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# Exploring implementation of the Careful Nursing Philosophy and Professional Practice Model© in hospital-based practice

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**Aim**: To explore the effectiveness and feasibility of implementing the two clinical dimensions of the Careful Nursing Philosophy and Professional Practice Model© (Careful Nursing) in an acute care hospital.

**Background**: Implementation of a professional practice model by nurses in hospitals supports nurses' control over their practice and enhances the quality of their contribution to patient care. Implementing such change is complex and initially best approached on a small scale.

**Methods**: A mixed methods exploratory design was used. Data were sought from 23 professional nurses practising in a 26-bed acute medical ward for older persons. Quantitative data were collected on nurses' control over and documentation of their practice. Qualitative data were collected on nurses' perceptions of their practice.

**Result**: Nurses' control over practice and adherence to practice documentation standards increased. Overall, the nurses perceived Careful Nursing-guided practice positively. Feasibility issues were identified and addressed.

**Conclusion**: Exploratory evidence suggests that Careful Nursing could influence nurses' practice and overall perception of practice positively; its implementation is feasible.

**Implications for Nursing Management**: Careful Nursing offers a distinctive nursing framework for professional practice. This study can provide a strategy for implementing Careful Nursing-guided changes in hospital-based practice on an exploratory level.

KEYWORDS

careful nursing, clinical implementation, NANDA-I-NOC-NIC, nursing documentation, professional practice model

## 1 | BACKGROUND

It is widely recognized that the nursing profession has a central and critically important role in contributing to hospitalized patients' safety and quality of care. Strengthening and supporting this nursing role is of major concern to the profession and health systems at large (Institute of Medicine, 2011). The development in the 1990s of the Magnet Recognition Program® addressed this concern by identifying hospital practice environments that supported nurses' professional autonomy and control over practice enabling them to exercise their knowledge and skills in aiming for practice excellence (Fasoli, 2010). Achievement of Magnet recognition is sought widely because it is associated with significant improvements in nurses' practice environment and patient and nurse outcomes (Kutney-Lee et al., 2015).

The nursing practice framework developed to structure Magnet recognition was the professional practice model (PPM). Magnet recognition now presupposes the demonstrated use of a PPM to guide achievement of excellence (American Nurses Credentialing Center, 2014). In turn, aspiration to Magnet recognition drives the development and implementation of PPMs. Slatyer, Coventry, Twigg, and Davis (2016) identified 38 PPMs, 34 developed in the United States; 36 developed for use in a particular hospital or organisation and two developed independently.

### 1.1 | Professional practice models

A professional practice model is a conceptual framework of interrelated nursing care delivery structures, relational processes and values that are meaningful to nurses in clinical practice and support their control over their practice and practice environment (Slatyer et al., 2016). Most PPMs incorporate an external theoretical foundation, often a caring theory. Jacobs (2013) emphasizes that PPMs are different from conceptual models and theories in that their concepts are a combination of commonly recognized human values, such as compassion, and practice aims, such as evidence-based practice. Professional practice models do not identify the type of statements about concepts, or relationships among them, that are necessary for theory development.

Slatyer et al. (2016) found that professional practice models varied considerably but identified six concepts that all share: leadership, independent practice, collaborative practice, development and recognition, environment and research/innovation. These concepts function in practice in different ways in different organisations, according to their nursing culture. All levels of nurses participate in PPM decisions and aim together for the achievement of excellence in nursing practice. Although PPMs are complex and challenging to implement, their use is worthwhile because they can improve outcomes for patients and nurses, offer potential to address widespread breaches in the quality and safety of patient care (Stallings-Welden & Shirey, 2015) and could help to prevent nursing practice failures such as those highlighted by the Mid-Staffordshire Hospital enquiry (Slatyer et al., 2016).

### 1.2 | Careful Nursing Philosophy and Professional Practice Model© (Careful Nursing)

Careful Nursing is one of two professional practice models developed independently of a hospital. It is a historical research-based interpretation of the knowledge and practice of early to mid 19th-century Irish nurses (Meehan, 2012). These nurses "early attained brilliant prestige in nursing" and had "skilled nurses when the Crimean War broke out" (Dock, 1907/2000, p. 86), accomplishments appreciated by Nightingale (1863). Careful Nursing is structured as an interrelated philosophy and PPM composed of three philosophical principles, four practice dimensions and 20 practice concepts (Meehan, 2012), as shown in Figure 1.

Figure 1 includes minor revisions made to enhance clarity since the most recent 2012 Careful Nursing journal publication. Based on philosophical consultation and experience in clinical implementation, the philosophical principles were stated more specifically. Also, inherent human dignity was added to the therapeutic milieu (TM) dimension, recognition was added to the watching and assessment concept and responsibility was added to the professional authority dimension.

Careful Nursing is comprehensive and this study implemented a modified form comprising the three philosophical principles and two direct clinical practice dimensions the therapeutic milieu and practice competence and excellence (PCE), as indicated by the shaded sections (see Figure 1). The two dimensions not included remained in the background. A number of United States hospitals have embraced Careful Nursing as their professional practice model (Weaver, 2015; Weldon et al., 2014). The present study is the first implementation evaluation of Careful Nursing.

The Careful Nursing philosophical principles and two practice dimensions implemented in this study lie at the heart of nurses' direct clinical care of patients. The therapeutic milieu focuses on relational aspects of practice and practice competence and excellence on the nursing process. Making explicit the philosophy of the nature of nurses and patients as human persons, the spiritual aspect of human life and the nature of health is important because nurses' understanding of philosophical assumptions underlying their practice is vital to their application of practice concepts (Bruce, Rietze, & Lim, 2014).

One PCE concept, diagnoses–outcomes–interventions, is prominent in Careful Nursing and operationalized as a care planning structure using the North American Nursing Diagnosis Association – International (NANDA-I) (Herdman & Kamitsuru, 2014), nursing outcomes classification (NOC) (Moorhead, Johnson, Maas, & Swanson, 2013) and nursing interventions classification (NIC) (Bulechek, Butcher, Dochterman, & Wagner, 2013); together referred to as NANDA-I, NOC and NIC (NNN). Identifying patients' nursing diagnoses is an essential first step in this care planning structure. A nursing diagnosis is "a clinical judgement concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community" (Herdman & Kamitsuru, 2014, p. 25). The term diagnosis is used instead of problem because diagnosis means that a problem is identified accurately, and nursing accuracy is crucial to patient safety. The NANDA-I diagnoses maximize accuracy because each is made according to its defining characteristics and related factors, which enable accurate differentiation among similar problems. The NANDA-I diagnoses give nurses a nursing language with which to discuss their practice and are the most widely used nursing diagnoses internationally (Tastan et al., 2014). The NOC outcomes are defined in detail; each includes a 5-point Likert-type measurement scale and a number of outcome indicators to assist with measurement. The NIC offers a comprehensive range of defined nursing interventions. Most importantly, these standardized languages are evidence-based, frequently up-dated and are easily used together (Johnson et al., 2012).

