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Abstract

Aims

This review aimed to synthesize literature describing the development and/or implementation and/or evaluation of a professional practice model (PPM) to determine the key model components.

Background

A PPM depicts nursing values and defines structures and processes that support nurses to control their own practice and deliver quality care.

Evaluation

A review of English language papers published up to August 2014 identified 51 articles that described 38 PPMs. Articles were subjected to qualitative analysis to identify the concepts common to all PPMs.

Key issues

Key elements of PPMs were theoretical foundation and six common components: leadership; nurses' independent and collaborative practice; environment; nurse development and reward; research/innovation; and patient outcomes.

Conclusions

A PPM provides the foundations for quality nursing practice. This review is an important resource for nurse leaders who seek to advance their organization in a journey for excellence through the implementation of a PPM.

Implications for Nursing Management

This summary of published PPMs provides a guide for nurse leaders who seek to develop a PPM. The essential elements of a PPM; theoretical foundation and six common components, are clearly described. These elements can provide the starting point for nurse leaders' discussions with staff to shape a PPM that is meaningful to direct care nurses.

Keywords

Professional practice model, Magnet, shared governance, leadership, empowerment, nursing

BACKGROUND

The dual imperative to retain a skilled nursing workforce and achieve better patient experiences is evident worldwide (Duffield et al., 2011, Auerbach et al., 2013, Chan et al., 2013, Lartey et al., 2014). The enquiry into the failure of care at the Mid-Staffordshire Hospital in the United Kingdom (UK) emphasized the need for staff to be engaged and committed to ensure good clinical care (Roberts, 2013). The quality of hospital care environments has been shown to influence nurses' commitment, satisfaction and consequent patient outcomes (Aiken et al., 2008, Friese et al., 2008, McHugh et al., 2013). A Professional Practice Model (PPM) for nursing provides the foundation for safe, high-quality, patient-centered care. A PPM is a conceptual framework that enables nurses in an organization to envision and communicate their practice. The PPM depicts nursing values and defines the structures and processes that support nurses to control their practice and the care environment (Hoffart and Woods, 1996). The Magnet Recognition Program®, originating in the United States (US) has provided the impetus for the implementation of nursing PPMs across US health care settings (Latta and Davis-Kirsch, 2011, Mensik et al., 2011, Harwood et al., 2013, Johnson and Ezekielian, 2014). Based on the Magnet® theoretical framework, PPMs are associated with nurse satisfaction and organizational engagement (Kelly et al., 2011).

Evidence of better outcomes for nurses and those they care for provides an impetus for wide application of PPMs as nurse leaders seek innovative solutions to common problems of rising health system pressures and looming staff shortages. However the PPM concept and terminology is likely to be new and potentially difficult to navigate for nurses unfamiliar with the Magnet® theoretical framework, particularly those in international settings. This review sought to appraise PPMs published to date and synthesize the common components. While the characteristics of practice environments that support professional nursing may seem intuitive, a concise summary of key elements provides a robust basis for model development. Similarly, the findings provide direction for nurse leaders who seek to implement a PPM in their own organizations, not only those on the journey to Magnet® recognition but wherever nurses pursue excellence in nursing.

METHOD

Aim

The aims of this review were (a) to identify published literature describing PPMs developed to date, and (b) to synthesize their key elements.

Inclusion Criteria

All English language papers up until August 2014 that described the development and/or implementation and/or evaluation of a nursing PPM were included. It was decided not to limit the inclusion criteria to current literature (i.e. previous five years) in order to capture seminal works in the area (McDonagh,

1989, Zelauskas and Howes, 1992, Wolf et al., 1994, Hoffart and Woods, 1996, O'Hara et al., 2003). Eligible articles were not limited to empirical research but included theoretical papers, discussions and commentaries to obtain all PPMs published to date.

Search Strategy

The search was undertaken using five electronic databases: CINAHL, MEDLINE, EMBASE, Scopus, and ISI Web of Science. Initially, a search was conducted using six terms: *professional* and *practice* and *model* and *magnet* and *nurs** and *conceptual framework.* The search terms were adapted for the different databases, and all terms were searched with Medical Subject Headings and as key (text) words. Prominent concepts identified in this preliminary review informed a further search using key words: *shared governance* and *shared leadership* and *advancement programs* and *peer review* and *autonomy* and *decision-making*. The references of all included articles were checked, and citing articles sought using citation alert with ISI Web of Knowledge. The study retrieval process is summarized in Figure 1.

Screening

Two researchers independently screened the article titles and abstracts to identify relevant papers. Discrepancies were resolved through joint discussion and a total of 39 papers were retained for analysis. Both researchers then independently reviewed the reference lists of the selected articles and agreed on the inclusion of a further 12 articles.

Data Extraction

The included studies were reviewed to extract the following data:

- Location.
- Setting.
- Theoretical foundation.
- Approach to development and/or, implementation and/or evaluation.
- Key components of the model.

Data synthesis

Descriptive data were extracted. Synthesis of the key PPM concepts was conducted using constant comparison analysis (Glaser and Strauss, 1967, Onwuegbuzie et al., 2012). Each document was read in its entirety and then examined line-by-line to identify meaningful words, phrases and sentences, which were coded with descriptive labels. Chunks of coded text were then clustered to develop themes in the data that described the common model components (Onwuegbuzie et al., 2012). Two researchers undertook coding independently to confirm the reliability of the emergent categories and themes. Inconsistencies were resolved by joint review and discussion with a third researcher. Conceptual links between categories crystalized during report writing.

RESULTS

The 51 included articles described the features of 38 PPMs. Table One briefly summarizes the characteristics of the included PPMs.

Location and Setting of PPMs

The majority of published PPMs were developed in the US (n=34), with others being from Australia (n=1), Canada (n=1), Ireland (n=1), and the Middle East (n=1). The results of this review chronicled the development of the PPM concept from early models implemented primarily in single units (Boyd et al., 1990, Zelauskas and Howes, 1992, Tyler, 1993, Wolf et al., 1994) to the most common hospital-wide models and, later, system-wide applications (McCrea et al., 2003, Wolf et al., 2004, Mensik et al., 2011, Berger et al., 2012). A Canadian model developed from the work of Wolf et al. (1994) was tailored to a renal nursing service comprising of several units (Harwood et al., 2003, Harwood et al., 2013). The synthesis of the identified PPMs revealed that the vast majority had a theoretical grounding, whether in a key concept, the organization's core values, or one or more external theories. Six components common to all PPMs were also apparent. These essential elements of a PPM are summarized in Figure 2.

Theoretical Foundation of a PPM

A PPM is by its nature a theoretical framework for professional nursing practice. The findings of this review indicated that PPMs were commonly grounded in a well-established nursing concept, such as shared governance or relationship-based care or a selected theory or theories. The majority of models also incorporated organizational core values. Only two PPMs did not describe a theoretical foundation (Zelauskas and Howes, 1992, Cann and Gardner, 2012). The development of PPMs from fledgling shared governance models (McDonagh, 1989, Wong et al., 1993) to highly evolved systems integrating nursing and/or organizational theory (Robinson et al., 2003, Hitchings et al., 2010, Erickson and Ditomassi, 2011, Small and Small, 2011, Harwood et al., 2013, Johnson and Ezekielian, 2014) was evident. An overview of common concepts and types of theories selected by nurse leaders to shape a PPM for their setting is provided below.

Concept

The concept of shared governance as the basis for a PPM was a recurring theme in the data. Shared governance refers to structures and practices that endow nurses at all levels with the ability to influence decision-making (Kramer et al., 2009). Unit and institutional level councils provide mechanisms through which nurses have input into organizational affairs supported by management that allows nurses latitude to control their own practice. PPMs based on shared governance were seen by nurse leaders to empower clinical nurses.

Early shared governance models sought to promote nurses' autonomy and accountability within hospital bureaucracies (McDonagh, 1989, Parkman and Loveridge, 1994). It was thought that making nurses' decision-making visible fostered ownership of those decisions (McDonagh, 1989, Massaro et al., 1996). Related concepts were ownership, accountability and partnership (Kramer et al., 2009). For example one PPM, described as a partnership model, included unit-level "governance" (p. 35) where nurses of various levels partnered to manage care and support professional development (Hastings, 1995). Another PPM developed in 1996 and revised in 2006 was founded upon the concept of collaborative governance (Erickson and Ditomassi, 1998, Erickson et al., 2003, Erickson and Ditomassi, 2011). Again, the impetus was to empower nurses through increased organizational participation and accountable decision-making. Shared governance proved to be an enduring concept with a number of later PPMs defined by nurses' participation in councils and committees designed to empower shared decision-making (Newcomb et al., 2009, Sharkey et al., 2009, Dickey, 2012, McGlynn et al., 2012, George and Lovering, 2013). Along with organizational values, concepts used to ground PPMs included the Forces of Magnetism (Hitchings et al., 2005, Hitchings et al., 2010) and, commonly, the linked concepts of caring and relationships which aligned with long held organizational nursing principles (McCrea et al., 2003, Duffy et al., 2007, Latta and Davis-Kirsch, 2011, Edmundson, 2012).

