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Synthesized Grounded Theory Expansion of the Quadruple Aim in Acute Care Nursing

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has been found to be complete and satisfactory in all respects,

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Walden University

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Abstract

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by

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MSN, University of Phoenix, 2010

BSN, University of Phoenix, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

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Abstract

Conflation of moral and compassionate healthcare within the business model that is focused on customer service, disempowers, dehumanizes, and destabilizes nursing as well as the financial stability of healthcare. The purpose of this research was to determine nurses' perceptions of how their work environment supported or contradicted a potential expansion of the quadruple aim. The quadruple aim was the primary conceptual framework for this research. The overarching research question was about how the environment of care supports professional nurses' provision of high-quality person-centered care and bolsters meaningful and purposeful careers. The synthesized grounded theory methodology was used to collect and analyze data, which were obtained from a sample of acute care bedside nurses from six regions of the United States. One- and two-way observational methods were used to collect data. Two-way observations included reflective journals and follow-up clarifying interviews. Themes included positive aspects of nurse identity, barriers to nursing practice, and three emerging themes. During the last two decades schools have focused on teaching the biomedical model to nursing students, which causes nurses to lose sight of their scope of practice. Nurses, when able to practice at their highest level of nursing education, can contribute positively to the four tenets of the quadruple aim, and to positive social change. When the value of nursing service is fully recognized, nursing satisfaction and client satisfaction improve. As a result, healthcare organizations realize a stabilization of the work force and financial outcomes.

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Dedication

I would like to dedicate this work to my respiratory therapy and nursing colleagues and those in public service including first responders, human, and animal healthcare professionals. I would also like to acknowledge my family who valued education and dedicated their lives to the public service of our great nation and humanity around the world. They taught me to respect and serve others while appreciating the differences and vulnerabilities of all humanity as does the Nightingale pledge that graduate nurses take at their pinning ceremonies prior to licensure. Many authors have written versions of the Nightingale Pledge. I have taken the liberty to edit a version so that it meets my personal needs while keeping the original meaning intact.

> I solemnly pledge myself before God of all faiths and in the
> presence of the readers. To make moral and ethical choices.
> In life and the practice of professional nursing. I will do my best
> to avoid that, which is harmful and will not take or knowingly administer
> harmful substances. I will do that, which is within my power, to maintain
> and elevate the standard of my profession. I will hold in confidence
> personal and family matters shared with me in my practice. I will
> seek to collaborate with other healthcare professionals and devote
> myself to the welfare of those in my care, by taking both the
> art and science of nursing into account.

Acknowledgments

First, I would like to acknowledge the guidance of my dream team, Drs. Jay Greiner, Sandra Rasmussen, and Debra Rose Wilson. I appreciate and treasure their contribution to my growth. Others who have contributed pertinent education during this endeavor include the founder of CMBM, J. Gordon and his team for what they have done to reduce traumatic stress in this world. B. L. Seaward and E. J. Gentry were generous in helping me to understand complex and secondary traumatic stress that healthcare providers and first responders often experience. Micky, Marci, and Terri I appreciate your support from the world of holistic nursing. I am grateful to the HN teams with whom I collaborated to author HN conceptual papers and update nursing diagnosis. I am grateful for the stabilizing force of my feline family, Skeeter and Conan for their emotional support and the education they gave to me, as their human mother. Both have a huge chunk of my heart. I will be eternally grateful to Dr. Register who helped me to cope and care for them when they were critically ill in the middle of this "stress bath." I am grateful to Dani McVety, DVM the founder of the Lap of Love, for a short intensive with her and the hospice team as related to this work and the eventual loss of Skeeter. They touched my heart deeply and helped me gain a deeper understanding of the importance of this work from a perspective different than nursing. I am especially grateful to Carol, Heather, and Pamela, their precious supportive friendships. Finally, I would like to thank the nurses who supported this research with their participation.