#### 1.2.1 | Implementation decision

The decision to explore implementation of Careful Nursing was made by the director of nursing and nurse managers because the

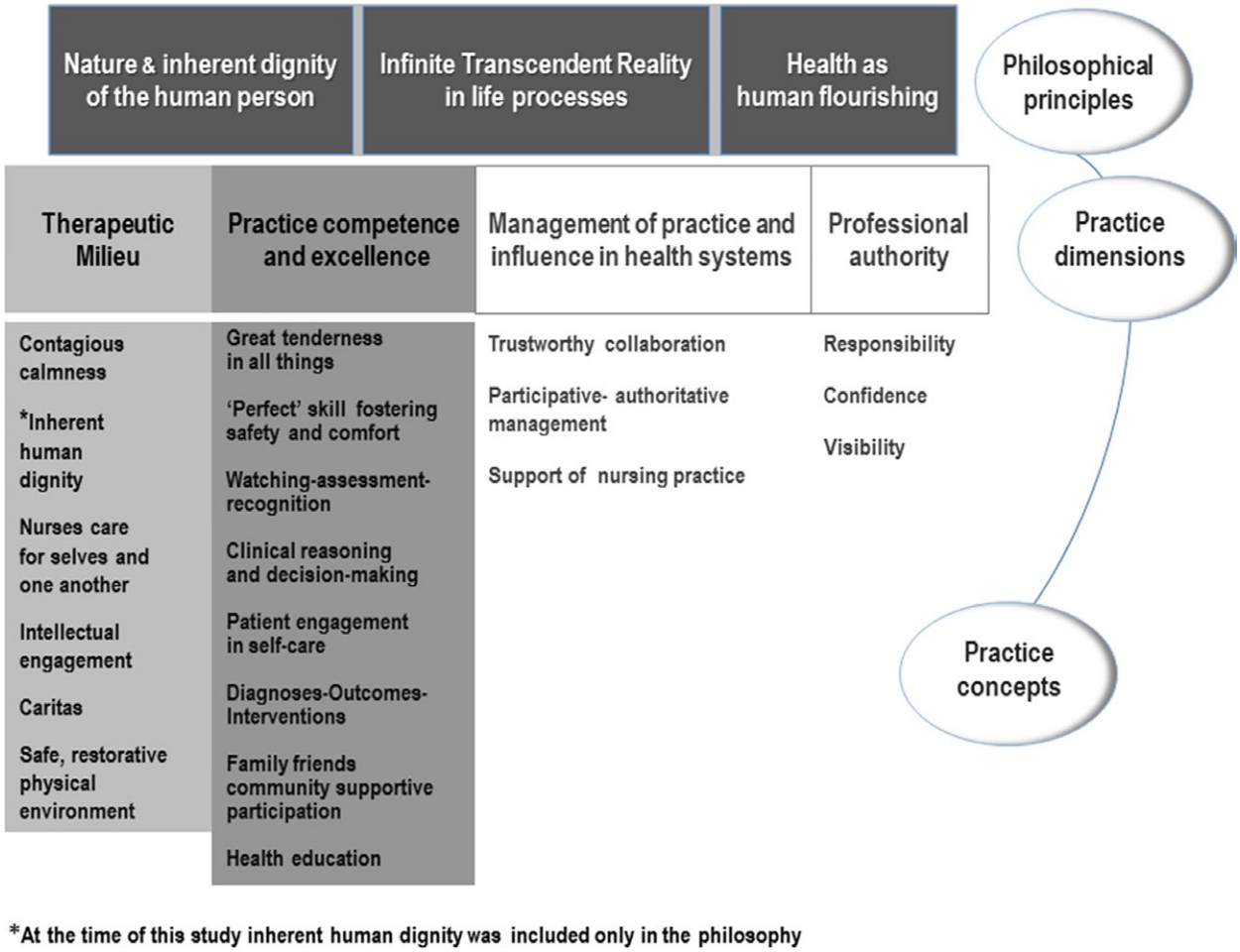



**FIGURE 1** Careful Nursing philosophical principles, and practice dimensions with their concepts

currently endorsed conceptual model of nursing was ineffective. Careful Nursing was selected because it supported hospital values such as respect for human dignity, generosity of spirit and compassion. Implementation was agreed despite a serious shortage of nurses due to a protracted Government-imposed moratorium on recruitment. Implementation was limited to one ward because it constituted a major change in how nurses approached their practice and such change is best initiated on a small scale (Reed & Card, 2016). The nurses practicing on the implementation ward, together with the multidisciplinary team and care assistants, welcomed the study.

### 1.3 | Aims

The study aimed to determine if the modified form of Careful Nursing described above would increase nurses' control over their practice, increase nurses' adherence to hospital nursing documentation standards, positively influence nurses' perception of their practice, and be feasible to implement.

## 2 | METHODS

### 2.1 | Design and setting

A mixed methods exploratory design was used, employing quantitative and qualitative methods. The study was conducted over 16 months during 2012–2013 in a 26-bed acute medical ward at a 544-bed urban hospital in Ireland. Patients were aged 65 years and older and their medical diagnoses were mainly stroke and dementia.

### 2.2 | Instrumentation

Nurses' control over practice was measured using the Control Over Nursing Practice Scale (CONP) (Parsons & Murdaugh, 2007), designed to measure hospital-based nurses' freedom to evaluate and modify their practice. The CONP is composed of 16 statements, each with a 7-point Likert scale. Scores range from 1, minimal to 7, maximum control. The CONP includes two subscales: Clinical Autonomy (CA) including eight items measuring nurses' freedom to practise patient care using independent clinical decision-making and Control Over

Unit Operations (COUO) including eight items measuring nurses input and engagement in decision-making about patient care operations. Parsons and Murdaugh demonstrated good internal consistency, using Cronbach's α, for the total scale (α = 0.94) and each subscale (α = 0.92). They examined construct validity using confirmatory factor analysis within structural equation modelling. The CONP loaded at 0.87 on both CA and COUO; CA loaded between 0.61 and 0.86 on its eight indicators and COUO loaded between 0.59 and 0.84 on its eight indicators.

