MD and NM)

Family Orientation and Camaraderie

Family orientation and camaraderie, defined as “a feeling of close friendship and trust among a group of people; a spirit of friendly familiarity and goodwill that exists between comrades,” was described by 37% of the respondents, slightly more often by staff nurses (41%) than by the others.

Family encompasses a great deal of affection on both sides and includes every-

We're close-knit and we see each other socially outside of work. If something happens in your family, call someone and they'll take care of replacing you—come in on day off and no grumbling.

Physicians tended to describe this value as follows:

We like one another; many of the nurses are my friends. They are positive, upbeat and work is fun. We enjoy it; we laugh and cry together. We like one another; we want to be here. Work is an upper; not a downer. It's a nurturing work environment where

you can be trusted to see that the patient gets it. You never leave until you get it or see that someone else gets it for the patient.

I can trust that when my peers do something for my patient, they will give my patient the same quality of care that I would give.

Integrity and Honesty

Integrity and honesty as evidenced by effective, efficient, genuine communication was a core value cited by 25% of the respondents, more so by nurses (26%) and managers (28%) than by physicians (19%).

We tell it as it is; if you make a mistake, admit it. We know

Be courteous and treat everyone, patients and coworkers, as equals and in a dignified manner.

thing that you would expect and receive from your family. Family always has to take you in even if you do something they don't like. They must accept you as you are and have unconditional positive regard for you as a person and as a nurse; they are concerned about you as a person not just a fellow employee.

We're there for each other; they watch my back and provide emotional support. I had a very sick child. They came in and took care of the rest of my children.

everyone can express their concerns and feelings.

Respect, Trust, and Equality

Respect, trust, and equality toward each other and with patients was a core value cited by 35% of the interviewees on some units in all hospitals. This value was fairly evenly divided among nurses, managers, and physicians. Be courteous and treat everyone, patients and coworkers, as equals and in a dignified manner.

Everyone has value, is valued, and is treated well. We are trusted to do what we are supposed to do. If the patient needs something,

that we will not be chastised, judged, or belittled.

The personal characteristics and attributes of the individual were part of this value.

A “quality person” is hard to explain in an interview. The best I can do is to describe our pattern of communication. We talk openly to one another; you can bring up any issue and discuss it; the goal is to fix the problem, not find blame. If it's something we are not to know about, fine, then come right out and say that, but don't fabricate or dress it up.

Part of honesty is working hard, showing up when you are supposed to be here, and being motivated to do a good job.

Clinical Autonomy and Patient Advocacy

A total of 25% of the interviewees described the values clinical autonomy and patient advocacy, both of which involve decision making of some type. The 2 values are grouped together because that is the way interviewees presented them. Not only in this study, but in other studies¹⁶⁻¹⁹ as well, clinical autonomy, defined as making decisions in the best interests of the patient, encompasses 2 major arenas: (1) the “need to rescue,” ongoing surveillance, “avert disaster or complications” and (2) advocacy for the patient, do or get him/her what they need. Both autonomy and advocacy were described by all 3 groups of interviewees, but physicians cited autonomy appreciably more often (37%) than did nurse managers (13%). Staff nurses (32%) cited patient advocacy more often than did physicians (11%).

Comments on autonomy included the following:

A core value of this unit and one that I value the most is the nurses’ ability and willingness to make decisions for the benefit of the patient . . . I can’t tell you how often nurses on this unit have averted patient harm—well not always harm, but certainly discomfort and misadventure for the patient. I trust them. They look ahead and

foresee what might happen; often they make observations and have information I don’t have, so they make better decisions than I could. They call these things to my attention so that together, the patient gets much safer and better care. (MD)

You can and are expected to practice autonomously on this unit. You can use all your skills and make decisions independently or by working collaboratively with physicians, therapists, and others.

Interviewees spoke of advocacy as follows:

As a nurse, you bring to the situation that which is uniquely nursing—caring, teaching, advocating, and interpreting for the patient/family.

What do I mean by patient advocacy? I see the nurses are doing what needs to be done to help the patient progress toward independence. (NM, rehabilitation unit)

I see the arrangements the nurse makes so that we know that the patient is going home to a safe environment. (MD)

Nurses advocate for the patient; they plead their cause. There are times when the nurses judge that

what I have ordered is not what is best for the patient. They speak up and say so. And, more often than not, I change the order. Sometimes, it’s a matter of one or the other of us not having complete information. (MD)

The nurses interpret to me how the patient is feeling, what the patient is trying to say, what they need. The nurse will ask the patient a question or, just this morning, the nurse said to the patient, “Ruth, tell Doctor ____ exactly how your stomach and chest feels, the same way you told me this morning.” (MD)

I see nurses educate the patients, go the extra mile for them. (MD)

Part of autonomy and advocacy is respecting patient’s privacy; keeping the patient and family informed of what’s going on, in the loop, anticipating their needs. Advocacy is “feeling with,” getting for the patient and family what they want and need and what they would do for themselves if they were able.

