Nurses are beset by multiple tasks and responsibilities while simultaneously supervising others and coordinating healthcare teams. There is little time for meaningful relationships with patients and families or other members of the healthcare team. A powerful editorial by a former nursing administrator observed that hospital-based registered nurses (RNs) were assigned so many tasks that they “established relationships with medication carts and IV pumps because that’s all they had time for.” Yet, when asked about the value of patient relationships, RNs reported that taking the time to learn specific patient information, using subtle patient cues, and understanding patients’ views helped them to know what approaches would work, anticipate outcomes, and make important clinical decisions.

Nurses, knowing that the formation of caring relationships with patients and families is a central tenet of practice, have developed theories that explain components of caring relationships. Yet, establishing and maintaining caring relationships with patients is assumed and integrated among the myriad tasks nurses perform. Recent evidence, however, has demonstrated a link between nurse caring and patient outcomes. For example, 3 studies found that demonstrated significant positive relationships between nurse caring and patient satisfaction. Another study showed an increase in patient satisfaction scores after a caring intervention was implemented in a small community hospital. Functional status scores improved faster when more nurse caring behaviors were demonstrated as reported by patients recovering from ambulatory surgery.

Not only has nurse caring been linked to clinical and service outcomes but it has also been deemed financially beneficial. How can we explain this disconnect between current practice and what nurses intuitively know and evidence is beginning to substantiate? Would implementation of a relationship-centered practice model strengthen the quality of relationships in acute care and contribute to improved healthcare outcomes?

The Quality-Caring Model©

The Quality-Caring Model© exposes the hidden value of nursing (caring), guides practice, and provides a foundation for outcomes evaluation and research. In this model, the evidence-based practice environment of present-day healthcare is simultaneously merged with the caring processes of nursing. Caring values, attitudes, and behaviors dominate the process of care and establish the foundation for 2 key relationships. The independent patient-nurse relationship is primary and includes all interactions and interventions for which nurses are accountable and implement autonomously. Collaborative relationships include “those activities and responsibilities that nurses share with other members of the healthcare team.” Together, these 2 “relationship-centered professional encounters” dominate the process of nursing and, in concert with certain structural variables, are hypothesized to influence quality healthcare outcomes.

The model places relationships, particularly the patient-nurse relationship, at the core of the therapeutic process. It is an evolving, developmental process that seeks to understand the unique perspective of patients/families. Through caring relationships, nurses interact, connect, and come to know the context, meaning of illness, beliefs, and preferences of patients and families. As a result, individuals feel “cared for” and are more willing to share, work together, change old patterns, and adhere to new regimens.

Implementing controversial practice models has been a traditional charge of nursing administrators; yet, the challenge in applying the
model is the creation of caring environments where relationships not only matter but they are also primary. The model posits that nursing’s primary role is initiating, cultivating, and sustaining caring relationships with patients and families. Second, nursing has a responsibility to cocreate caring relationships with members of the healthcare team in order to foster cohesive teams for effective caregiving. Since the model places these activities at the core of nursing work, operationalizing it has major implications for the practice of nursing in acute care. The model suggests a major redesign, with implications not only for nurses but also for other health team members.

**KEY STEPS TO SUCCESS**

Implementing the model means that care providers and administrators must first learn how to think differently about interacting with patients and with each other. Interacting with an intent to know, or understand another, is risky because the hurried environment of acute care does not reward human interaction. In fact, “the current culture is that it is not OK to sit down and talk with patients.” Starting with the top leadership team, value must be placed on human relationships such that staff members learn that it is a foremost priority. To accomplish this, the leadership team must spend time reading, discussing, comprehending, and eventually embracing the model’s components and propositions. The model’s congruence with the current philosophy and mission of the nursing department and the organization should be assessed. A consultant familiar with implementing the model may be helpful in facilitating understanding at a series of offsite meetings. At this stage, the leadership team must be willing to engage in discussion regarding strengths and weaknesses of the model and must address the feasibility of implementation in a particular organization. In this phase, a shared leadership vision of the value of relationships, consensus of the model’s benefits to the organization, and commitment to its implementation are the goals.

Appointing a person or committee responsible for model implementation is essential. This person(s) should be highly regarded throughout the organization, with excellent interpersonal skills and an absolute knowledge of the model. Without a responsible party whose goal is to ensure successful implementation in a specific time frame, the implementation process can be sidelined as a perceived nonessential task.

Implementing a conceptual model is best accomplished in phases, and requires a supportive infrastructure. To assess readiness, an analysis of the current organizational structure, policies and procedures, role designations and job descriptions, and healthcare outcomes of various departments is needed. Understanding where the organization is relative to what is required for success will help drive the redesign plan. Next, a written implementation plan will provide the blueprint for action. In this phase, departments can be chosen for pilot implementation, time lines are developed, and steps to implementation are delineated. It may be wise to choose at least 1 department where the gap between what is and what is needed to succeed is not too wide to realize positive results in a timely fashion. Such feedback provides encouragement and data necessary for continuation.