Nurses' adherence to documentation standards was measured using the hospital-constructed Nursing Documentation Audit Tool, designed to evaluate the specificity and comprehensiveness of nurses' documentation in patient charts. It consisted of seven documentation standards containing a total of 46 Yes/No questions, each rated with an adherence score from 0 to 3. Total adherence scores ranged from 0 to 100. The original audit tool used for pre-adoption measurement was modified for post-adoption measurement; the original tool language of the 11 questions of Standard 6: "Identification of priorities of care" was converted to the language of the new care planning system. For example, pre-adoption question 1, "Post assessment, are the Nursing Problems identified?" was converted to 1. "Post assessment, are the Nursing Diagnoses identified and recorded correctly?" The converted post-adoption language was reviewed independently by four nurses familiar with the audit tool and the new care-planning system.

## 2.3 | Qualitative data

Focus group sessions were used to obtain nurses' perceptions of adopting the therapeutic milieu concepts. A semi-structured interview guide was developed, organised according to the therapeutic milieu concepts. For each concept prompts included "In your practice how did you find the idea of (concept)?" and "Was it something that you could implement in your practice?"

A Careful Nursing Care Plan Questionnaire was constructed to obtain in writing nurses' perceptions of the benefits and challenges of their adoption of the new care planning system and its documentation. It was composed of the five open-ended questions, shown in Table 3.

## 2.4 | Participants

The 23 nurses practising in the ward prior to adoption of Careful Nursing were invited to participate in the study. Eighteen completed a demographic data form, indicating their consent to participate. The age range of this core convenience sample was 24 to 52 years (median = 29). This core sample was mainly female (*n* = 16), and from an Irish (*n* = 7), Indian (*n* = 5), Philippine (*n* = 5) or Nigerian (*n* = 1) cultural background. All had a bachelor's degree in nursing and predominantly had some knowledge of NNN. During implementation five resigned and four were replaced. Following adoption, qualitative data were sought from the 22 remaining nurses.

## 2.5 | Implementation procedures

Implementation was managed by an implementation steering committee, guided by a detailed project plan, and took place in three phases: ward preparation, education workshop and ward adoption.

### 2.5.1 | Ward preparation

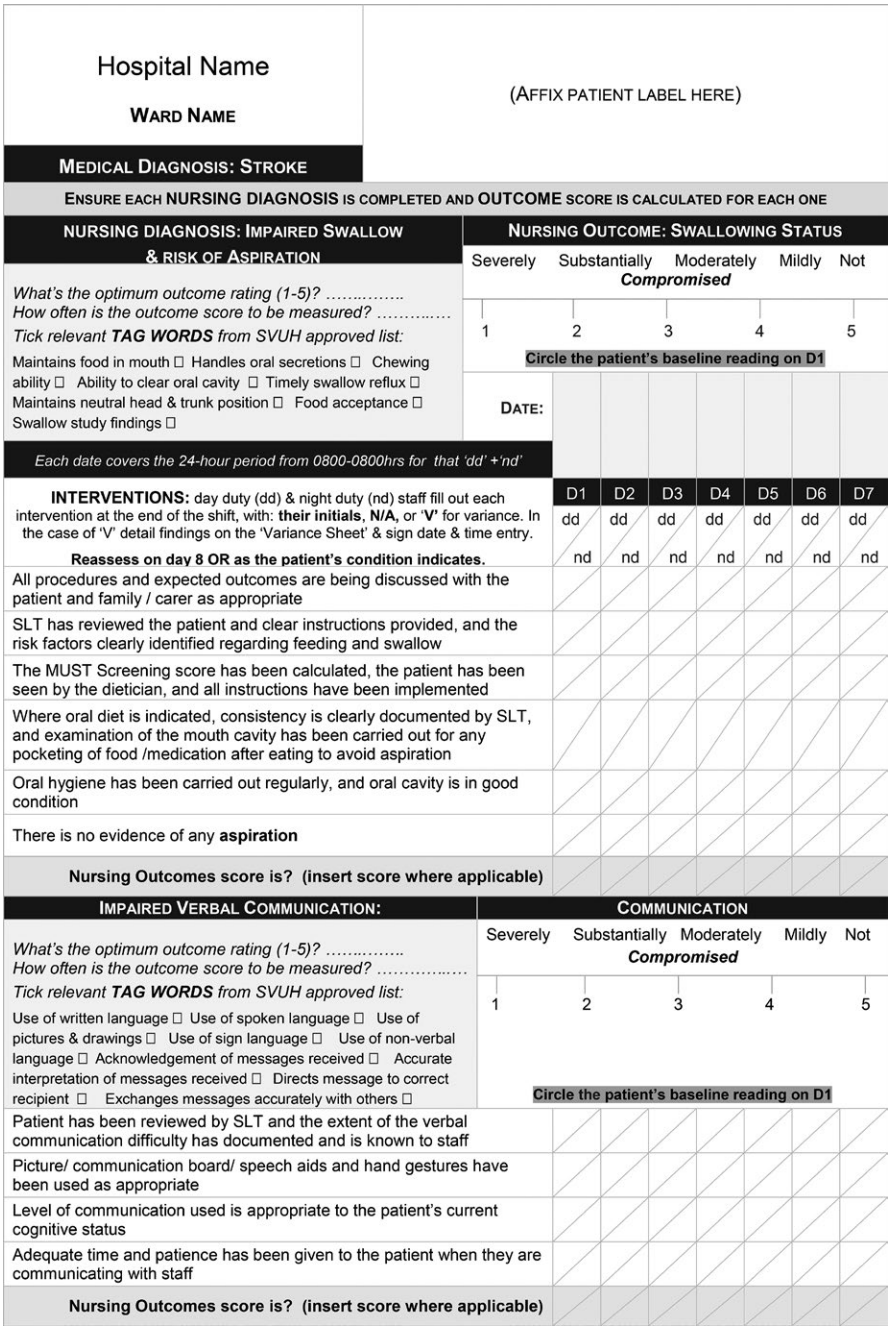
Over a 6-month period a clinical facilitator (CF), appointed to plan and manage implementation, conducted a comprehensive review of nursing care planning and held detailed discussions with ward nurses about their current care-planning, which focused substantially on patients' medical care accompanied by ad hoc identification of patients' nursing problems and needs, documented free-style in a written nursing record. The Careful Nursing approach, especially use of NNN and their implications for revised care-planning and patient safety, was discussed extensively. Concurrent introduction of collaborative problems (Carpenito, 2013) was also discussed and agreed on with the multidisciplinary team. Collaborative problems complement nursing diagnoses by structuring nurses' vital 24/7 collaborative role in identifying and monitoring patient risks for physiological complications, using the watching-assessing-recognition concept.