Table of Contents

List of Figures

Chapter 1: Introduction to the Study

Introduction

Globally, healthcare organizations have been struggling with how to improve healthcare and population health since the early 1900s (Rutherford, 2014). Berwick et al. (2008) introduced the triple aim as a framework for providing high-quality, and safe healthcare systems. Bodenheimer and Sinsky (2014) updated the model by adding a fourth aim to the triple aim. The new quadruple aim recommended that healthcare leadership and managers help professional caregivers to improve their professional work life (Bodenheimer & Sinsky, 2014; Perlo & Feeley, 2018; Sikka, et al., 2015).

Nursing turnover rates in the United States (U.S.) have run close to 20% since the early 2000s (Jones, 2008). American healthcare expenditures in 2012 were 17.9% of the Gross Domestic Product (GDP) or $8,953 per capita (Florida Hospital Association [FHA], n.d.). Kerfoot (2015) said a turnover rate of 14% for a 300-bed hospital cost a facility approximately $4.4 million. Each percentage point of registered nurse turnover in a U.S. based hospital costs approximately $300,000 (Jones, 2008). The turnover rate in an acute care hospital with 600 beds in the U.S. ranged in cost from $5.9 to $6.4 million (Jones, 2008). These expenses were absorbed by the national healthcare system because a substantial part of healthcare is paid for by the government (Martin et al., 2014).

Career Satisfaction

Compassion fatigue, chronic and complex stress, burnout, bullying an oppressed workforce, unstable environments of care and salaries contribute to nursing and patient

dissatisfaction and high turnover rates (Dyrbye et al., 2017; Han et al., 2011; Hunsaker et al., 2015; Lewis et al., 2014). Some healthcare organizations have employed healthcare strategists to improve patient satisfaction, by scripting interactions but that has not improved satisfaction scores for nurses or clients (Austin, 2011; Ritzer, 1983). Scripting is used to exceed the customers' expectations.in the fast-food and entertainment industry.

Person centered caring is dependent on the interpersonal carative relationship between the nurse and client (Lewis et al., 2014; Peplau, 1997; Stimpfel et al., 2016; Watson, 2012 & 2018). The value that nurses bring to the healthcare environment influences patient care satisfaction, and financial stability of healthcare organizations (Jones & Gates, 2007; Lewis et al., 2014, McHugh et al., 2011).

When nurses feel valued and respected by leadership it increases professional satisfaction. Nurses when able to practice at the highest level of their education can contribute positively to the four tenets of the quadruple aim. Multiple organizations have developed programs to improve client and nursing satisfaction and to reduce the problems that cause career dissatisfaction, reduced safety, and that contributes to ineffective communication. The Joint Commission (2012; 2016; 2017, & 2018) addressed the afore mentioned communication issues during root cause analysis investigation of various separate sentinel event alerts.

Government departments, professional organizations, social scientists, professional nursing organizations, and traumatologists have developed programs to improve expensive turnover rates in healthcare (American Nurses Association/American

Holistic Nurses Association [ANA/AHNA], 2013; ANA Enterprises, n.d.; Flarity, et al., 2013; Lewis et al. 2014; Sikka et al., 2015). Duplicate work occurs and confounding professional guidelines make it expensive and difficult to implement changes because the organizations are not collaborating.

Lack of transparent communication cultivates lack of understanding between professionals regarding specific client care responsibilities. When organizational leaders do not understand the scope of professional practice authority and control over practice it may lead to conflict that limits productive communication. An absence of mutual understanding between medicine and nursing is an example of conflict that this research may help resolve. The goal is to increase professional understanding and collaborative efforts among business, medicine, and nursing.

The aim of this research was to better understand how the environment of care relates to the caritive model of nursing to support client health and wellbeing. Watson (2018) wrote that when nurses are immersed into an organization focused on the curative medical model, it pulls nurses away from what grounds their practice. Nurses are unable to meet professional expectations when they are separated from nursing's theoretical and philosophical roots and that leads to career dissatisfaction (Lewis et al., 2014; McElligott et al., 2010; Shanahan et al., 2018; Watson, 2012, 2018).