Stewardship and Compassionate Caring

In addition to the 7 values just described that were cited by some interviewees in each of the 8 study

hospitals, stewardship (154 responses; 8%) and compassionate caring (115 responses; 6%) were described by interviewees on some units in 2 or 3 of the hospitals. Stewardship means that we wisely care for and share human, environmental, and financial resources held in trust, to serve needs now and in the future, entrusted to us in a spirit of accountability and responsibility for the common good. It means keeping on schedule so that you guard and value patients' time and energy, nurses' and physicians' time and energy, and are able to provide service to clients. An example was provided by staff on the cardiac rehabilitation unit:

An example of stewardship? Our program is more expensive, but we get better results. We monitor different things. It's not a money-maker, but the hospital backs us up because our outcomes are better.

Resources are finite, not limitless. We must be cognizant of this and use them wisely. From a practical, personal point of view, what does this mean? I am a resource for quality patient care. I must use my time, skills, competency wisely, give it to those patients who need it the most, and delegate work that can safely be done by techs to the techs. If a hospital runs out of resources, they go under, and then no one gets the care they need.

The core value described as compassionate caring had several components:

Practicing compassion means to care for all patients whether they can afford to pay or not, and you treat all equally and with respect whether they are paying or not. Compassion means to feel with the patient and family; it means empathy, tenderness and kindness and then wanting to do something about it.

Feeling for and understanding their suffering and then a desire—no, I'm driven to want to alleviate their suffering, to make things better.

It is a privilege to be with a person transitioning to everlasting life.

It's a deep feeling for and understanding of the misery and suffering of another person, and the concomitant desire to promote its alleviation. A "passion for nursing"—"a fire in the belly."

Summary

When the 1932 value responses cited by the 446 interviewees were grouped into 9 value categories, the dominant core values on all units in the 8 magnet hospitals were patient/family-centeredness and teamwork. Next, in order, were competent performance, family orientation and camaraderie, and respect, trust, and equality. In the next tier were integrity and honesty and clinical autonomy and patient advocacy. Staff nurses identified patient advocacy as

a dominant core value more frequently than did physicians. Physicians cited competent performance and autonomy more often and teamwork less often than did the other 2 groups. The 1932 value responses could have been grouped into 2 other broad categories: values that were patient focused and those that were staff focused. If this grouping had been used, the 2 patient-centered core values (patient first and autonomy and advocacy) would have accounted for 83% (n = 1604) of the total responses, justifying the conclusion that these 8 magnet hospitals had cultures in which the predominant value was concern for the patient.

Hospital Values

Core hospital values and descriptions as provided in hospital documents are presented in Table 2, listed in order of prevalence within the 8-hospital sample. Some, but not complete, correspondence exists between hospital values and unit core values. Allowance must be made for differences in how values are labeled and defined. Agreement between hospital and units is almost 100% for the top 4 values, the top 5 if collaboration and teamwork are considered the same:

1. Quality care, including advocacy and patient-centered values
2. Respect and equality
3. Integrity and honesty
4. Continual improvement and competent performance
5. Collaboration and teamwork.

For 2 unit core values, family orientation and camaraderie and autonomy and advocacy, the unit and hospital had no direct parallel. For 2 hospital values, community

Table 2 Presence of stated core values in 8 magnet hospitals

Core values and descriptions	Hospital							
	1	2	3	4	5	6	7	8
Quality care, clinically excellent care, amazing service including patient advocacy, holistic care	X	X	X	X	X	X	X	X
Respect for each individual, equality, honor the intrinsic dignity of those we serve and who serve	X	X	X	X	X	X		X
Integrity, honesty, fairness, adherence to ethical practice	X	X		X	X	X	X	X
Continual improvement, research, clinical innovation, constant pursuit of quality, growth	X	X	X	X	X	X	X	
Stewardship, efficient and responsible use of all resources, responsibility	X		X	X	X		X	X
Compassion	X		X	X		X	X	
Community (make a positive difference in health of the community we serve)		X	X		X	X	X	
Collaboration (join others in commitment to the common good), teamwork including fun, enjoy				X		X	X	X
Justice, care for all, especially poor and vulnerable; health care is a right			X	X		X		
Teamwork	X				X			
Hospitality (courteous and generous reception of all persons)								X

and hospitality, the hospital and unit had no direct parallel. In general, unit values are focused inward, and hospital core values are more outwardly focused.

Although the 8 hospitals had many commonalities in the core values, they also had unique differences, making each hospital individual and “special” to the various communities the hospital serves. Some hospitals were more family oriented than others were; some were research focused and emphasized the advancement of technology, including robotics; others placed high value on commitment and loyalty to the hospital and to the corporation. Two hospitals were characterized by particularly “giving” environments: giving to the patients, to employees, and to the community. In one of these hospitals, nurses donated some of their accumulated leave hours either to provide special duty care for extremely critically ill patients or to hire special duty nurses for such care.