Working together, the clinical facilitator and ward nurses selected a group of NANDA-I diagnoses, with linked NOC outcomes and modified NIC interventions, which addressed patients' needs. Some diagnoses were modified minimally for contextual reasons, and some combined for practical reasons, for example, impaired swallowing with risk for aspiration. Diagnoses were organised according to the body systems-based assessment then in use. For example, cardiovascular system diagnoses included decreased cardiac output and impaired peripheral tissue perfusion. Each diagnosis drove a 7-day care plan mapped to a NOC desired outcome, and related NIC interventions which were merged with hospital policy and guidelines for best practice. Forty care plans were agreed and constructed in a semi-electronic format. Each diagnosis was linked to a 12-hr intervention and measurable NOC outcome documentation grid to be initialled by nurses every 12 hr. The first page of a 4-page care plan is shown in Figure 2.

Variations in patients' status and care were recorded on a Variations Page. Patient watching–assessment–recognition was to be on-going, with full reassessment conducted every 7 days or earlier if necessary. Care plans were up-loaded to a care plan-designated computer-printer, ready for selection, printing and placement in patients' documentation folder.

### 2.5.2 | Education workshop

All ward nurses attended one of three repeated Careful Nursing workshops each conducted over two consecutive, 7.5 hr days. Care assistants attended a modified 5 hr philosophy and TM dimension-focused workshop. Workshops were structured according to a detailed Careful Nursing workbook which described and illustrated the philosophy, dimensions and their concepts. Two hours focused on the philosophy. Three hours focused on the therapeutic milieu dimension



Hospital Name

WARD NAME

(AFFIX PATIENT LABEL HERE)

MEDICAL DIAGNOSIS: STROKE

ENSURE EACH NURSING DIAGNOSIS IS COMPLETED AND OUTCOME SCORE IS CALCULATED FOR EACH ONE

NURSING DIAGNOSIS: IMPAIRED SWALLOW & RISK OF ASPIRATION

What's the optimum outcome rating (1-5)? ……..……..
How often is the outcome score to be measured? ……..…..
Tick relevant TAG WORDS from SVUH approved list:
Maintains food in mouth ☐ Handles oral secretions ☐ Chewing ability ☐ Ability to clear oral cavity ☐ Timely swallow reflux ☐ Maintains neutral head & trunk position ☐ Food acceptance ☐ Swallow study findings ☐

NURSING OUTCOME: SWALLOWING STATUS

Severely Substantially Moderately Mildly Not Compromised

1 2 3 4 5

Circle the patient's baseline reading on D1

DATE:

Each date covers the 24-hour period from 0800-0800hrs for that 'dd' +'nd'

| INTERVENTIONS: day duty (dd) & night duty (nd) staff fill out each intervention at the end of the shift, with: their initials, N/A, or 'V' for variance. In the case of 'V' detail findings on the 'Variance Sheet' & sign date & time entry. Reassess on day 8 OR as the patient's condition indicates. | D1 | D2 | D3 | D4 | D5 | D6 | D7 |
|---|---|---|---|---|---|---|---|
| | dd / nd | dd / nd | dd / nd | dd / nd | dd / nd | dd / nd | dd / nd |
| All procedures and expected outcomes are being discussed with the patient and family / carer as appropriate | | | | | | | |
| SLT has reviewed the patient and clear instructions provided, and the risk factors clearly identified regarding feeding and swallow | | | | | | | |
| The MUST Screening score has been calculated, the patient has been seen by the dietician, and all instructions have been implemented | | | | | | | |
| Where oral diet is indicated, consistency is clearly documented by SLT, and examination of the mouth cavity has been carried out for any pocketing of food /medication after eating to avoid aspiration | | | | | | | |
| Oral hygiene has been carried out regularly, and oral cavity is in good condition | | | | | | | |
| There is no evidence of any **aspiration** | | | | | | | |
| **Nursing Outcomes score is? (insert score where applicable)** | | | | | | | |

IMPAIRED VERBAL COMMUNICATION:

What's the optimum outcome rating (1-5)? ……..……..
How often is the outcome score to be measured? ……..…..
Tick relevant TAG WORDS from SVUH approved list:
Use of written language ☐ Use of spoken language ☐ Use of pictures & drawings ☐ Use of sign language ☐ Use of non-verbal language ☐ Acknowledgement of messages received ☐ Accurate interpretation of messages received ☐ Directs message to correct recipient ☐ Exchanges messages accurately with others ☐

COMMUNICATION

Severely Substantially Moderately Mildly Not Compromised

1 2 3 4 5

Circle the patient's baseline reading on D1

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Patient has been reviewed by SLT and the extent of the verbal communication difficulty has documented and is known to staff | | | | | | | |
| Picture/ communication board/ speech aids and hand gestures have been used as appropriate | | | | | | | |
| Level of communication used is appropriate to the patient's current cognitive status | | | | | | | |
| Adequate time and patience has been given to the patient when they are communicating with staff | | | | | | | |
| **Nursing Outcomes score is? (insert score where applicable)** | | | | | | | |

**FIGURE 2** First page of a semi-electronic NANDA-I nursing diagnoses-guided nursing care plan

during which nurses formulated "I will" statements specifying how they agreed as a group to express each concept of the therapeutic milieu dimension in practice. Ten hours focused on the PCE dimension, particularly the new care planning system and its documentation. Detailed folders described, explained and illustrated the NANDA-I diagnoses, their defining characteristics and related factors; NOC outcomes and their measurement; and NIC interventions.

### 2.5.3 | Ward adoption

During the first 2 months of this 8-month period the clinical facilitator visited the ward daily and then gradually less frequently, supporting and guiding nurses and resolving adoption issues. A communications diary captured feedback when the clinical facilitator was absent. Therapeutic milieu "I will" statements (examples shown in Table 1) were displayed prominently and NNN textbooks were available for nurses to consult.

As issues arose they were discussed and solved with clinical facilitator guidance. For example, consulting NOC textbooks in measuring outcome scores proved awkward and time-consuming, so for each outcome "tag-words" consistent with its indicators were identified and listed in a pocket-sized laminated booklet that nurses could consult quickly.

## 2.6 | Data collection and analysis

The CONP scale was administered to the 18 participants prior to ward adoption and to the 13 remaining participants plus their four

**TABLE 1** Nurses' therapeutic milieu "I will" statements

| |
|---|
| **Caritas** I will: |
| Respect patients' values and beliefs |
| Put myself in patients' shoes |
| Respect myself and colleagues |
| Be sensitive and kind to patients |
| **Nurses' care for themselves and one another** I will: |
| Try to be more understanding and patient |
| Get enough sleep |
| Respect myself and colleagues |
| Be helpful and supportive to colleagues |
| **Intellectual engagement** I will: |
| Find a relevant article in nursing literature each month |
| Think about research findings I am using |
| Question the reason I use procedures |
| Think about how I can best keep patients safe |
| **Contagious calmness** I will: |
| Maintain a soothing manner in my work |
| Remember to smile at others |
| Compare times when I'm calm with times I'm not calm |
| Pause and take deep breaths when I feel stressed |
| **Safe and restorative physical environment** I will: |
| Check often that the ward is clean, especially patient tables |
| Frequently test equipment to be sure it's working |
| Watch for physical threats to patient safety |
| Minimize noise so that ward is restful |

replacements following adoption. Fifteen scales were returned anonymously. Because the sample size was small and the pre-post data non-paired, the Kolmogorov–Smirnov test was performed to test for normality. Because the test showed the data were normally distributed, independent sample *t* tests were used for analyses.