Frontline nursing staff suffer consequences of compassion fatigue, which involves burnout and traumatic stress (Figley,1995; Gentry, 2012; Stamm, 2010). Limiting the term to burnout alone in the quadruple aim may reduce the efficacy of the model. It may

be beneficial to better define professional nursing to enhance the way nurses understand the complexity of the problems discussed in the quadruple aim. Conflation of compassionate healthcare with customer service disempowers nurses, creates a loss of autonomy, and hinders their ability to practice at the top of their education.

Morgan and Yoder (2011) credited Peplau with describing person-centered care as being "the crux of nursing" (p. 7). Collaboration between those who use the carative nursing model and those who use the curative medical model may better serve the quadruple aim goals. Creating an environment which supports patients and professional satisfaction requires collaboration between medical and nursing staff, healthcare leadership, and managerial teams (McHugh et al., 2011).

Study Background

Researchers, including McHugh et al., 2011 and Romano et al., 2013 said that a balanced professional quality of life promotes wellbeing for nurses and clients. The research by Jones and Gates (2007), Kovner et al. (2014), and O'Brien-Pallas et al. (2006) showed a significant connection between nurses' wellbeing, patient safety, retention of staff, and the financial stability of healthcare organizations. When the health and wellbeing of nursing staff lacks balance, and nurses lacked a sense of professional career satisfaction it increased healthcare costs. This created environmental safety concerns involving absenteeism, presenteeism, increased nurse turnover rates and reduced client satisfaction (Jones, & Gates, 2007; Killian, 2008; Kovner et al., 2014; O'Brien-Pallas et al., 2006). Nurse's health and the cost of private healthcare insurance

increased due to stress of nursing practice (Kovner et al., 2014). This increases costs to healthcare organizations as more services must be provided to staff members. Patient safety and return to hospital within a 30-day window increases based on the same factors that influence career satisfaction and turnover rates.

Professional caregivers are often overcome by burnout and traumatic stress (Gentry, 2012; Joint Commission, 2008, 2016; Stamm, 2010). Burnout is external and related to a toxic work environment whereas traumatic stress is intrinsic (Gentry, 2012). Bullying is an endemic problem within professional nursing and a source of traumatic stress that contributes to a lack of safety, communication problems, and nurse turnover rates (Gourley, 2008; Joint Commission, 2008, 2016). Bullying is known to be a driving force of depression and burnout, which contributes to suicide (Davidson et al., 2018; Gentry, 2012).

Based on the complex nature of stress and resilience experienced by those in healthcare, the term secondary traumatic stress is inclusive of traumatic and complex stress. The symptoms of traumatic stress and burnout are similar, but they are not the same condition (Gentry, 2012; Stamm, 2010). These can be acute or chronic conditions and are time dependent.

The nurse practice acts in each state are written by interpreting these professional works and consider the *Nursing's Social Policy Statements* (Fowler, 2015b). Like medicine, nursing also has social covenants and a social contract with the public. The

Guide to Nursing's Social Policy Statement discusses policies and covenants (Fowler, 2015b).

Collaboration between those who use the carative nursing model as defined by Watson (2018) and those who use the curative medical model may provide more support for the quadruple aim. Traumatic stress and burnout are indicative of the negative aspects of caregiving. Burnout conflates problems found in a toxic environment and makes the environment unsafe (Gentry, 2012). Several researchers maintain that burnout is used to victim shame and make the nurse responsible for a toxic environment (Dean et al., 2019; Litz et al., 2009). Toxic work environments are unsafe and related to client and nurse satisfaction scores (Gentry, 2012; Gourley, 2008; Harr, 2013; Houck, 2013; Hughes & Clancy, 2009).

The curative role of medicine and caritive role of nursing models are regulated by different professional standards. It may better support the caring environment by including nursing theory and philosophy as part of the defining characteristics in the four tenets of the quadruple aim when the nursing profession is involved. The *Code of Ethics for Nurses with Interpretive Statements* (Fowler, 2015a) and the *Nursing: Scope and Standards of Practice* regulate the nursing profession (ANA, 2015b).