No attempt was made to identify norms related to hospital values as

was done with the unit values. Considerable evidence indicated that hospital values were “talked.” The values were prominently posted near the central elevators, in the lobby, and on the way to the cafeteria; displayed in the hospital logo or stationary; and often inscribed on the reverse side of employee name badges. Being able to quickly list a hospital’s core values does not mean that the values were “normed” or “walked.” A parallel analogy was presented by one of the speakers at the 2006 National Teaching Institute conference in Anaheim, California. The speaker was describing procedures used in conjunction with introducing companionship dogs into hospital settings. In addition to requirements for physical check-ups and for name badges with photo identification that were affixed to a dog’s collar, the back of every dog’s name badge listed the hospital core values. The speaker jokingly mentioned that this was done so that, when requested, the dog could bark out the core values

for members of the Joint Commission or other visitors. In summary, we can say that some of the core hospital values extend to the unit level, where considerable evidence indicates that staff, managers, and the team build and nurture a unit culture, including appropriate values and corresponding norms.

What These Findings Mean to Critical Care Nurses

A mark of excellence in organizations is the extent to which a system of common and shared core values is in place, values that go beyond the technical requirements of a job and convert neutral organizations into viable, dynamic institutions.⁴⁰ Going beyond the technical requirements is what the administrators, the nurse managers, and the staff in excellent hospitals have done. What makes for dynamic organizations or units is the extent to which common core values are normed or walked. Only the staff, the team, can translate values into norms (ie, “commonly agreed-upon

ways of behaving³³) or, to use the metaphor, walk the values. Through their actions, nurses decide “how we practice nursing here.” “On this unit we do it this way” is a frequently used preface to the expression of a norm. In addition to being involved in the development of values and norms, staff must also be involved in their transmission to newcomers, and in changing values and norms when necessary. The following excerpt from an interviewee says it far better than we could:

On this unit, we help one another. Nobody goes home till everyone is done. You watch out for the other guy and their patients. If you see they are getting swamped or a patient is in difficulty, you go and help. You don’t wait to be asked. You just go and do. . . .

Mary transferred into our unit from the neuro ICU and that’s not the way they do it there. They practice like cowboys and loners down there. We told her that if she wanted to “fit in” here, this is what she would have to do. At first, we wanted to say, “Look, if you don’t do it this way, we’re never going to come and help you,” but you can’t really do that because that’s taking it out on her

patients. Then, something I learned in school. You norm your values by controlling consequences. So that’s what we did. We didn’t make her feel a part of the group until she could see the benefits of everyone working together. There may be some units where the “lone cowboy” approach is best, but it’s not here.

We did not pursue identification of the norms through which hospital values are operationalized or walked. However, increasing evidence indicates that determination of the norms is necessary. Just as clinical nurses need to be able to present the evidence for the autonomous decisions they make, managers need to use evidence-based management results to inform managers’ decisions. Pfeffer and Sutton⁴² note that in order to make evidence-based decisions the “new cultural norm,” leaders must ask subordinates for the evidence to support the need and efficacy for changes the subordinates propose. Many nurses in magnet hospitals have noted that in order to sustain excellence and quality patient care, the values represented by the Forces of Magnetism must become entrenched and part of the culture of the organization. To accomplish this, the values represented by the Forces must be translated into action (norms).⁴³ Some investigators⁴⁴ have attempted to measure the impact of hospital culture (values and norms) on the outcomes of care. If such research is to continue, and it should, we need more information and data on the

norms that support a hospital’s cultural values.

The articulateness of the interviewees in describing their values, putting into words and exemplifying abstract concepts was truly amazing. Educators and staff development would do well to have their students and orientees read the excerpts that these interviewees used to describe values such as autonomy and advocacy, which are at the very heart of nursing.

Conclusion

Control of nursing practice and a patient-centered culture promote both the quality of nurses’ work environments and the quality of patient care. Control of nursing practice enables nurses to control/improve the context of nursing practice; use of evidence-based practices enables nurses to improve the quality of care provided to patients. Culture is the normative glue that preserves and strengthens the group and provides the healing warmth essential to quality care. Walk the talk is a best practice through which the values of unit and hospital culture are lived and control of nursing practice by nurses can be achieved. The 8 attributes of a healthy work environment identified by staff nurses in magnet hospitals must become part of the hospital and unit culture if excellence and quality in patient care are to prevail.

Walk the talk is also one of the role behaviors of nurse managers universally identified by staff nurses as supportive. In the next article in this series, we present the results of studies related to the last 2 essentials of a healthy work environment: nurse manager support and perceived adequacy of staffing. CCN



To learn more about patient-focused care, read “Changing the Work Environment in Intensive Care Units to Achieve Patient-Focused Care: The Time Has Come,” by Kathleen McCauley and Richard S. Irwin in the *American Journal of Critical Care*, 2006;15: 541-548. Available at www.ajconline.org.

Now that you've read the article, create or contribute to an online discussion about this topic using eLetters. Just visit www.ccnonline.org and click "Respond to This Article" in either the full-text or PDF view of the article.

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