A retrospective chart review was conducted to measure nurses' adherence to practise documentation standards. Pre- and post-adoption ten charts were randomly selected from patients discharged from the ward over 3 months pre-adoption and over 3 months post-adoption. Charts were audited by one nurse not directly involved in the project. For each chart an adherence score was calculated, and a mean score was calculated for each sample. The Mann-Whitney test was used to compare samples. All quantitative data were analysed using IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corporation.

During the latter adoption period the total number of nurses practising on the ward was reduced to 22. All were invited to participate in post-adoption focus groups and complete the Careful Nursing Care Plan Questionnaire. Seven (32%) attended one of two 1-hr focus group sessions, four in one session and three in the other. Sessions were facilitated by one researcher, not involved with the hospital or Careful Nursing, who guided participants to discuss their perceptions of implementing the therapeutic milieu concepts, using the interview guide. Despite use of the interview guide participants frequently moved discussion to the new care planning system. The facilitator audio-taped the sessions, and then transcribed and cross-checked the data by re-listening to the audio-taped sessions. A conventional focus group content analysis was used to identify a prominent practice theme for each therapeutic milieu concept.

**TABLE 2** Means and standard deviations for CONP total and subscale scores

| Group | *n* | Mean | *SD* | *SEM* |
|---|---|---|---|---|
| CONP total pre | 18 | 5.07 | 0.833 | 0.174 |
| CONP total post | 15 | 6.15 | 0.591 | 0.153 |
| CA subscale pre | 18 | 5.50 | 0.715 | 0.149 |
| CA subscale post | 15 | 6.29 | 0.553 | 0.142 |
| COUO subscale pre | 18 | 4.66 | 0.769 | 0.160 |
| COUO subscale post | 15 | 5.97 | 0.545 | 0.140 |

CONP, control over nursing practice; CA, clinical autonomy; COUO, control over unit operation.

Eleven completed care plan questionnaires (50%) were returned anonymously. For each question the responses were analysed together by the clinical facilitator. The responses were read, re-read and cross-checked, listed as statements, and sorted according to similarity.

No data were collected from patients because many were frail and had difficulty communicating. Assessment of feasibility of implementation of Careful Nursing was on-going through perusal of the project plan and steering committee minutes.

## 3 | RESULTS

### 3.1 | Nurses' control over their practice

Total and sub-scale mean scores and standard deviations are shown in Table 2.

Independent sample *t* tests showed that post-implementation, nurses had a significant increase in CONP scores ($t = 4.4$, $df = 36$, $p = .001$) and in both subscale scores: CA ($t = 3.6$, $df$, 36, $p = .001$), and COUO ($t = 5.7$, $df$ 36, $p = .001$). Due to the small sample size used for analysis these results indicate that following adoption of Careful Nursing nurses' control over their practice, clinical autonomy and control over ward operations may have increased.

### 3.2 | Nurses' adherence to documentation standards

During the 3 months pre-adoption, adherence to hospital nursing department standards for documentation of nursing practice scores ranged from 43 to 57 (mean = 54.9; median = 52.5) and during the 3 months post-adoption, the adherence scores ranged from 63 to 94 (mean = 85.1; median = 88). Nurses' post-adoption adherence to documentation standards increased by 30.2%, compared with pre-adoption ($U = 98$, $p = < .001$). Due to the small sample of charts used for analysis, these results indicate that following adoption of Careful

Nursing, nurses' adherence to hospital nursing documentation standards may have increased.

### 3.3 | Nurses' perception of their practice

The focus group data gave rise to a prominent practice theme for each therapeutic milieu concept. For caritas the theme was "quiet presence which particularly helps patients with dementia or who are dying". For contagious calmness the theme was "our underlying philosophy which particularly helps patients who are agitated or hostile". For nurses' care for themselves and one another the theme was "working together closely with one another". The theme for intellectual engagement was "constantly questioning and thinking, has anything changed?". The theme for safe, restorative physical environment was "nothing new; something we always do". Themes from discussion about the new care planning system are reported beside similar responses to questions on the Careful Nursing Care Plan Questionnaire in Table 3. A representative sample of participants' responses to the five questions on the Careful Nursing Care Plan Questionnaire is reported in Table 3.

### 3.4 | Feasibility of implementation

The steering committee minutes revealed two main issues of concern; securing funding to support the clinical facilitator position and maintaining the ward staffing levels; both of which were achieved.

## 4 | DISCUSSION

This implementation study explored the effectiveness and feasibility of implementing the philosophy and two clinical dimensions of Careful Nursing in one ward in a major acute care hospital. Its purpose was to improve patient care and safety by enhancing nurses' practice milieu, strengthening nurses' control over their practice and structuring their accurate planning and documentation of the patient care and outcomes for which they are accountable.

Nurse Managers' early recognition that implementation of Careful Nursing constituted a major change in practice, and should begin on a small scale was important. Taylor et al. (2014) argue that failure to begin studying implementation of change in health care organisations on a small scale is likely to limit change adoption. Review of change implementation shows that when studies are commenced on a small scale and then gradually increased in size in an iterative process, greater stakeholder engagement and feedback on organisational fit is achieved and the risk of wasted organisational resources is reduced (Reed & Card, 2016).

The central importance of nurses having autonomy and control over their practice is emphasized in Magnet Recognition programmes and PPMs (Slatyer et al., 2016). In this study nurses' control over practice was measured using the CONP scale, and CA and COUO subscales (Parsons & Murdaugh, 2007), which have acceptable psychometric properties. The statistically significant increases in nurses' post-adoption CONP scores, and CA and COUO subscale scores appear encouraging but should be discounted because of the small sample.

Still, qualitative data suggest some participants perceived greater control over practice: "we support ourselves, stay calm"; "spend more time in assessment, planning and evaluating". Participants emphasized the importance of patient assessment. Without emphasis on assessment nurses lose control over their practice and patient safety is jeopardized because nursing diagnoses cannot be made (Herdman & Kamitsuru, 2014). Logically, for nurses to have control over their practice it must be visible to them. Some participants reported that Careful Nursing "makes nursing more visible, more clear what nurses do within the multidisciplinary team"; "it is nursing oriented and nursing language is used"; "need to think nursing".