Organizational core values

In some PPMs, nurse leaders chose to use their hospital's or system's core values as the conceptual base for the PPM. This approach ensured that nursing was thoroughly integrated with and reflective of the organizational culture (Boyd et al., 1990, McCrea et al., 2003, Duffy et al., 2007). In others, nurse leaders sought nursing theories to which caring relationships were central (Latta and Davis-Kirsch, 2011, Mathes, 2011) to provide a philosophical foundation and support model components.

External theory

A number of PPMs were grounded in theory explaining the nature of nursing care; most commonly Swanson's (1991) middle range theory of caring (Latta and Davis-Kirsch, 2011, Tonges and Ray, 2011, Berger et al., 2012), Watson's (2008) science of human caring (Sharkey et al., 2009, Mathes, 2011, Ondrejka and Barnard, 2011), and the work of Nightingale (Ondrejka and Barnard, 2011, Dickey, 2012). Koloroutis's (2004) relationship-based care was another commonly used theory, whether by itself or in combination with Swanson's (1991) or Watson's (2008) work (Latta and Davis-Kirsch, 2011, Mathes, 2011, Small and Small, 2011).

An alternative to caring theory was to use Benner's (1984) seminal work explaining the development of nursing expertise. Her novice to expert framework provided a standalone basis for one PPM built on the premise that a supported, effective nursing workforce will deliver quality care (O'Hara et al., 2003, Robinson et al., 2003). Benner's (1984) model was also used in conjunction with other theory or

concepts to inform particular aspects of the PPM, such as a clinical advancement program (Jost and Rich, 2010), narrative culture (Erickson and Ditomassi, 2011) or transformational model (Harwood et al., 2007a, Harwood et al., 2007b). Taking a different approach, The Roy Adaption Model (Roy and Andrews, 1991) guided the development of nursing standards in one shared governance model (Parkman and Loveridge, 1994). The addition of components, such as a care delivery system and career advancement program, saw the model evolve into a mature PPM as nurses became more skilled in defining and measuring their practice (Parkman and Loveridge, 1994).

Another option was to shape the PPM using organizational theory. In essence, organizational theory accounts for the relationship between organizational characteristics and work outcomes, in this context the delivery of quality nursing care. An early example was the experimental Enhanced Professional Practice Model (EPPM) developed using Structural Contingency Theory in the 1980s and tested in five nursing units across three US hospitals (Ingersoll et al., 1996). This theory postulates that organizational practices are defined both by the specialization to complete a unique task and by the need to integrate and collaborate to achieve an outcome. In practice, the EPPM supported direct care nurses to assess levels of complexity in their areas and develop structures tailored to their unit's needs.

Later, one US hospital used organizational theory to directly link expert nursing practice to the organizational goals (Ingersoll et al., 2005). Its PPM integrated two such theories in recognition of the complexity of healthcare. These were Sociotechnical Systems Theory (Happ, 1993) which pertains to environmental, social and technological influences on organizational culture, and Senge's Fifth Discipline Model (1990), where positive interactions and ongoing learning lead to systems thinking and consequent positive outcomes.

Alternative sources of theory to ground a PPM included models developed in an author's earlier work (Wolf et al., 2004, Meehan, 2012, George and Lovering, 2013) or adopted from other settings (Mullen and Asher, 2007, Edmundson, 2012, Harwood et al., 2013). One PPM was described in a theoretical paper that integrated Carper's Patterns of Knowing and Aristotle's intellectual virtues into a model for practice (Bennett Jacobs, 2013).

Regardless of the theoretical foundation, our review identified six components common to all PPMs. These were: (a) leadership, (b) nurses' independent and collaborative practice; (c) environment; (d) research/innovation; (e) nurse development and rewards, and (f) patient outcomes. Although interlinked in practice, these key components are described as discrete entities. Selected examples of PPMs that exemplify each component are provided.

Key components of the model

Leadership

A key concept across the PPMs was that of nurses as leaders, both within the organization and of clinical patient care. Nursing leadership at organizational level related to nurses having an equal voice in

interdisciplinary forums and the operational power to define nursing practice at unit and institution level (Harwood et al., 2003, George and Lovering, 2013, Harwood et al., 2013). Leadership in this context aligned closely with shared governance, and committee structures through which nurses of all levels could lead system decision-making (Latta and Davis-Kirsch, 2011, Tonges and Ray, 2011, Johnson and Ezekielian, 2014). Moreover, a PPM provided processes to develop nurse leaders to ensure leadership continuity (Jost and Rich, 2010, Latta and Davis-Kirsch, 2011).

A PPM empowered direct care nurses to lead clinical care within interdisciplinary teams. A clinical leader is one who uses their expertise and communication skills to act as a role model and motivate others to deliver quality care (Stanley, 2006). Authentic leadership was a fundamental layer in the pyramid-shaped PPM at one hospital (Jost and Rich, 2010). As authentic leaders, all nurses were coordinators of care; able to champion collaborative solutions and invested in lifelong learning and self-renewal. Taking a different approach, the serving leader was one of three fundamental concepts in the PPM enacted across one health system (Small and Small, 2011). This PPM integrated the notion that all nurses lead at some level with the imperative that patients and families participate in their own care. Despite the various interpretations, leadership and the use of a PPM to articulate nurses' roles as organizational and clinical leaders was a constant in this review. Similarly, recurrent themes indicated that PPMs provided a framework for nurses' independent and collaborative practice in the delivery of quality patient care.

Nurses' Independent and Collaborative Practice

Nurses' independence in clinical care and in defining the scope and credentialing of nursing practice was underpinned by two concepts: autonomy and accountability. *Autonomy* related to nurses' right to manage one's own decision-making within collaborative teams (Hoffart and Woods, 1996, Arford and Zone-Smith, 2005). For example, one PPM described two domains, professional self-confidence and professional visibility, which came together as "professional authority" (p. 2909) and consequent optimal patient outcomes (Meehan, 2012). Shared governance, embodied by councilor structures fostered autonomy, providing nurses with a voice and a forum through which to advocate for patients and themselves (McGlynn et al., 2012). *Accountability* provided the framework for nurses' autonomous decision-making and responsibility to deliver best practice. Integration of practice standards into a PPM, such as those developed by the American Nurses Association provide defined criteria for safe and quality clinical care (Mensik et al., 2011). Responsibility shifts to the individual nurse to demonstrate competence in specialized skills required to meet such standards (George and Lovering, 2013). At an organizational level, accountability related to shared governance and nurses having control over the scope of and credentials required for nursing practice.

The PPMs recognized that while nurses work autonomously, they rarely work in isolation (Duffy et al., 2007, Jost and Rich, 2010). Rather, collaboration and communication were essential to nurses' role as coordinators of care (Berger et al., 2012). C*ollaboration* related to nurses' relationships with both patients

and other health professionals. Collaboration with other health disciplines facilitated interdisciplinary partnerships and a respectful workplace (Jost and Rich, 2010). Collaboration was effected through *communication,* for which all nurses were responsible, and which was considered crucial to care delivery in a technical practice environment (Robinson et al., 2003, Jost and Rich, 2010)

Environment

A number of PPMs specified the nurses' practice environment as a component that was referred to in one of two ways. Firstly, the environment contributed to the quality of nurse-patient relationships and, therefore, to care delivery. Three PPMs exemplified this link by including elements essential to a healing environment (Duffy et al., 2007, Small and Small, 2011, Johnson and Ezekielian, 2014). Secondly, the environment related to the workplace where a healthy work environment promoted the retention of nurses (Latta and Davis-Kirsch, 2011). A respectful work environment was also seen to facilitate interdisciplinary collaboration as the basis for quality care (Jost and Rich, 2010).

Nurse Development and Recognition

A prominent theme was that a PPM should provide a framework to support the professional development of nurses. Firstly, nurses required critical thinking and technical expertise to inform independent and collaborative practice (Erickson and Ditomassi, 2011, Murphy et al., 2011). Secondly, the advancement and recognition of nurses were positively linked to nurse retention (Erickson and Ditomassi, 2011). One PPM was effectively a clinical advancement model, founded on the assumption that the development of nurses would facilitate an effective workforce and, ultimately, improved patient outcomes (Robinson et al., 2003). The concept of compensating nurses was closely linked to their professional growth (Erickson and Ditomassi, 2011, Latta and Davis-Kirsch, 2011). Accordingly, a number of PPMs required a revision of nurses' job descriptions to reflect desired competencies, and performance appraisal systems to drive nurses' development (Duffy et al., 2007, Mullen and Asher, 2007, Murphy et al., 2011).