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Traumatic stress and burnout are indicative of the negative aspects of caregiving. Burnout is caused by a toxic work environment (Gentry, 2012). Burnout conflates problems found in a toxic environments and makes the environment unsafe. Burnout alone does not define the negative aspects of caregiving. Several researchers maintain that burnout is used to victim shame and make the nurse responsible for a toxic environment (Dean et al., 2019; Litz et al., 2009). Toxic work environments are unsafe and related to client and nurse satisfaction scores (Gentry, 2012; Gourley, 2008; Harr, 2013; Houck, 2013; Hughes & Clancy, 2009).

Expanding the quadruple aim to include traumatic stress along with burnout may be significant because researchers and clinicians including van der Kolk (2014) and Gentry (2012) state that the two conditions though they may be related, they are not the same. Shoji et al. (2015) stated that a relationship exists between traumatic stress and burnout and that both effect professional satisfaction. Prevention of traumatic stress, burnout, symptomology of the conditions, and restoration of professional career satisfaction is an imperative (Gentry, 2012; Gourley, 2008; Joint Commission, 2012; Perlo & Feeley, 2018). Career satisfaction consists of five components one of which is joy.

The quadruple aim might be stronger if what nursing is and what it entails is defined using the context of professional nursing documents. The documents that regulate professional nursing practice are different than those which regulate medical practice. If professional nursing is to achieve the outcomes of the quadruple aim, then nursing must be defined in the context of professional nursing documents rather than being viewed from the perspective of other professions. The nursing documents used to identify nursing include, (a) *Nursing's Scope and Standards of Practice,* the *Guide to Nursing's Social Policy Statement: Understanding the Profession from Social Contract to Social Covenant;* (b) the *Guide to the Code of Ethics for Nurses: With Interpretive Statements: Development, Interpretation, and Application; and (c)the Holistic Nursing Scope and Standards of Practice.*

Turnover Rates

Professional registered nurse turnover rates are an expense that healthcare executives consider as a cost of doing business, but turnover is indicative of dissatisfaction with the work environment (Jones & Gates, 2007; Kovner et al., 2014; O'Brien-Pallas et al., 2006; Shanafelt et al., 2017). Goetzel and Ozimkowski (2008) said that a significant reduction of healthcare turnover rates occurred when worksite health promotion programs were developed, and high-level managers and leaders supported staff participation in the programs. McElligott et al. (2010) and Shanahan et al. (2018) have developed holistic nursing programs that have contributed to the transformation of the work environment and reduced turnover rates in numerous hospitals.

Traumatic Stress and Burnout

McElligott, et al. (2010) showed that when nurses used interventions based on the five core values of the *Scope and Standards of Holistic Nursing Practice* (see Appendix D) that it stabilized the work environment. The reduced turnover rates approached zero and maintained that lower rate for up to a year after completing their research. The quadruple aim offers a reasonable solution in that it encourages nurse managers and team leaders to take an active and supportive role with the nursing staff by asking nurses what is important to them as related to the work environment (Bodenheimer & Sinsky, 2014; Perlo & Feeley, 2018; Sikka et al., 2015).

In the literature nurses were aware of burnout, but seldom were they aware of traumatic stress based on the work that they do. However, nurses when filling out a research instrument omitted each question on the ProQOL that showed they were suffering from traumatic stress (Mullen, 2010; Neville & Cole, 2013). Nurses also cited barriers to practicing selfcare strategies including having too heavy of a workload (Hunsaker et al., 2015; McHugh et al., 2013; McHugh & Ma, 2014).

Not attending to the precipitating sequelae of burnout, and traumatic stress becomes destructive to the nurse's health and wellbeing (Figley, 1995; Gentry, 2012; Stamm, 2010), the client, and to the healthcare organization for which the nurse works (Jones & Gates, 2007; O'Brien-Pallas et al., 2006). Nurses cannot optimally achieve their personal and professional mission nor the mission of the healthcare organizations for

which they work unless they are mentally and emotionally present (Gentry, 2012; Stamm, 2010). Burnout and traumatic stress interfere with self-actualization (Gentry, 2012).