Evidence of a nursing care delivery structure is also of central importance in PPMs (Slatyer et al., 2016), and precise care planning documentation is recognized as vital for many reasons, especially patient safety. Figure 2 shows that NNN effectively structured planning and documentation of patient care. Although the statistically significant 30% increase in post-adoption adherence to documentation standards appears promising, it should be discounted because of the small chart samples.

However, qualitative data suggest that some participants found the new care planning documentation more clear and efficient, "a great improvement"; "it prompts what needs to be done". On-going measurement of NOC scores allowed participants to "see better if patient is improving or not". Large studies show that NNN-driven care planning and documentation is effective in describing and managing nursing practice and predicting nursing outcomes. (Castellan, Sluga, Spina, & Sanson, 2016).

Nonetheless, qualitative data also reveal some participants' resistance to and difficulty with adopting Careful Nursing, the care planning system and documentation: it is "very theoretical"; a "book picture of nursing"; "outcome indicator does not make sense without reading the book". The new documentation gives no freedom to "fully express myself" or "express the total picture of the patient"; "it can be hard not to write something". These perceptions and concerns such as where to document patients' expectations of care and use of the Variance Form, provide important insights into the need for further education and possible revisions to the documentation system. The new documentation was also found to be "very limiting and deskilling" because the care plans are already laid out; "it reduces critical thinking". The 40 care plans were constructed prior to adoption because nurses did not yet have the experience needed to construct a plan individually on patients' hospital admission. These comments highlight the need for on-going evaluation of the adoption process and its fit in the hospital system.

Evaluation of the influence of the philosophical principles and closely-linked therapeutic milieu concepts was beyond the scope of this study. But no study of Careful Nursing can be implemented without including its philosophy and therapeutic milieu concepts because they are inherently part of Careful Nursing practice: "doing nursing, being a nurse, contains as much a philosophical dimension as it does a practical one" (Forss, Ceci, & Drummond, 2013, p. iii). Qualitative

**TABLE 3** Nurses' responses to Care Plan Questionnaire with related focus group themes

| Nursing care plan questionnaire | | Focus groups | |
|---|---|---|---|
| **Questions** | **Representative written statements** | **Themes** | **Representative verbal statements** |
| How has the Careful Nursing Model made a difference to how you carry out your nursing? | Nursing more visible, we support ourselves, stay calm, better understanding of patients' feelings. Has helped my confidence in my nursing care<br>Not much difference but goes deep into nursing assessment, planning, and diagnosis. Approach to patient is different<br>Less paperwork. More time for patient care. Stops repetitive documentation for long-term patients. Less mind bothering taking notes. Can carry out duties without rushing<br>More time on day shift as less written work, but more paper work on night shift and less time for patients. More time to organise my care, particularly in the morning<br>Documentation easy; more aware of therapeutic milieu, which is important in nursing | Better use of time<br>Model is engaging<br>Meaningful participation in change | Improved the time we can give to patients<br>Much less time spent with unnecessary paperwork<br>Previous models were just care plans<br>We were very involved in making it work for us. Our input was listened to and adjustments made |
| Explain if and how the new nursing documentation has changed the way you approach your nursing care | More time in assessment as no lengthy writing. It is more organised<br>Makes nursing more visible, more clear what nurses do within multidisciplinary team and together we are creating a therapeutic environment that nurtures healing<br>Formally reassessing patients weekly is good because we can see better if patient is improving or not; ensures issues like continence and mobility are updated and clear to any "bank" nurse<br>Spend more time in assessment, planning and evaluating. Don't need as much time documenting. More time to interact with patients and their relatives<br>Documentation is appropriate to the care plan and nursing evaluation is important<br>Approach hasn't changed; care and standards the same; but way written is different<br>Seems like no change but have more time to spend with patients. Documentation easier and less time consuming | Participation made change possible<br>Previous informal re-assessment became formal<br>Improved nurse communication | High level of nurses' inclusion in change reduced its impact and led to its acceptance. People became comfortable about it because they could express their concerns<br>Increased focus on re-assessment very valuable<br>It improved quality of our nursing care<br>More questioning and discussion among ourselves |
| What have you found beneficial about the new nursing documentation? | Nursing diagnosis and detailed nursing care plan prompts what needs to be done. It saves time spent documenting care for long-term patients but not for those acutely ill<br>Time saved can be used for other important nursing jobs like talking and listening to patients<br>Saves time, detailed reassessment sheet is very helpful and informative; system-wise reassessment is excellent to make nursing diagnoses. Helps document patients' progress<br>Detailed assessment and reassessment forms. Is organised and easy to access because all forms are available on the computer. Less unnecessary writing and have more time at bedside<br>It is nursing orientated and nursing language is used. Need to think nursing before writing. Interventions are standardized, professional and accessible<br>Have more time for patient care in mornings. Less time needed to sign off at end of shift<br>Found documentation a great improvement and have enjoyed being part of the pilot | More time with patients<br>Much less writing<br>Support important<br>New system comprehensive | More time available to engage directly with patients<br>Less unnecessary paperwork<br>Felt we were listened to. CF responded very quickly to our concerns and needs<br>Formal patient reassessment each week made us very aware of need for continual patient reassessment<br>Clearer, more concise understanding of patients' status |

(Continues)

**TABLE 3** (Continued)

| Nursing care plan questionnaire | | Focus groups | |
|---|---|---|---|
| **Questions** | **Representative written statements** | **Themes** | **Representative verbal statements** |
| What have you found challenging about the new nursing documentation? | Not sure whether to put common problems like incontinence in the variance form<br>No place to put blood sugars. Can't fully express myself in the new care plan. We cannot express the total picture of the patient. There is a chance of missing something<br>On night duty you have to read and sign everything and this is difficult and time-consuming. It is very limiting and deskilling because the care plan is already laid out. It reduces critical thinking which is encouraged in nursing. It feels like there's something missing<br>No freedom of documentation because interventions are already decided and we just sign for what is already there. Staff will be thinking about documentation only at the end of the shift<br>Initially outcomes and diagnosis were challenging but the more I used Careful Nursing, the more confident I got. All issues were dealt with quickly by [the CF]<br>It is very theoretical. It gives us a book picture of nursing. The outcome indicator doesn't make sense without reading the book. It takes a lot of time and effort to read and do the care plan | Change is difficult<br>Easy to slip back to old ways | It's hard for nurses who have been qualified longer<br>Initially consultant doctors uncertain about changes<br>Initially families thought little writing meant patients not being cared for<br>Huge change; takes time to get used to it<br>Requires new way of thinking<br>It can be hard not to write something |
| What changes would you like to see made to the nursing documentation? | I prefer the old continuation sheet, although the assessments and reassessments are very helpful and informative<br>We need care plans for all problems and all body systems<br>The nursing documentation is nursing orientated, it only tells you what nurses do, not how patients feel. It would be better if it was more patient orientated<br>The outcome indications are working as numbers and it is difficult to get the outcomes book all the time to understand what the numbers mean<br>There is still a lot of writing and repetition going on in the Variance Form. The Variance Form is not big enough to write all the individualized care occurrences/variances. This needs more education<br>We cannot express the total picture, unlike the previous documentation style<br>The end of each shift feels incomplete with no satisfaction that everything is documented<br>Is there a way to document the patient's expectation of care? If we could make some room for patients' concerns, they would have more realistic expectations<br>How far does a care plan cover a nurse legally if any issues should arise that need to be dealt with in court? | None | None |

studies are needed to examine these aspects of Careful Nursing in practice.