Research/Innovation

Nurses' clinical advancement was underpinned by knowledge discovery and translation, and the use of evidence-based practice. Berger et al. (2012) referred to the body of knowledge that characterizes nursing as a profession. The concept of generating knowledge to support nurses' expert care was variously termed as research, clinical inquiry, innovation and translational research, innovation and improvement, (Mullen and Asher, 2007, Hitchings et al., 2010, Erickson and Ditomassi, 2011, Latta and Davis-Kirsch, 2011, Johnson and Ezekielian, 2014). Together these elements embodied nurses' systematic problem solving and leadership in providing quality care.

Patient outcomes

The ultimate aim of a PPM was to provide structures and processes that empowered nurses to achieve quality outcomes. With the five preceding components in place, nurses were well placed to improve patient and family experiences and satisfaction. The PPMs emphasized the interaction between nurse and patient (or family) and resourcing nurses to influence the quality of care at unit and organizational level. Accordingly, many PPMs were represented schematically with patient outcomes placed either centrally or encircling the structures that supported professional nursing activities (McCrea et al., 2003, Duffy et al., 2007, Sharkey et al., 2009, Latta and Davis-Kirsch, 2011, Mathes, 2011, Mensik et al., 2011, Ondrejka and Barnard, 2011, Small and Small, 2011, Dickey, 2012, Harwood et al., 2013, Johnson and Ezekielian, 2014).

The six preceding concepts were found in all PPMs included in this review. There was considerable variation in the terminology used to describe these concepts and the way they were linked within the models. This was because each PPM was developed by nurses to reflect the culture of nursing in their individual setting. It was evident that this was a sizeable undertaking, but necessary if nurses were to see the PPM as relevant to everyday practice.

Development, Implementation and Evaluation of PPMs

While the focus of this review was to identify essential components of a PPM, several key points about model development, implementation and evaluation emerged. Twenty-eight of the 38 identified PPMs described the process of model development at least in part (see Table 1). Very few were developed solely by nurse leaders. Rather, nurses were supported to interpret nursing in their organization through focus groups, councils, retreats or surveys. The starting point was commonly a philosophy, theory or concept with historical significance or identified from the literature. An iterative process driven by a steering group then ensued to refine the model. The scale of this undertaking increased significantly when organizations sought to redesign job descriptions and/or clinical advancement ladders to align with the PPM.

Implementation of the PPM was described in 29 models. A broad reading of the papers included in this review indicated that use of clear language and a catchy education program facilitated uptake of a PPM into nurses' everyday practice. Strategies included: a) communication (i.e. face-to-face discussion, newsletters, posters); b) education; c) use of champions; d) creation of councilor structures to facilitate nurses' participation in unit and hospital decision-making; and e) formalized self-scheduling, reward and recognition. The majority of published PPMs included a visual model. Simplicity in the model and in the language was fundamental to the uptake of a PPM.

Of the 38 PPMs located, 26 had been evaluated to some degree. Earlier models tended to report anecdotal evidence, while later evaluations compared pre and post implementation data related to patient outcomes (satisfaction, clinical outcomes, and call bell use) and/or nurse outcomes (satisfaction,

experience of the practice environment, organizational commitment, and turnover). Several used comparative data to analyze cost implications (Wong et al., 1993, Witzel et al., 1996).

Discussion

Our review of published PPMs to date revealed that the concept of a model for professional nursing practice has not only survived but evolved over time. Literature from the late 1980s and early 1990s captured this journey. It was evident that a robust PPM integrates aspects of nursing practice in a way that is easily understood by nurses at all levels. Widespread consultation is necessary if nurses are to interpret the integral parts of the PPM to be meaningful and articulated by all.

Nurses' decisions to ground PPMs in theories of nursing care speak to the centrality of the patient, interpersonal interaction, and healing environments. The work of Benner (1984) provided structure for nurses' clinical advancement, while organizational theories delineate structures and systems that resourced nurses for optimal performance. It was evident that the related concepts of shared governance and nursing leadership were central to a PPM that supported nurses to have control over nursing practice and equal participation in organizational decision-making. While shared governance provides robust structures for nurses to have a voice, it is leadership that promotes nurses' autonomy and accountability at all levels which ensures they truly control their own practice.

Access to information and support through participation in organizational forums and interdisciplinary collaboration has been shown to increase perceived autonomy and job satisfaction (Laschinger and Finegan, 2005). With these in place, nurses have a platform for autonomous decision-making within a framework of accountability, professional standards and collaboration. Collaboration emphasizes the caring relationship with patients and recognizes that nurses do not practice alone but in partnership with their multidisciplinary colleagues. Analysis of the PPMs revealed that quality patient outcomes were closely linked to positive practice environments. Such environments are imbued with visionary leaders, collaborative relationships and empowered nurses who feel able to produce positive patient outcomes and experience subsequent job satisfaction (Kramer et al., 2011).

There has been a drive to implement PPMs, particularly through the Magnet Recognition Program®. However, it is evident that a PPM provides the foundations for quality nursing practice. Amidst current pressures to retain an engaged nursing workforce to ensure quality patient outcomes, it would seem a PPM is more important than ever.

Strengths and Limitations

The strength of this review is that it presents a comprehensive review of published PPMs in simple terms that can assist nurse leaders who are unfamiliar with Magnet® to implement a PPM. The findings provide direction for practice and future research. Despite the broad inclusion criteria, it is possible that some articles describing a PPM were not identified by our search. We may have omitted relevant search

terms or missed articles where a PPM was not the focus of the paper. Additionally, the need to include discussion and review papers in order to capture all PPMs precluded a systematic quality appraisal of included articles.

Conclusion

This review of PPM literature provides an important resource for nurse leaders who seek to advance their organization in a journey for excellence. The essential elements of a PPM are clearly described and would be helpful to support nurses' efforts to promote a positive practice environment and patient outcomes. While the quest for Magnet® designation is often the catalyst for model development, implementation of a PPM provides the foundation for quality nursing practice and applicable wherever nurses pursue excellence in nursing.

Implications for Nursing Management

Implications for practice

This summary of published PPMs provides a guide for nurse leaders who seek to develop a PPM. The essential elements of a PPM; theoretical foundation and six common components, are described. A PPM requires a conceptual base and several options are provided. Nurse leaders may wish to consider key concepts or external theory, drawn from nursing or organizational disciplines, which resonate with nursing in their setting. The concept of shared governance is central and provides committee structures giving nurses a voice at unit and organizational level. Nursing leadership supports nurses to use such structures to full effect and was the first of the six components emerging from this synthesis of PPMs. These components can provide a starting point for nurse leaders' discussions with direct care nurses to shape a model that will reflect the culture and practice of nursing for them. To be successful a PPM must be meaningful to nurses and simply described. The implementation of a PPM is a significant undertaking but once achieved will provide the foundations for quality nursing practice.

Implications for research

Further research to evaluate the benefits of a PPM is warranted to add to the evidence base. Quantitative methods are appropriate to capture changes in nurse satisfaction and retention, measurement of the practice environment and improved patient outcomes. Qualitative approaches can be used to explore nurse and patient experiences of a PPM and how these contribute to outcomes.