Nurses who succumb to the sequela of traumatic stress and burnout often feel demoralized and lack professional job satisfaction or resilience in terms of caregiving (Gentry, 2012). One way that nurses cope with the demoralization or burnout (Gentry, 2012; Stamm, 2010) is to change positions within hospitals or to resign from their positions within the healthcare industry (Jones & Gates, 2007; O'Brien-Pallas et al., 2016). Perlo and Feeley (2018) who authored educational programs using quadruple aim addressed the effects of having a lack of joy rather than burnout because it was more positive than focusing on the negativity of burnout.

These educational programs call on healthcare organization managers and executive leadership to support their staff in overcoming burnout**.** McClelland and Vogus (2014) said that healthcare executives who provided compassionate and pastoral practices for staff found that nursing staff were more responsive to patients needs as evidenced by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.

Nurses and other acute care providers suffer from more than burnout. They also suffer from traumatic stress patterns due to exposure to patient experiences, the therapeutic use of self, and empathy for those who have suffered primary traumatization (Neville & Cole, 2013). Patient traumas may be related to accidents, disasters, illnesses like cancer that are often terminal (Houck, 2013), and to traumatic pregnancy and delivery (Leinweber & Rowe, 2008).

Gentry (2012) said traumatic stress contributes to burnout. Van der Kolk (2014) also said previously and repeated trauma exposures are precipitants to later traumatization including *post-traumatic stress disorder* (PTSD) and other patterns of traumatic stress. Repeated traumatizing exposures reduces resilience and makes one more susceptible to burnout and traumatic stress (Gentry, 2012; van der Kolk, 2014).

Christie and Jones (2014) discussed bullying and incivility and referenced Coniti-O'Hare's theory of nurse as wounded healer as a potential contribution to burnout and traumatic stress. Christie and Jones found that 44% to 85% of nurses were victimized by bullying behaviors and that 93% of those in the nursing workforce had been a witness to bullying. Christie and Jones, and Gentry (2012) discussed the Jungian wounded healer archetype occurring among frontline professional service providers such as nurses.

Presenteeism

Presenteeism and absence promote suboptimal performance that indirectly drives the cost of care higher and contributes to accidents (Warren et al., 2011). Warren et al. found that 50% of the nurses in their sample, which included nurses and pharmacists reported that presenteeism was most often related to anxiety and depression. The highest reported physical symptoms associated with presentism were due to being tired, having a lack of energy, and back and neck pain (Warren et al., 2011). When extrapolated to the sample from the study, the cost was $12,605 per person.

The mean salary per person was $97,584 for a joint sample of nurses and pharmacists (Warren et al., 2011). This salary is artificially high due to the salaries of

pharmacists. Nurse salaries are not comparable to pharmacists. In a 2008 United State (U.S.) national sample of the hospitals the cost burden of presenteeism was $33 trillion. In addition to personal actual cost an executive also needs to consider the cost of one's inability to fully engage with patient care and the accidents and errors that may also influence the cost of doing business for a healthcare organization (Perlo & Feeley, 2018; Warren et al., 2011).

Purpose

The overarching reason to use a synthesized grounded theory approach for this research is to identify the most meaningful set of patterns that support the broadest and most inclusive framework for the healthcare improvement. The aim of this research is to help healthcare organizations achieve the four tenets of the quadruple aim by humanizing the work environment which will reflect in positive social change (Perlo & Feeley, 2018; Sikka et al., 2015; Watson, 2018). Expanding the quadruple aim to include traumatic stress with burnout and by expanding the creation of joy to into professional satisfaction with joy as a part of the greater whole may support a more comprehensive improvement. Asking nurses, "what matters to them" (Perlo & Feeley, 2018 p 68) in their work environment in the context of this research may allow the acute care nurse to have a broader platform from which to directly address the fourth aim.