Redesigning the actual work is a difficult phase of struggling to meet the needs for a revised focus amidst a conventional bureaucratic system. For example, to realize the goal of “caring relationships are initiated, cultivated, and sustained and are the foundation for practice,” professional nurses must go beyond the traditional biomedical model and choose to own the responsibility for caring relationships. Knowing aspects of patients’ lives such as roles and responsibilities, preferences, concerns, worries, available social networks, home environments, educational levels, and daily routines suggests that dedicated time is made available to interact with patients and families. Furthermore, the interaction must be of a quality that patients feel “cared for.” Learning or relearning communication principles, including verbal and nonverbal behaviors, demonstrating cultural and language sensitivity, helping patients and families learn in their own unique way, frequent surveillance, providing encouragement, comforting, and demonstrating concern for what is important to patients and families requires excellent human relationship skills and a willingness to use them frequently. Reprioritization of nursing actions is needed, with increased emphasis on human relationships and less emphasis on routine tasks.

Placing caring relationships central to practice requires removing demands that RNs presently meet and ensuring adequate time for “being with” patients. Identification of nurses who are committed from admission through discharge to assume primary responsibility for forging caring relationships connotes professionals who work in a consistent pattern and interact frequently with patients, families, and team members. In short, designated RNs in this model would assume more relationship-centered activities and make clinical decisions based on the caring connection established with patients and families. This has implications for staffing and scheduling plans as well as compensation and reward systems. Reallocation of work may be necessary for those with roles that support RNs. Examination and revision of traditional shift work, including the popular 12-hour model, may be necessary to the model’s success. Revision of patient assessment and documentation tools that include more holistic views of patients/families and evaluation tools with built-in reward systems for effective caring relationships are necessary supports to the model. In this phase, staff nurse involvement in cocreating the redesigned work is essential to success.

A sound professional development program that introduces staff
**IN MY OPINION**

and leadership to systems thinking,15 model components, the work redesign plan, required competencies, and supporting policies and procedures should precede and continue throughout implementation. It is important to go slow and maintain flexibility during implementation. Choosing a small number of departments to start and then gradually expanding will allow the requisite time for revision and adjustment to new ways of thinking and acting.

After a reasonable amount of time is spent in pilot implementation, evaluation is necessary to validate the credibility of the model and to measure overall goal achievement. Maximizing results requires routine measurement of patient, nursing, and system outcomes, multidisciplinary forums for recommending practice changes, and evaluation. Designing an evaluation plan, collecting and analyzing data, and disseminating the results in a useful manner are necessary prerequisites. Opportunities for improvement and/or revision of the implementation will result, leading to eventual expansion of the program.

**RISKS AND BENEFITS**

In this way of thinking about patient care, professional nurses do not focus on tasks, equipment, or the latest technology. Rather, the model calls for the integration of current knowledge and evidence with the unique characteristics and contexts of relating human beings. Patients are viewed as knowledgeable partners who share the responsibility for health while professional nurses facilitate health through relationship. For example, in helping a patient learn about a new medication, the nurse (who may not be familiar with it) and the patient together may look it up on the World Wide Web. The nurse’s role in this model would be to help the patient sort out quality Web sites, understand what he or she is reading, and together create a plan for adherence. Both the nurse and patient benefit from this interaction in terms of new knowledge gained, increased potential for adherence and/or self-care, and satisfaction with the process.

Achieving full implementation of the model involves an investment of time, resources, and the involvement of all care providers. Avoiding common barriers to success such as failing to get “buy-in” from nursing staff, organizational leadership and physicians, going it alone without advice from others, and failure to appoint responsibility and establish time frames are important. Conversely, facilitators such as making full use of a shared governance model and clinical nurse specialists, frequent communications, effective reward systems, and ongoing evaluation may enhance full implementation.

Embracing the model as the foundation for practice supports the emerging evidence of the value of caring relationships in optimizing patient, nurse, and system outcomes. While there are risks associated with its implementation, the potential benefits are enormous. Patient satisfaction may improve (as has been documented in the literature) and decreased adverse outcomes (and their associated costs) may result as RNs spend more time “being with,” observing, advocating for, and anticipating, patients. Nurse satisfaction and retention may improve as RNs spend more work time doing what they were educated to do.

The Quality-Caring Model is being tested in a clinical trial, funded by the National Institute of Nursing Research. While data are still being collected, the model is presented here for consideration by readers as a way to support the genuine work of nursing in acute care.

**REFERENCES**