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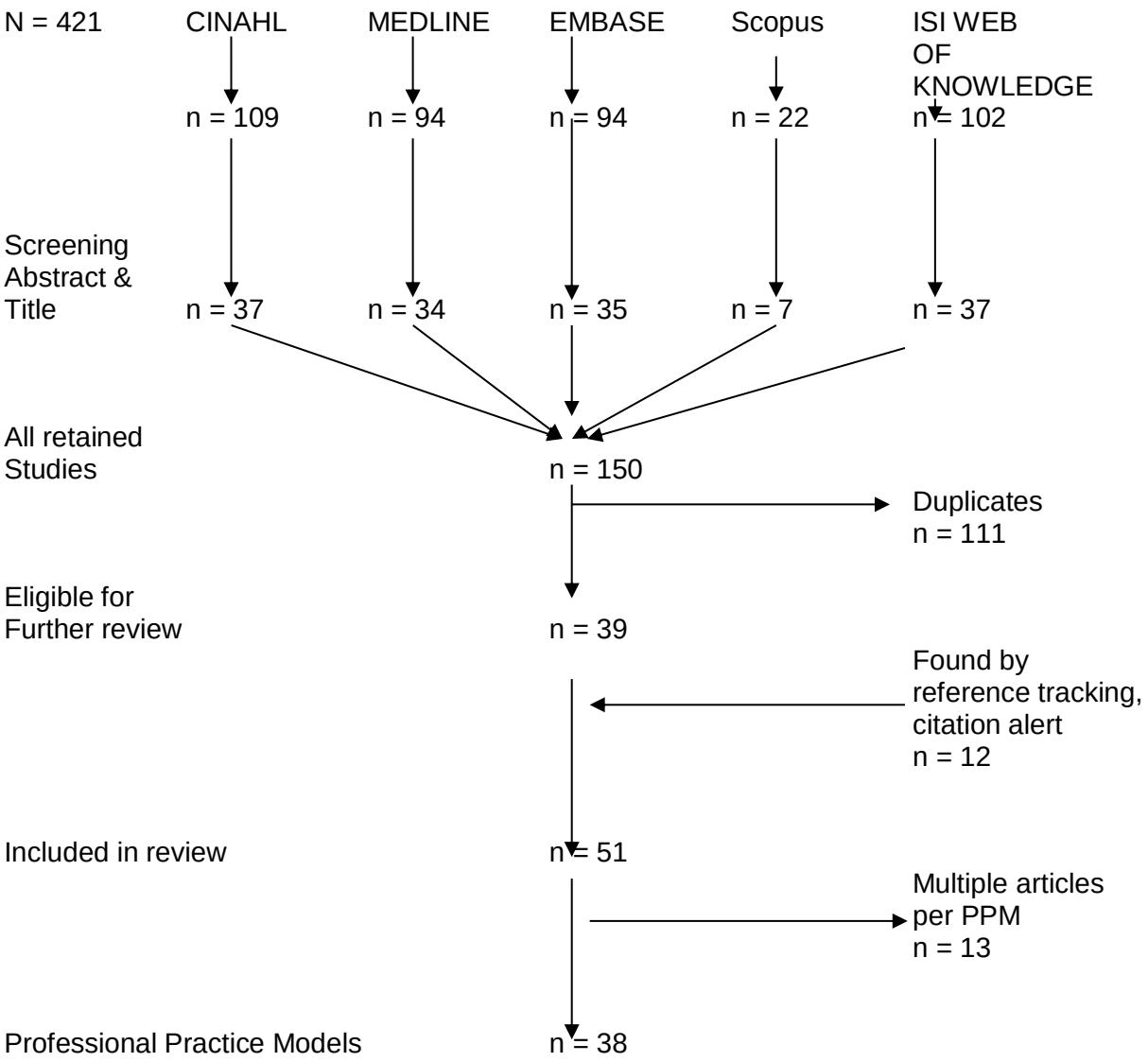

Figure 1 – Flow Diagram of search results and study selection

Figure 2. Essential elements of a PPM

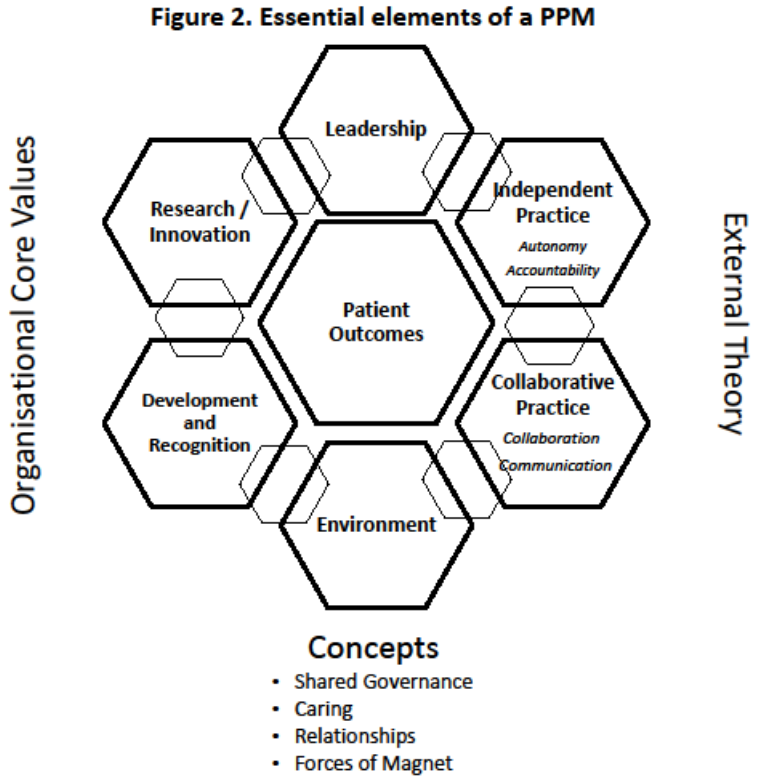

Table 1. Brief summary of characteristics of included professional practice models (from most recent year of publication)

LOCATION	1st NAMED AUTHOR	YEAR	SETTING	BRIEF SUMMARY OF KEY COMPONENTS
Ohio, US	Johnson	2014	Hospital-wide	Leadership/governance; Professional relationships; Innovation/research; Patient care; Development/recognition
Saudi Arabia	George	2013	Hospital-wide	Shared leadership; Accountability/privileging; Partnership; Patient/family as focus of care; Professional nursing; Professional development
Connecticut, US	Bennett Jacobs	2013	Not stated	Human flourishing; Art of nursing; Advocacy of nursing; Science of nursing; Ethics of nursing
Kentucky, US	Berger	2012	System-wide	'I provide excellent care; 'I believe; 'I commit to'; 'I am accountable for'; 'I achieve'
Queensland, Australia	Cann	2012	Hospital-wide	Not stated
Ohio, US	Dickey	2012	Hospital-wide	Health promotion; Nursing practice; Patient advocacy/outcomes; Evidence-based practice; Environment; Interdisciplinary relationships; Unit-based care delivery model
New York, US	McGlynn	2012	Hospital-wide	Leadership; Professionalism; Excellence/safety; Caring/honoring the human spirit; Collaboration
Kansas, US	Edmundson	2012	Hospital-wide	Caring for patients and families; Caring for each other; Caring for community; Caring for self; Quality Caring Model©; Mutual problem

				solving; Attentive reassurance; Respect/encouraging manner; Healing environment
Ireland	Meehan	2012	Not stated	Therapeutic milieu; Practice competence; Professional authority; Management of practice; Influence in health systems
North Carolina, US	Tonges	2011	Hospital-wide	Relationship-based care delivery; Leadership; Compensation/rewards; Professional nursing values; Professional relationships
Washington, US	Latta	2011	Hospital-wide	Excellent patient/family outcomes; **C**ompetence; **H**ealth; **I**ntegrity; **L**eadership; **D**iversity
Louisiana, US	Mathes	2011	Hospital-wide	Patient and family; Relationship-based care; Watson's caring theory
Western states, US	Mensik	2011	System-wide	Excellent patient care; Contribution to patient; Contribution to profession; Contribution to society
Illinois, US	Murphy	2011	Hospital-wide	Relationships and caring; Leadership; Critical thinking; Evidence-based practice; Technical expertise
Colorado, US	Ondrejka	2011	Hospital-wide	Nurse; Environment and caring; Patient/family; Advocacy through caring; Quality nursing practice
Ohio, US	Small	2011	System-wide	Shared vision; Quality/safety; Healing environment; Research/evidence-based practice; Professional development
Pennsylvania, US	Hitchings Hitchings	2005 2010	Hospital-wide	Clinical practice; Quality; Professional excellence; Research; Collegial review/recognition

Pennsylvania, US	Jost	2010	Hospital-wide	World-class patient care; Integrated primary nursing; Translational research; Evidence-based practice; Partnerships; Shared governance; Authentic leadership; Respectful workplace; Communication; Collaboration
Georgia, US	Sharkey	2009	Hospital-wide	Patient/family; Compassion/healing; Leadership; Research; Professional development; Excellence
Texas, US	Newcomb	2009	Hospital-wide	Family-centered care; Collaboration; Respect; Critical thinking; Professional development; Art and science
Maryland, US	Duffy	2007	Hospital-wide	Patients/families; Communication; Nursing responsibility; Caring practices; Environment
Midwest, US	Mullen	2007	Hospital-wide	Patient needs: Complexity; Vulnerability; Participation in decision-making/care; Resource availability Nurse competencies: Clinical judgment; Caring practices; Advocacy; Collaboration; Systems thinking; Clinical inquiry; Facilitator of learning
Ontario, Canada	Harwood Harwood Harwood Harwood	2003 2007a 2007b 2013	Service-wide (renal program)	Professional practice component: Leadership; Collaborative practice; Care delivery system; Communication; Professional development Process component; Outcome component
New York, US	Ingersoll	2005	Hospital-wide	Social; Technical; System Expert practice; Nursing outcomes; Patient/family outcomes; Organizational outcomes