It is important for those involved in using the quadruple aim to create change within the healthcare environment and for researchers to be transparent about the characteristics of professional nursing. Healthcare leadership, medical professionals, and

the public often do not understand what nursing is or what nurses do. Nurses often fail to understand the role, for which they are responsible in healthcare. The understanding of professional nursing is often missing due to minimal exposure to nursing theory and philosophy in nursing schools. Nursing theory and philosophy education has been cut from some curriculum in favor of more disease management education. The term disease management and biomedical model are synonymous terms that are used interchangeably.

Additionally, nurses often switch to business administration education prior to obtaining adequate education in nursing theory and philosophy and this creates a professional disconnection form nursing. Nursing theory and philosophy does not occur until graduate school therefore a nurse does not have a clear understanding of what nursing is. Nursing students educated in a biomedical model will in turn have no interest in nursing theory or philosophy because they believe it is inconsequential to their professional practice (Smith, 2019).

The medical and nursing professions are two separate autonomous professions. Both professions have a social policy and covenants with those whom they serve (Fowler, 2015). Both professions pledge to follow moral and ethical practice guidelines. Nursing is not a part of medicine though it does collaborate with medicine. It is important to better define professional nursing to make the quadruple aim more inclusive and meaningful when including nursing practice in the healthcare business model where the nurse is expected to collaborate with medical providers.

Creation of Positive Healthcare Change

This research was designed to support a positive shift in healthcare environments, to help nurses connect with their work, to reduce turnover rates, to improve safety, meet client needs, and stabilize the financial standing of healthcare within society. The cost of healthcare reaches from the individual client to the nurse and to the federal healthcare budget and influences the gross domestic product. The tenets of the quadruple aim are for the most part congruent with the American Holistic Nurses Association's five core-values (ANA/AHNA, 2019; see Appendix D) and with Walden University's mission and vision statement that states students staff needs to be involved as agents of positive social change.

The fourth tenet of the quadruple aim is that managers and leadership ask nurses what is important to them in their work environment to help them have joyful caregiving experiences. Expanding the depth and breadth of the quadruple aim may help healthcare organizations to develop more inclusive solutions that consider what nurses need to provide cost effective, and safe quality care that would achieve more far-reaching solutions for the system. Though it was important to ask nurses what their perceptions were about their professional relationships and connection between clients, and other team members, it is also important to remember that the client is in charge of their care. Nurses to achieve care satisfaction must be able to provide relationship centered care (Watson, 2018).

Qualitative Research Question

The overall qualitative research question that guides the research is, how does the environment of care support the professional nurses' provision of high-quality person-centered care and bolster a meaningful and purposeful career? The following four specific research question are the foundation upon which the reflective journaling and interview prompts were developed. Each of the four specific research questions are followed by an example of an interview question (See Appendix B).

Research Question 1: Based on the experience of acute care nurses can burnout be expanded to include traumatic stress. Sample interview question: How did the environment of care support the nurse's provision of high-quality and safe person-centered care?

Research Question 2: Based on the experience of acute care nurses could joy be included as part of the larger context of professional satisfaction? Sample interview question: What is your sense of being valued by the organization for which you work?

Research Question 3: How did the environment of care support the acute care nurses' provision of high-quality, safe, and person-centered care? Sample interview question: Identify unique impediments to your working in the local context.

Research Question 4: How did the environment of care bolster the acute care nurses career satisfaction? career? Sample interview question: How did the environment of care support your mission and vision of a meaning and purposeful career?

Conceptual Foundation

The primary conceptual framework of this research is the quadruple aim. Other contributing theories and models include the professional quality of life (ProQOL; see Appendix A & figure 2), holism, complex systems theory, psychoneuroimmunology (PNI), theory of interpersonal relations, and human caring science. I will discuss less prominent conceptual models where they are important to the discussion.

The ProQOL and traumatology are written from the context of professional psychology. The Joint Commission and Magnet ® credential are also important considerations used in this research? Joint Commission is an accrediting body that promotes safety through collaboration. Magnet® is a nursing credential awarded to healthcare organization. Nurses who work in Magnet ® credentialed organization are more likely to achieve career satisfaction because they are fully engaged in nursing work (Aiken et al., 2008; Lake & Friese, 2006; Weston, 2010).