The Care Plan Questionnaire that all ward nurses were asked to respond to anonymously following adoption was returned by only 11 nurses (50%). This response could mean that only half of the ward nurses were interested enough in the new care planning system to comment on it. But, considering Rogers' (2003) theory of diffusion of innovations, it is also possible that this low response might be expected and represents "innovators" and "early adopters" of an innovation (pp. 282–283), estimated to be around 16% of a group asked to adopt a change.

Although this study was small and explored the implementation of Careful Nursing under challenging practice circumstances with questionable results, it is still worthwhile. The study results served as a basis for expansion of implementation in the study hospital. The study provides an example of issues to be faced and addressed in setting out to achieve practice excellence. This is important considering the central and critically important role of the nursing profession in

contributing to hospitalized patients' safety and quality of care and widely publicized breaches in the profession's fulfilment of this role.

## 5 | LIMITATIONS

This study had several limitations. Because it was conducted in one ward, it employed a small convenience sample. Despite anonymity in the collection of CONP and Nursing Care Plan Questionnaire data, the participants could still have been vulnerable to desirability response bias. The post adoption audit tool itself could have influenced documentation measurement due to the changes made to the 11 questions of Standard 6. These limitations preclude generalizability of the results and limit the likelihood that statistically significant results represent a true effect. Further, low response rates in qualitative data collection weakened the trustworthiness of these data shown in Table 3, and selected from the quoted statements above.

## 6 | CONCLUSIONS

Despite the inherent limitations of a small study, the results of this study suggest that Careful Nursing, as implemented, could have a positive overall influence on nurses' practice. Implementation of Careful Nursing is feasible.

## 7 | IMPLICATIONS FOR NURSING MANAGEMENT

Implementation of Careful Nursing on a small scale offers nurse managers a feasible opportunity to make nursing practice visible to nurses themselves, and to patients and the multidisciplinary team. Careful Nursing involves collaborative practice with a distinctive nursing contribution, rather than integrated interdisciplinary care. Careful Nursing offers important practical advantages due to its natural incorporation of the standardized nursing languages NNN. These languages focus on accuracy in practice and strengthen nurses' control over practice; they drive patient safety because they guide evidence-based care planning and a practice documentation system that requires nurses to emphasize patient assessment, think in detail about their practice and how it contributes to enhancing the quality of patient care. In particular, NNN enable the on-going measurement of nursing-sensitive patient outcomes. Equally important for nurses are the Careful Nursing's philosophical foundation and therapeutic milieu concepts; they bring to life for nurses the deeply relational power of nurse–patient relationships and give meaning to their practice.

Implementation of Careful Nursing would bring a major change in practice and would need to be assessed for organisational fit. Implementation would also require wide consultation with nurses, the multidisciplinary team and assistive personnel. If implementation is decided it should take place in small steps beginning with one ward, be based on a detailed project plan and monitored by a steering committee. Appointment of a clinical facilitator, committed to clinical practice, to guide implementation would be essential for initial guidance and support of nurses' adoption. Implementation of Careful Nursing even on a small scale is a major undertaking but it has the potential to strengthen a journey to excellence in nursing practice.

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## ETHICAL APPROVAL

Ethical approval was obtained through the hospital ethics and research committee expedited review. Nurses gave their informed consent to participate and focus group participants were assured in writing that audio-taped data would be kept confidential.

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## SUPPORTING INFORMATION

Additional Supporting Information may be found online in the supporting information tab for this article.

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**Supplementary Table**. Careful Nursing philosophical principles, the therapeutic milieu dimension, and the practice competence and excellence dimension

| *Philosophical principles* | *Assumptions* | *Meaning in practice* |
|---|---|---|
| Nature and inherent dignity of the human person | A human being is a unitary* person with a rational nature and inherent capacity of goodness: has two distinguishable realities (not parts), a bio-physical reality of body and senses – an outward life – and a psycho-spiritual reality of mind and spirit – an inward life: is an individually unique, relational being. Every human person has inherent dignity and all are equal in dignity. | Nurse-patient relationships are experienced as unitary relationships. At the same time, nurses attend to patients' bio-physical reality of body and senses (e.g., wound dressing, pain relief) and psycho-spiritual reality of mind and spirt (e.g., fearfulness, confusion). Nurses' have unconditional respect for their own inherent dignity and that of patients and others. |
| Infinite Transcendent Reality in life processes | There exits an Infinite Transcendent Reality which is inherent in life processes and is the source of all creation, unitary wholeness and healing in the universe. It is composed of boundless love and goodness, often experienced as wonder and beauty, and draws all things to it. It is experienced as spirituality and has different names among different peoples and cultures. | Patients have potential to experience spirituality. They may understand and describe this in different ways, which nurses must be sensitive to and respect. Nurses' understanding of their spirituality can enhance their healing influence through calmness, patience, empathy, kindness, compassion and gentleness. Taking at least five minutes personal time each day in 'stillness' (any meditative practice) supports these abilities. |
| Health as human flourishing | Essential needs are met, e.g., safety, food, clothing, shelter, human relationship. Ideally associated with the relative absence of disease but can still be fully experienced in states of disability or chronic illness. Enhanced through using intellect and will to develop good habits and natural capacities for goodness in self and to intend goodness for others for their own sake. Healing is a unitary process and flourishing an unfolding of human potential. | Nurses monitor patients 24/7 for threats to immediate bio-physical and psycho-spiritual safety, ensuring relief from pain and easing fear and anguish to every extent possible. All patients are helped to use their intellect and will to engage in self-care to achieve the most complete recovery possible or to live in the healthiest way possible with disability or chronic illness. At a deep level patients' seek meaning and a sense of purpose in life. |
| *Therapeutic milieu* † | *Definition* | *Meaning in practice* |
| ***Therapeutic milieu*** | **The optimally safe, healing surrounding and culture that nurses create primarily for patients, but also for themselves and others. It is rich in therapeutic inter-personal relationships and co-operative attentiveness to patients, and defined by its five concepts.** | **A ward or unit culture is nurse-led, reflecting the long-established principle that the milieu of hospital wards or units is the professional responsibility of nurses. It is created by *how* they are in themselves; in their attitudes and activities as they implement its eight concepts.** |
| *Caritas* | The spiritual, unconditional love of healing relationships which | Expressing intention to help and foster healing in all patients, |