Pennsylvania, US	Wolf	2004	System-wide	Professional practice: Transformational leadership; Care delivery; Professional growth; Collaborative practice
Tennessee, US	Robinson O'Hara	2003 2003	Hospital-wide	Six key functions: Continuous learning; Communication/collaboration; Problem solving; Patient/family education; Continuum of care planning; Planning/managing care
California; Texas, US	McCrea	2003	System-wide	Excellence; Leadership development; Shared governance; Culture/caring; Collaboration; Clinical practice; Care delivery model; Clinical ladders
East coast, US	Erickson Erickson Erickson	1998 2003 2011	Hospital-wide	*1996* Values/philosophy; Practice standards; Collaborative decision-making; Professional development; Patient care delivery model; Credentialing/peer review; Research *2006* Vision /values; Practice standards; Innovation/entrepreneurial teamwork; Clinical recognition/advancement; Research; Patient care delivery model; Collaborative decision-making; Narrative culture; Professional development
Ohio, US	Pierce	1996	Unit-based	Not described
Florida, US	Massaro	1996	Unit-based	"Quality circles": Functional responsibility; Accountability; Implementing solutions; Primary nursing delivery system; Decentralized decision-making; Salary compensation; Self-scheduling

Maryland, US	Hastings	1995	Unit-based	Partnership levels: Managing partner – nurse manager; Senior partners – unit leaders; Full partners –experienced nurses; Associate partners – new nurses
California, US	Parkman	1994	Hospital-wide	Environment; Managed care; Standards of care; Shared governance; Unit-based quality improvement; Peer review; Career advancement program
Pennsylvania, US	Wolf Wolf	1994 1994	Unit-based	Relationship between patient/nurse/physician; Transformational leadership; Collaborative practice; Care delivery system; Professional growth
New York, US	Ingersoll Ingersoll Hoffart Witzel Ingersoll	1993 1995 1995 1996 1996	Unit-based (n=5 units across 3 hospitals)	Collaborative practice; Continuity of care; Continuing professional development; Control over nursing practice; Compensation/ recognition/reward
Maryland, US	Tyler Wong	1993 1993	Unit-based	Decision-making; Problem solving; Written agreements; Financial incentives
Maryland, US	Zelauskas	1992	Unit-based	Decision-making by committee; Salary structure; Peer review

California, US	Boyd	1990	Unit-based	Leadership; Mentoring; Shared governance; Participation; Responsibility; Autonomy; Accountability
Georgia, US	McDonagh	1989	Hospital-wide	Accountability; Professional/clinical work; Cooperation; Collaboration; Executive support; Control over practice

Table 2. Summary of characteristics of included professional practice models (from most recent year of publication)

Location • **First Author**	**Year**	**Setting**	**Theoretical foundation**	**Key components**	**Development / Implementation /Evaluation**
Ohio, US • Johnson	2014	Hospital-wide	Concept Not stated Philosophy, vision, values • **W**orld class • **E**mpowered • **C**ompassionate • **A**ccountable • **R**espectful • **E**xcellent External Theory • Koloroutis et al.'s Relationship-based care	• Leadership and governance • Professional relationships • Innovation and research • Patient care • Development and recognition	Development • Focus groups with nurses articulated relationship-based care philosophy • Schematic representation developed Implementation 'Wave' strategy to introduce relationship-based care: • Decentralized groups reviewed principles of relationship-based care and developed unit-based implementation plans • 4 caring relationships enacted: *Care of self* • Inspirational self-care reading developed by mental health nurses and distributed via newsletter • Complementary modalities, including aromatherapy, quiet reflection space, massage *Care for colleagues* • Commitment to co-workers resource • Sharing appreciative reflections on caring behaviors *Care for patients and families*

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					• Customized unit-level primary nursing *Caring for community* • Coordinated service programs • Community outreach funds • Recognition for staff community impact <u>Evaluation</u> • Participation in National Database of Nursing Quality Indicators • RN satisfaction survey • Monthly primary nursing audits
Saudi Arabia • George	2013	Hospital-wide	<u>Concept</u> • Shared governance <u>Organizational, values</u> • Vision for nursing excellence <u>External Theory</u> • George's	• Shared leadership • Accountability, privileging • Partnership • Patient and family are focus of care • Professional nursing care • Professional development	<u>Development</u> • Commenced nursing quality monitoring program • Instituted unit and central councils • Discussions with direct care nurses to select <u>Implementation</u> Not stated <u>Evaluation</u> • National Database for Nursing Quality Indicators for RN satisfaction comparison to non-Magnet and

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			Crescent of Care nursing model		Magnet hospital means. • Nursing turnover • Nurse-sensitive outcomes benchmarking
Connecticut, US • Bennett Jacobs	2013	Not stated	Concept Not stated Organizational core values • Nursing is a moral ideal; • Organizational External Theory • Carper's Patterns of Knowing; Patterns of research; • Aristotle's intellectual	• Human flourishing o Goods of the body o Goods of the soul o External goods • Art of nursing o Imagination/creativity o Caring • Advocacy of nursing o Innovation o Safety • Science of nursing o Inquiry • Ethics of nursing o Integrity o Introspection	Development • Integration of theoretical patterns of knowing in nursing, values, and paths to research Implementation Not described Evaluation Not described

Location • **First Author**	**Year**	**Setting**	**Theoretical foundation**	**Key components**	**Development / Implementation /Evaluation**
			virtues		
Kentucky, US • Berger	2012	System-wide	<u>Concept</u> Not stated <u>Organizational values</u> • Organizational culture <u>External Theory</u> • Swanson's middle-range theory of Caring	• 'I provide excellent care' • 'I believe' • 'I commit to' • 'I am accountable for' • 'I achieve'	<u>Development:</u> • Kotter and Rathberger's model for successful organizational change • Design team brainstormed elements of PPM / Review of other organizations' PPMs • Simple model • Introduced at council & committee meetings, to direct care nurses & nursing leaders • Refined with nursing feedback <u>Implementation:</u> • Poster displays • Champions identified • PPM printed on mouse pads • Mandatory education - 30 minute computer-based training or virtual journal club • Exemplars of PPM use published in newsletters <u>Evaluation</u> Not stated

Location • **First Author**	**Year**	**Setting**	**Theoretical foundation**	**Key components**	**Development / Implementation /Evaluation**

Queensland, Australia
• Cann
	2012	Hospital-wide	<u>Concept</u>
			Not stated
			<u>Organizational values</u>
			Not stated
			<u>External Theory</u>
			Not stated
				Not stated	<u>Development</u>
					Not stated
					• First implemented at Prince Charles Hospital, Queensland
					<u>Implementation</u>
					• Rapid change management strategy
					• Targeted staff education - short in-service and resource manual
					• Environmental modifications, to allow patient allocations to be arranged around specific work stations
					<u>Evaluation</u>
					Pre-test / post-test design
					• Patient measures
					  ○ Falls
					  ○ Medication errors
					  ○ Call bell use
					  ○ Feedback
					• Nurse measures
					  ○ Satisfaction

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					○ Retention / recruitment / sick leave
Ohio, US • Dickey	2012	Hospital-wide	Concept • Shared governance Organizational values **Ex**cellence **C**ompassion **E**fficiency **L**eadership **S**afety External Theory • Nightingale's examination of evidence for practice	• Health promotion • Nursing practice • Optimal patient outcomes • Evidence-based practice • Environment • Clinical expertise • Interdisciplinary relationships • Patient advocacy • Unit-based care delivery model	Development • Task force - 24 direct care nurses • Nurse survey • Literature review • Schematic representation developed Implementation • Unit-level activities to enact components Evaluation Not stated
New York, US • McGlynn	2012	Hospital-wide	Concept • Shared governance	• Leadership • Professionalism • Excellence	Development Not stated Implementation

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			Organizational values Not stated External Theory Not stated	• Caring • Collaboration • Safety • Honoring the human spirit	• Unit-based Collaborative Care Councils© • Education • Ongoing educator facilitation/support Evaluation • Nurse satisfaction measures o Index of Work Satisfaction, Part B o Practice Environment Scale of the Nursing Work Index
Kansas, US • Edmundson	2012	Hospital-wide	Concept • Caring Organizational values • Family-centered care External Theory • Duffy's Quality Caring Model	• CMH&C Nurses We Care • Caring for patients and families • Caring for each other • Caring for community • Caring for self • Quality Caring Model© o Encouraging manner o Mutual problem solving o Attentive reassurance o Human respect o Basic human needs	Development • Formation of model selection team • Literature review • Site visits • Quality Caring Model© selected Implementation • Education developed • Education delivered during Nurses Week • Focus groups • Web-based tutorials • Video vignettes competition – Quality Caring