Professional research guidance based in holistic nursing is found in *Holistic Nursing Scope and Standards of Practice* (ANA/AHNA, 2019), health psychology (focus psychoneuroimmunology; PNI) is one of the scientific foundation upon which holistic nursing is built. The study of PNI explains how stress influences safety and is a more subtle aspect of this research.

Nurses who work in healthcare organizations that achieve the Magnet® credential have professional autonomy and control over their nursing practice. They work in healthier environments of care (Aiken et al., 2008; Lake & Friese, 2006; Weston, 2010).

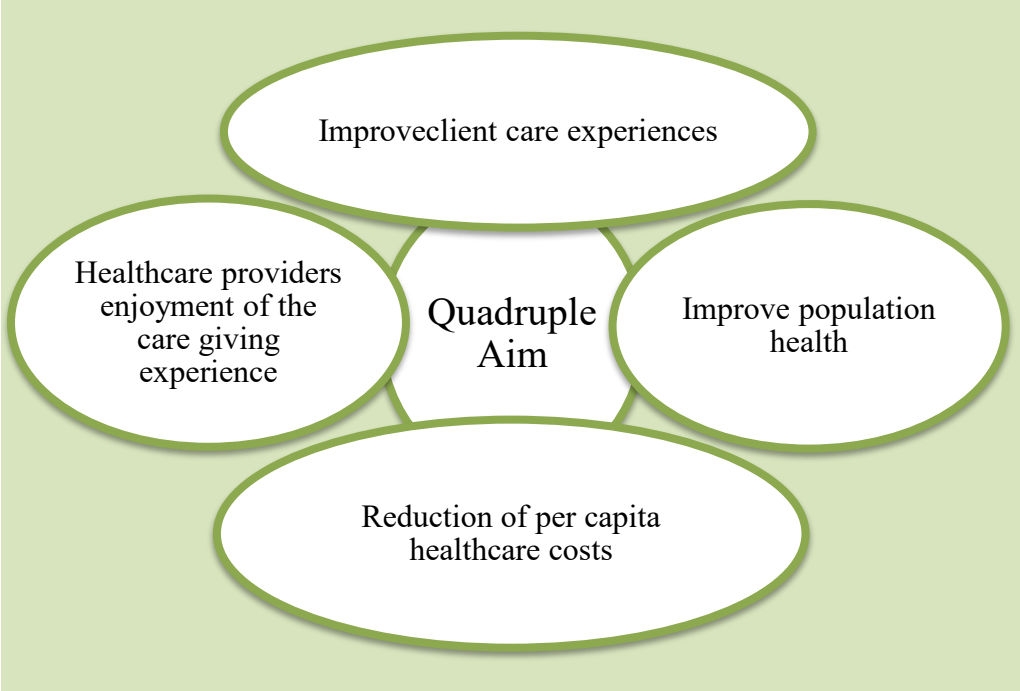
Mark et al. (2009) state there is no additional cost to healthcare organization when nurse autonomy and control over practice is the standard of practice. However, control over practice and autonomy are significant to nurse satisfaction, and reduces turnover rates (Kramer & Schmalenberg, 2004).

Quadruple Aim

Bodenheimer and Sinsky (2014) discussed the term burnout in the quadruple aim. Perlo and Feeley (2018) also contributing authors from the Institute of Healthcare Improvement (IHI) used the term burnout when discussing the four tenets of the quadruple aim. Sikka et al. (2015) focused on the four tenets of the quadruple aim to 1) improve patient satisfaction 2) provide a model for population health improvement 3) reduce systemic healthcare costs and 4) to help professional care providers find meaning and purpose in their careers (see Figure 1).