| | | |
|---|---|---|
| | has its source in Infinite Transcendent Reality. Is characterised by patience, attentiveness, empathy, kindness, compassion, joyfulness and peacefulness. It arises in the inward life and resides in the will, not in transient emotions. | unconditionally, by acting with patience, kindness and compassion; being gentle and tender in all practice activities; being empathically aware of patients' needs; and conveying inner joy and peacefulness in all practice relationships. |
| *Nurses' care for themselves and one another* | Nurses' attentiveness to, and respect for, their own health and the health of nurses they work with, in unitary, bio-physical and psycho-spiritual terms. Working together in harmony to develop friendship as a virtue in professional relationships. | Having a healthy diet, regular rest, relaxation, exercise, enjoyable social interaction, and engaging in meditative stillness each day. Being sensitive to, and acting with kindness towards, self and colleagues. Welcoming and assisting new colleagues. |
| *Intellectual engagement* | Ability to conceptualise and reason creatively and critically. Theorising about distinctively nursing knowledge and practice experience drawing on all related knowledge, and in relation to the cultural, political and economic contexts of practice. | Using philosophy and a nursing model to guide practice that enhances the healing mission of healthcare settings. Reviewing and using nursing and other scientific research to guide practice. Reading and sharing articles from nursing and other literature. |
| *Contagious calmness* | Ability to experience and convey an inner sense of calm even under the most urgent or stressful circumstances. Having a manner of composed confidence and alertness to the needs of patients and practice situations. Enables reasoned judgements. | Taking at least five minutes of personal time each day in 'stillness' (any meditative practice). Over time this develops and supports a naturally calm disposition. Pausing for a few seconds of 'stillness' and calmness frequently during practice. |
| *Safe and restorative physical environment* | A safe and meticulously clean surrounding for patients; a ward or unit; that is orderly, free from potentially harmful physical factors, as quiet as possible, and maximises the effects of natural healing elements such as light, fresh air, space and colour. | A hospital ward or unit is the professional domain of nurses. They have ultimate responsibility for its safety, cleanliness and ambiance so that patient healing and their practice is supported, even if work done to ensure it is delegated to others. |
| *Practice competence and excellence* | *Definition* | *Meaning in practice* |
| ***Practice competence and excellence*** | **A contemporary interpretation of the nursing process. It follows the pattern of nurses' attitudes and activities as they engage in direct clinical care of patients. It is defined by its eight concepts which are implemented at least with competence and always with intention to develop excellence.** | **Being tender and accurate in all aspects of practice. Using scientific knowledge, intuition and standardised nursing languages to communicate practice. Monitoring 24/7 for, and responding rapidly to, bio-physical threats to patient's safety. Engaging and educating patients in their own self-care.** |
| *Great tenderness in all things* | Conscious intention to act toward patients and implement all procedures with gentle sensitivity, respectfulness, patience, empathy, kindness, and compassion. It brings the therapeutic | All clinical actions are guided by tenderness. Need to be aware that attending to a patient for any clinical reason creates a unitary (holistic) nurse-patient relationship in which the nurse's |

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|---|---|---|
| | milieu concept of caritas directly into care-giving actions. | conscious intention to act with tenderness is communicated. |
| *'Perfect' skill in fostering safety and comfort* | Meticulous attention to detail in all aspects of clinical practice, from the most elementary care to complex clinical interactions and techniques. Faultless detail sometimes required, e.g., in medication administration, but is also an ideal to work toward. | Conscious attention to detail and accuracy in both physical and intellectual actions. All physical actions, simple or complex, can be done as perfectly (as beautifully) as possible. Thinking also must be accurate, e.g., assessment and clinical decision-making. |
| *Watching-assessment-recognition* | A threefold concept in which its interrelated qualities give rise to nurses' knowledge of patients' bio-physical, psycho-spiritual and unitary condition and needs. Its qualities are distinctive but folded into one another to form one concept. | Awareness that nurses' distinctive 24/7 watching is a protective function and can be the 'first alert' of a patient problem. It is also the background for assessment, and aids recognition of what patients' objective and subjective assessment data means. |
| *Clinical reasoning and decision-making* | Logical and intuitive thinking processes and strategies used to understand patient data and choose between alternatives in identifying patients' nursing diagnoses, selecting and measuring nursing outcomes and implementing interventions. | Recognition that this concept is closely interrelated with watching-assessment-recognition. Literature and nursing practice experience show that it is unwise to allow emphasis on logical thinking to overshadow the importance of intuitive thinking. |
| *Patient engagement in self-care* | People participate in choosing and evaluating their nursing and health care to the extent that they are able to, and wish to do so. It is assumed that all people have the capacity to engage in choosing their care, even if very minimally. | Recognition that, mostly, nursing is needed when normal self-care is limited. Patients have a right to continue to engage in self-care, even if only minimally. Most require on-going assistance and support to re-engage in full self-care as soon as possible. |
| *Diagnoses-outcomes-interventions* | The NANDA-I nursing diagnoses, Nursing Outcomes Classification, and Nursing Interventions Classification standardised nursing languages are research-based, clearly defined, measurable, and drive high level nursing assessment. | Patient problems are called diagnoses because 'diagnosis' means identifying problems accurately. NANDA-I nursing diagnoses, with their defining characteristics and related factors motivate on-going measurement and reassessment of care-planning. |
| *Patient family, community supportive participation in care* | Collaboration with other health professionals to encourage, support and organise patients' family members, friends and community services to participate in patient's care, according to patients' wishes and as this is possible and appropriate. | Family and community supportive care is particularly important to support patient self-care when this has become very or chronically impaired, or when self-care has become complex. On-going collaboration is required to organise this. |

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| *Health education* | Ensuring to every extent possible that patients and their supportive persons are helped to learn information they need to enhance patient self-care and protect and enhance patient health over time. Ideally, this begins as soon as nursing care begins. | Almost all nurse-patient interactions offer the opportunity to assess, plan, and/or help patients to learn what they need to know to engage as fully as possible in self-care and to adapt required or recommended care to their particular way of life. |

* The term holistic is commonly used to mean unitary. Although holistic was originally coined to mean unitary, it is now widely misunderstood.

† The concept of inherent human dignity is now part of the therapeutic milieu dimension, but at the time of the study was included only in the philosophy.