Location • **First Author**	**Year**	**Setting**	**Theoretical foundation**	**Key components**	**Development / Implementation /Evaluation**
				○ Affiliation needs ○ Healing environment ○ Appreciation of unique meanings	Advocates celebrated during Nurses Week <u>Evaluation</u> Not described
Ireland • Meehan	2012	Not stated	<u>Concept</u> • Careful Nursing philosophy developed by Meehan (2003) <u>Organizational values</u> Not stated <u>External Theory</u> Not stated	• Therapeutic milieu • Practice competence • Management of practice & influence in health systems • Professional authority	<u>Development</u> • Document search • Analysis of primary and secondary sources • Concepts and dimensions derived from historical data • Expressed in contemporary language <u>Implementation</u> • Not described <u>Evaluation</u> • Not described
North Carolina, US • Tonges	2011	Hospital-wide	<u>Concept</u> Not stated <u>Organizational values</u>	• 'Carolina Care': Relationship-based care delivery model • Leadership	<u>Development</u> *(Carolina Care delivery model described)* • Consultation with high performing hospitals • Draft model

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			• My patient • My team • My hospital • My community • My profession <u>External Theory</u> • Swanson's Caring Theory	• Compensation and rewards • Professional nursing values • Professional relationships	• Units (n=2) selected to refine model • Steering committee established • Unit-level nursing and interdisciplinary teams • Unit-level patient surveys • Unit-level action plans • Guidebook for hospital-wide implementation developed • Oversight committee established <u>Implementation</u> • Unit-based teams • Patient interviews • Staff and environmental assessment • Components introduced over 8 weeks <u>Evaluation</u> Pre and post: • Call bell use • Patient satisfaction
Washington, US		Hospital-wide	<u>Concept</u> • Family-	• Excellent family experiences	<u>Development:</u> • PPM committee convened

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Latta	2011		centered care <u>Organizational values</u> • Core values and and nursing philosophy <u>External Theory</u> • Koloroutis's relationship-based care • Swanson's middle-range theory of caring	• Excellent patient outcomes • Nursing values o Accountability o Respect o Teamwork • **C**ompetence • **H**ealth • **I**ntegrity • **L**eadership • **D**iversity	• Literature review • Retreats to envisage new PPM • Gap analysis • Reframe nursing values • Presented and approved by key stakeholders <u>Implementation:</u> • In progress • Integration into recruitment • Posters • Peer evaluation • Learning modules • Planned – web-based training, unit-based forums - case studies, exemplars and storytelling from actual practice scenarios <u>Evaluation</u> Baseline survey of nurses Planned<u>:</u> • Nurse-sensitive outcome indicators (pain, skin integrity, falls, & hospital acquired infections

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					• Newly hired staff interviews • Peer evaluation appraisal tool
Louisiana, US • Mathes	2011	Hospital-wide	Concept • Caring Organizational values • Organizational mission and core values External Theory • Koroloutis's Relationship-Based Care - a model of transforming practice • Watson's caring theory	• Patient and family • Relationship-based care • Watson's caring theory	Development: • Collaborative care delivery model in place • Nurse leaders researched caring-centred nursing models and integrated relationship-based care Implementation: • Six nurse leaders attended structured program 'Re-Igniting the spirit of caring' (RSC) • Rolled out in 'waves' • Representative unit nurses attended RSC retreats • Wave 2: • Bulletin boards • Staff meetings • Team meetings • Relaxing environments • Champions Evaluation • Nurse measures before and after Wave 1 RSC

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					program o Healthy Collegial Relationship o Thriving Scale • Patient measure o Satisfaction
Western states, US • Mensik	2011	System-wide	<u>Concept</u> • American Nurses Association (ANA) Scope and Standards of Practice; • Institute of Medicine Dimensions of Quality <u>Organizational values</u> Nursing defined based on ANA	• Excellent patient care • Contribution to Patient o Assessment o Diagnosis o Outcome o Identification o Planning o Implementation o Evaluation • Contribution to profession o Environmental health o Ethics o Leadership o Evidence-based practice and research	<u>Development</u>: • Draft model developed by team of doctoral and masters prepared nurses • Stakeholder review • Refined with feedback (novice nurses, experienced nurses, educators, advanced practice nurses, nurse leaders) <u>Implementation</u> • Posters • Education • Integration into job descriptions, nursing awards, peer review, education, orientation, research projects <u>Evaluation</u> • Not stated

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			Social Policy Statement <u>External Theory</u> Not stated	○ Collaboration ○ Education ○ Communication ○ Professional practice evaluation ○ Quality of practice • Contribution to society ○ Safe ○ Equitable ○ Efficient ○ Effective ○ Timely	
Illinois, US • Murphy	2011	Hospital-wide	<u>Concept</u> • Relationships and caring <u>Organizational values</u> • Organizational mission, vision and values;	• Relationships and caring ○ Respect ○ Communication ○ Intentional presence ○ Collaboration ○ Sensitivity • Critical thinking • Evidence-based practice	<u>Development:</u> • Initiated by nursing leadership • Widespread input from nurses • Redesign of clinical advancement system • Expert panel review <u>Implementation</u> • New positions piloted on 5 units • Task force formation

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			• Division of nursing mission and vision <u>External Theory</u> Not stated	• Technical expertise • Leadership	• Focus groups to develop specific behaviours reflecting performance expectations • Toolkit developed • Education • Marketing • Collaboration with human resources representatives <u>Evaluation</u> • Nurse measures o Turnover o Professional practice (% staff bachelors, masters, doctoral qualification) o Satisfaction
Colorado, US • Ondrejka	2011	Hospital-wide	<u>Concept</u> • Patient-centered <u>Organizational values</u> • Organizational mission	• Nurse • Environment and caring • Health • Patient & family • Advocacy through caring • Quality • Nursing practice	<u>Development</u> • Teams of diverse nurses reviewed and synthesized nursing theories to develop nursing philosophy and model of practice • Language clarified • Articulated large domains within nursing philosophy • Graphic artist created visual model <u>Implementation</u>:

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation

			External Theory
			• Nightingale's environmental adaption theory
			• Watson's science of care theory
					• Rollout program developed – need for a model, Magnet process, model description, 'story telling' and nurses reflecting on their practice
					Evaluation
					• Nurse measures
					  ○ Practice Environment Scale of the Nursing Work Index
					  ○ Rollout session ratings
					Planned:
					• Annual Practice Environment Scale
					• Patient satisfaction

Ohio, US • Small	2011	System-wide	Concept • Patient and family centered care • Serving leader; • Relationship-based care; • Thinking in action	• Shared vision • Quality and patient safety • Healing environment • Research and evidence-based practice • Professional development and education	Development: • Steering committee of key stakeholders • Inquiry to other hospitals and systems • Input from physicians • System mapping • Ten focus groups (managers, assistant managers, advanced practice nurses, charge nurses, registered, and licensed practice nurses, nurse aids and clinical instructors)

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			<u>Organizational values</u> • Organizational guiding principle of 'Patients first' <u>External Theory</u> • Senge's fifth discipline model • Greenleaf's the serving leader concept • Koloroutis's relationship-based care • Benner, Hooper-Kyriakidis and Stannard's thinking-in-		<u>Implementation:</u> • Logos and slogans • Launched at annual Clinic Nurse Managers' leadership retreat • Roll out to nurses, using a proprietary tool kit, online educational modules and onsite presentations, is underway. • Mandatory training sessions • Champions <u>Evaluation</u> Planned: • Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) scores • Patient perceptions of care

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			action approach		
Pennsylvania, US • Hitchings • Hitchings	2005 2010	Hospital-wide	Concept • Forces of Magnetism Organizational values • Organizational culture and values; External Theory Not stated	• Clinical practice • Quality • Research • Professional excellence • Operations • Collegial review and recognition	Development • Built on shared governance model (developed in 1980s) • Literature review • Site visits Implementation • Councilor structure Evaluation • Qualitative • Employee satisfaction • PPM Status Assessment to measure development status of PPM (tool developed by organization) • Nurse measure: Professional practice assessment (tool developed by organization)
Pennsylvania, US		Hospital-wide	Concept Not stated Organizational	• Respectful workplace • Skilled communication	Development: • Nursing leadership and educators retreated off-site to envisage the PPM.

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Jost	2010		values • Organizational mission and values; divisional philosophy of nursing External Theory • PPM – not stated • Clinical Advancement and Recognition Program – Benner's novice to expert model	• Collaboration • Structure, process, outcome; lifelong learning • Authentic leadership; tradition • Shared governance; teamwork • Partnerships; opportunity • Evidence-based practice; professional • Innovation and translational research; diversity • Integrated primary nursing; integrity • World-class patient care; excellence	Implementation: • Massive media campaign • Education sessions (day and night) • Screen savers • Posters • Headers on meeting agendas • Bulletin boards • Lapel pins • Pens • Essay competitions, 'how I lived the model today....' Evaluation Not stated
Georgia, US		Hospital-	Concept	• Patient / family	Development

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Sharkey	2009	wide	• Shared governance <u>Organizational values</u> • Mission, vision, core values; <u>External Theory</u> • Benner • Watson • Henderson (theories not explicated)	• Compassion; healing, caring • Research; professional development; executive; leadership; practice • Leadership; structure; management; personnel; models; quality; improvement; resources; autonomy; community; teaching; image; teamwork; development • Excellence; measurement; service; leadership; accountability; alignment; communication; recognition	• Based on Shared Governance Professional Practice Model (developed in 1980s) <u>Implementation</u> • Councilor structure • Unit-level practice committees • Evolution of clinical advancement program • Acknowledged 8 Essential of Magnetism and 14 Forces of Magnetism <u>Evaluation</u> Annual nurse satisfaction surveys
Texas, US		Hospital-wide	<u>Concept</u> • Shared	• Caring • Collaboration	<u>Development</u> Not stated

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Newcomb	2009		governance <u>Organizational values</u> Not stated <u>External Theory</u> Not stated	• Respect • Family-centered care • Critical thinking • Professional development • Art and science	<u>Implementation</u> • Nursing councils created: • Coordinating Council as central governing body • 5 existing committees incorporated • 3 new councils <u>Evaluation</u> (linked to Magnet application • Pre-test / post-test o T1 Baseline o T2 One year post-baseline (at Magnet submission) o T3 Two years post-baseline (following Magnet recognition): • Measure - Nurse satisfaction
Maryland, US • Duffy	2007	Hospital-wide	<u>Concept</u> • Relationships characterized by caring <u>Organizational values</u> • Organizational	• Patients and families o Needs and preferences honored o Feel ‘cared for’ • Communication • Nursing roles and responsibilities	<u>Development:</u> • Leadership workshops • Strategic design team determined the elements <u>Implementation</u> • Patient care organized to PPM components • Revision nursing job descriptions

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			mission and philosophy of nursing <u>External Theory</u> Not stated	• Caring practices • Environment • Resource allocation	• Revision professional development program • Resource coordinator to monitor environment and supplies • New rules for nurse scheduling • Electronic communication supports • Nurses attended all-day meetings • Stakeholder discussion <u>Evaluation</u> • Pre-test / post-test design • Nurse measures: o Vacancy rates o Satisfaction • Patient measures: o Satisfaction o Pain o Functional status
Midwest, US • Mullen	2007	Hospital-wide	<u>Concept</u> • Nurse competencies matched to	• Patient needs o Stability o Complexity o Predictability	<u>Development:</u> • Convened team of nursing executive, advanced practice nurses, nursing management and staff nurses

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			patient / family need <u>Organizational values</u> • Organizational philosophy of family-centered care <u>External Theory</u> • American Association of Critical-Care Nurses' Synergy Model for Patient Care	○ Resiliency ○ Vulnerability ○ Participation in decision-making ○ Participation in care ○ Resource availability • Nurse competencies ○ Clinical judgment ○ Caring practices ○ Advocacy / moral agency ○ Collaboration ○ Systems thinking ○ Responses to diversity ○ Clinical inquiry ○ Facilitator of learning	• Extensive literature review • Adopted Synergy Model of Patient Care to guide care <u>Implementation</u> • Revision of job descriptions and performance appraisal system • PPM education - presentation or video. Computer-based learning program for new nurses • Champions • PPM on intranet during nurses week <u>Evaluation</u> Not stated
Ontario, Canada		Service-wide (renal	<u>Concept</u> • Case management;	• Professional practice component: ○ Collaborative practice	<u>Development</u> • Steering committee • Identified characteristics of professional nursing;

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Harwood • Harwood • Harwood • Harwood	2003 2007a 2007b 2013	program)	• Primary nursing <u>Organizational values</u> • Revision Corporate emerging vision <u>External Theory</u> • Benner's domains of nursing practice • Wolf et al's transformational model for professional practice in health care organizations	○ Leadership ○ Care delivery system ○ Communication system ○ Professional development • Characteristics of professional nursing practice • Process component • Outcome component	trends and future practice implications • Examined national practice standards • Reached consensus on values central to professional development • Articulated nursing roles and competencies <u>Implementation</u> • Newsletter communication • Multidisciplinary feedback sought and integrated • Posters • Introductory sessions • Professional development needs assessment • Learning resources developed • PPM information provided to non-renal services • Resource binders • Unit-specific sessions • Nursing Professional Practice Committee established <u>Evaluation</u> *Initial*

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					• Nurses, medical and allied health staff surveyed 6 months post implementation *Later* "Then and now" design: o Nursing Work Index – Practice Environment Scale o Conditions of Work Effectiveness II Questionnaire o Qualitative interviews <u>Revision - Development</u> (Harwood et al., 2013) • Steering committee • New nursing roles • Articulation of specific roles and accountability • Revised communication for practice change • Nursing leadership <u>Revision – Implementation</u> Planned <u>Revision - Evaluation</u> • Established QI processes
New York, US		Hospital-	<u>Concept</u>	• Social	<u>Development and Implementation</u>:

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Ingersoll	2005	wide	Not stated <u>Organizational values</u> • Organizational mission, vision; Philosophy of nursing <u>External Theory</u> • Sociotechnical systems theory; • Senge's fifth discipline model	• Technical • System • Expert practice • Nursing staff outcomes • Patient / family outcomes • Organizational outcomes	• Detail not provided • Performance management evaluation criteria linked to PPM <u>Evaluation</u> • Not stated
Pennsylvania, US • Wolf	2004	System-wide	<u>Concept</u> • Decision-making for patient care processes and outcomes	• Professional practice o Transformational leadership o Care delivery system o Professional growth o Collaborative practice	<u>Development</u> • Evaluation and selection of Wolf et al.'s Transformational Model for Professional Practice <u>Implementation</u> • Strategic visioning • Assessment and planning

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			<u>Organizational values</u> • Organizational vision, values, goals <u>External Theory</u> Not stated	• Process • Primary outcome • Strategic outcome	○ Identify gaps ○ Plan for change ○ Building support structures ○ Educational program ○ Project coordinator ○ Steering committee • Implementation and monitoring ○ Project teams ○ Monthly meetings ○ Progress tracking ○ Key standards of care ○ Standardize key roles, competencies, job expectations, education ○ Standardize patient education ○ Leadership development program ○ Documentation systems <u>Evaluation</u> ○ Benchmark analysis ○ Patient satisfaction ○ Nursing quality indicators

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					○ Cost analysis – education, orientation
Tennessee, US • Robinson • O'Hara	2003 2003	Hospital-wide	<u>Concept</u> • Performance-based career advancement <u>Organizational values</u> • Organizational mission and culture <u>External Theory</u> • Benner's novice to expert framework	• 6 key functions ○ Continuous learning ○ Communication and collaboration ○ Problem solving ○ Patient and family education ○ Continuum of care planning ○ Planning and managing care • Satisfaction • Quality • Cost effectiveness	<u>Development:</u> • Based on earlier nursing practice model (1993-93) • Sought to integrate performance appraisal system with career advancement program Steering committee • Problem identification • Information gathering – from nurses of all levels • Input from Chief Nursing Officer • Development of PPM with 6 key functions • Development of 4 RN practice levels • Nurse focus groups to define behaviors expected at RN levels • Development and piloting of performance evaluation tool and processes <u>Implementation</u> • Visible executive support • Visible management support • Inter-rater reliability of management teams

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					• Management and staff forums • Educational campaign • Illustrative case study <u>Evaluation</u> • Debriefing sessions • Feedback used to refine evaluation tools • Anecdotal
California; Texas, US • McCrea	2003	System-wide	<u>Concept</u> • Healing relationship between patient and nurse <u>Organizational values</u> • Organizational core values <u>External Theory</u> Not stated	• Patient; family; community; care team • Dignity; service; justice; excellence • Collaboration • Clinical practice • Culture/caring • Care delivery model • Clinical ladders • Leadership development • Shared governance	<u>Development</u> Not stated <u>Implementation</u> • Education • Discussion • Sharing practice reflections with nursing and multidisciplinary colleagues <u>Evaluation</u> Not stated

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
East coast, US • Erickson • Erickson • Erickson	 1998 2003 2011	Hospital-wide	<u>Concept</u> • Collaborative governance <u>Organizational values</u> • Organizational nursing vision, values and philosophy <u>External Theory</u> *2006* • Narrative culture – Benner's novice to expert model • Clinical Recognition Program – Dreyfus Model	*1996* • Values • Philosophy • Standards of Practice • Collaborative decision-making • Professional development • Patient care delivery model • Privileges, credentialing, peer review • Research • Descriptive theory models *2006* • Vision & Values • Standards of Practice • Innovation and Entrepreneurial Teamwork • Clinical Recognition and	<u>Development</u> • 1996 - initial development • 2006 - refined by nurse leaders <u>Implementation</u> Not stated <u>Evaluation</u> *2003* • Time-series design: ○ Baseline ○ T1 (1 year post-implementation) ○ T2 (2 years post-implementation) ○ T3 (3 years post-implementation). • Sample: ○ Nursing ○ Multidisciplinary staff • Measures selected from Lashinger's operationalization of Kanter's theory of structural empowerment ○ Conditions of Work Effectiveness Scale ○ Job Activity Scale

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			of Skill Acquisition	Advancement • Research • Patient Care Delivery Model • Collaborative Decision-Making • Narrative Culture Professional Development	○ Organizational Relationships Scale *2011* ○ Staff Perceptions of the Professional Practice Environment Survey ○ External measure: Magnet Recognition Program® accreditation
Ohio, US • Pierce	1996	Unit-based	<u>Concept</u> • Shared governance <u>Organizational values</u> Not stated <u>External Theory</u> Not stated	Not described	<u>Development</u> • Nurses in Clinical Advancement Program convened a retreat to develop: ○ specific work groups ○ operational philosophy of nursing ○ education - accountability, nursing models, committee work and case management <u>Implementation</u> Not described <u>Evaluation</u> • Pre-test / post-test design ○ Personal Information Tool (internally developed)

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					○ Quality of Employment Survey ○ Work Satisfaction Scale ○ Turnover rates
Florida, US • Massaro	1996	Unit-based	Concept • Shared governance Organizational values Not stated External Theory Not stated	• Quality circles – structures vested with functional responsibility, accountability for decision-making, and responsibility to implement solutions • Primary nursing delivery system • Decentralized decision-making • Salary compensation • Self-scheduling	Development • Primary nursing; peer review; and clinical ladder in place. • Evolution from Clinical Concerns Committee charged to enhance patient care to mature philosophy of nursing practice Implementation • Task force to manage transition salaried model • Shift premiums instituted • Staffing and scheduling circle managed staffing to achieve transition to ‘closed’ unit Evaluation • Turnover rate • Overtime hours • Anecdotal
Maryland, US		Unit-based	Concept • Partnership	• Partnership levels: ○ Full partners –	Development Not described

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
• Hastings	1995		<u>Organizational values</u> Not stated <u>External Theory</u> Not stated	experienced nurses ○ Associate partners – new nurses ○ Senior partners – unit leader ○ Managing partner – nurse manager • Nursing care delivery system • Unit-level governance • Career advancement	<u>Implementation</u> • Creation of unit-level professional nursing governance structures <u>Evaluation</u> • Partnership Readiness Scale (internally developed, administered 1991) • Partnership Perceptions Scale (internally developed, administered 1993) • University of Maryland Medical System Features Questionnaire (internally developed) • McCloskey-Mueller Satisfaction Questionnaire • Hackman-Oldham General Job Satisfaction scale • Organizational Commitment Questionnaire • Michigan Organizational Assessment Questionnaire (only 3-item scale to measure turnover used)
California, US • Parkman	1994	Hospital-wide	<u>Concept</u> • Shared governance <u>Organizational</u>	• Professional practice environment • Managed care	<u>Development</u> • Emergent model through pragmatic responses to internal and external environmental forces and evolution of professional practice philosophy

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			values • Professional philosophy of nursing External Theory • Roy's Adaption Model	• Standards of care • Shared governance o Unit-based quality improvement / quality assurance • Roy model integration • Professional (peer) review • Career advancement program	• Task force • Widespread canvassing of nurses • Job redesign • Literature review • Preparation for transition from case management to staff managed care • Substantiated support for staff nurses Implementation Not described Evaluation Planned using Renzulli's Key Features Model
Pennsylvania, US • Wolf • Wolf	1994 1994	Unit-based	Concept Paradigm shifts: • Practice evolution from needs-driven to limited resources • Direct correlation	• Professional Practice o Relationship between patient, nurse, physician o Transformational leadership o Collaborative practice o Care delivery system o Professional growth • Process	Development • Nurses canvassed to describe elements of effective and ineffective patient care • Conceptual analysis defined components essential for successful professional practice • Nelson and Burns model of organizational development used to operationalize PPM components Implementation

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			between manpower and quality • Replacement of standardized patient care to individualized, creative care • Evolution of accountability for clinical decision-making from manager to practitioner <u>Organizational values</u> Not stated <u>External Theory</u> Not stated	○ Critical thinking • Primary outcome ○ Caregiver satisfaction ○ Quality care ○ Patient satisfaction • Secondary outcome ○ Consumer, organizational and professional health	• Coordinated by nurse managers on each individual unit. • Group discussions about organizational mission, vision and strategic initiatives • Required paradigm shifts identified • Key components discussed • Leadership seminars • Creation of support networks for nurse managers • Unit-based assessment • Unit-based nurses canvassed to define and asses issues in relation to PPM components <u>Evaluation</u> • Anecdotal • Quantitative measurement of quality and satisfaction (results not reported),

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
New York, US • Ingersoll • Ingersoll • Hoffart • Witzel • Ingersoll	 1993 1995 1995 1996 1996	Unit-based (n=5 units across 3 hospitals)	<u>Concept</u> • Nurse satisfaction / nurse retention <u>Organizational values</u> Not stated <u>External Theory</u> • Structural contingency theory	• Collaborative practice • Continuity of care • Continuing professional development • Control over nursing practice • Compensation, recognition, rewards	<u>Development</u> • Developed from factors identified in the literature as contributing to nurse satisfaction and retention. • McClintock's program evaluation map adapted as process to support nurse managers to tailor PPM components to each unit. • Concepts, measures and activities identified <u>Implementation</u> • Regular communication – newsletter, meetings • Documentary description of PPM components • Unit based nurses initiated structures and processes to support key PPM components in their individual practice settings. <u>Evaluation</u> • Perceived Group Attractiveness and Cohesiveness Scale • Leadership Opinion Questionnaire • Index of Work Satisfaction – attitude component • Job Satisfaction Scale

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					• Cost-analysis • Qualitative case study(Findings not reported)
Maryland, US • Tyler • Wong	 1993 1993	Unit-based	Concept • Shared governance model Organizational values Not stated External Theory Not stated	• Decision-making • Problem solving • Written agreements • Financial incentives	Development Concurrent with implementation Implementation • Staff surveyed to determine interest in PPM • Implementation team formed • National PPM conference attended • Information disseminated • Committee formation • Goal development • Initial philosophy articulated • Contractual agreements signed • Vote to formalize PPM Evaluation • Anecdotal from staff feedback, policy change and self-appraisal • Cost evaluation – PPM units (n=8) compared to standard units (n=8)

Location • **First Author**	**Year**	**Setting**	**Theoretical foundation**	**Key components**	**Development / Implementation /Evaluation**
Maryland, US • Zelauskas	1992	Unit-based	<u>Concept</u> Not stated <u>Organizational values</u> Not stated <u>External Theory</u> Not stated	• Decision-making by committee • Salary structure • Peer review	<u>Development</u> • Designed by nursing staff and unit manager <u>Implementation</u> • Presentation of literature review by nursing unit manager • Staff meetings • Patient care delivery system identified by nursing staff and implemented before other components • Collegiality defined by nursing staff and given day-to-day focus and negotiation • Ensured self-scheduling already in place • Working committee structure instituted <u>Evaluation</u> • Quasi-experimental matched group design • Pre-test / post-test ○ Job Descriptive Index ○ Job Characteristics Inventory ○ Staff turnover* ○ Sick time* ◦ Cost per patient day*

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
					*Statistical significant not reported • Anecdotal
California, US • Boyd	1990	Unit-based	Concept Not stated Organizational values Organizational core values External Theory • Theory Z (Shortell, 1982)	• Mentoring • Leadership • Participation • Shared governance • Responsibility • Autonomy • Accountability • Outcome of nursing empowerment	Development Not described Implementation • Education – 2 weeks • Resource nurse remind nurses they are empowered • 4 committees: Nursing practice, Patient / family education Nurse education Fiscal responsibility and resourcing Evaluation • Anecdotal
Georgia, US • McDonagh	1989	Hospital-wide	Concept • Shared governance Organizational values	• Accountability • Professional and clinical work • Cooperation • Collaboration	Development • Not described Implementation • Not described Evaluation

Location • First Author	Year	Setting	Theoretical foundation	Key components	Development / Implementation /Evaluation
			• Organizational philosophy of clinical nursing functions are central to professional nursing; <u>External Theory</u> Not stated	• Executive support • Flat structure to promote control over practice	• Anecdotal