Figure 1

Four tenets of the quadruple aim



Adapted from "IHI framework for improving joy in work [White paper]" by Perlo, J., Balik, B., Swensen, S., Kabeenell, A., Landsman, J., & Feeley, D. (2017). *White paper* http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in Work.aspx

I chose the quadruple aim for the conceptual framework of this research because it has and the authors of the document recommends collaboration across professions. The authors of the quadruple aim took multiple agencies recommendations into consideration when preparing the model. Root cause analysis performed by Joint Commission, recommended that changes take place in healthcare environments to improve communications and increases safety (Joint Commission, 2012; 2016; 2017 & 2018). Turnover rates, employee insurance costs, absenteeism, and presenteeism rates contribute to the financial limitations placed on healthcare organizations and the national healthcare system (Jones, & Gates, 2007; Killian, 2008; Kovner et al., 2014; O'Brien-Pallas et al., 2006). These issues contribute to increasing the expense of healthcare and can be reduced to stabilized both the healthcare organizations and the national healthcare budget.

Frontline professional nurses suffer the complexities compassion fatigue, which involves burnout and traumatic stress (Figley, 1995; Gentry, 2012; Stamm, 2010). Limiting the term to burnout may reduce the efficacy of the quadruple aim. It may be beneficial to more clearly define professional nursing. This may enhance understanding of what contributes to the complexities of burnout in nursing professionals and impower nursing leadership and managers to better support nursing staff.

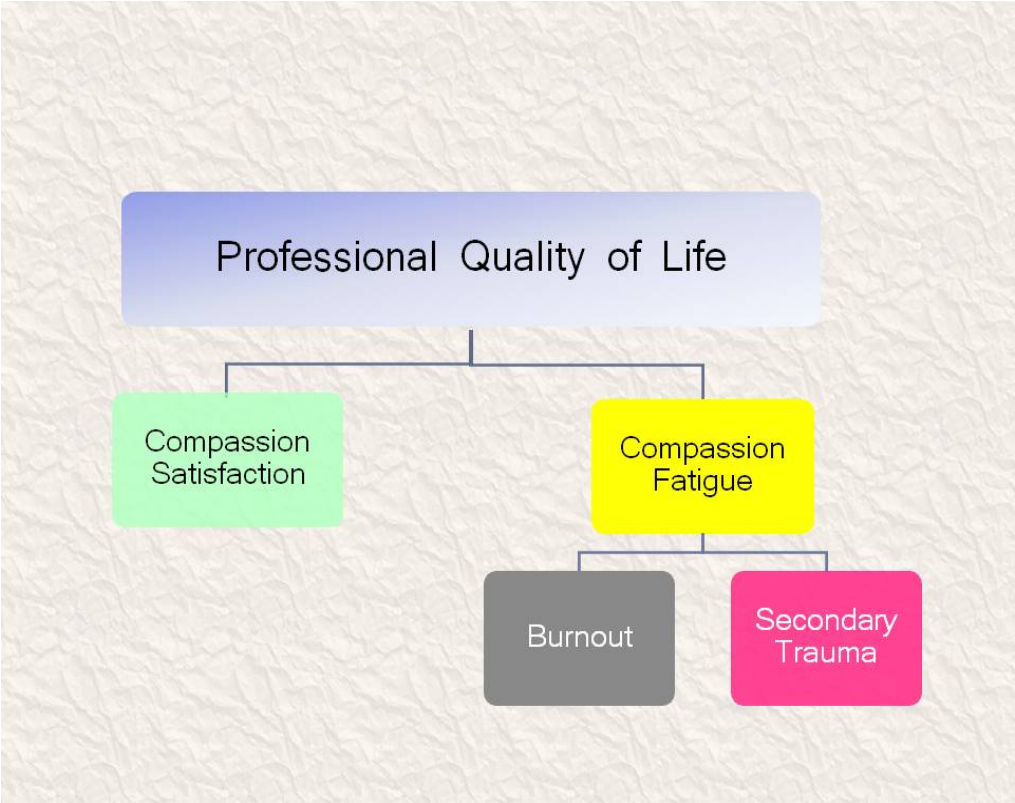
Professional Quality of Life

The professional quality of life ProQOL model (see Figure 2; see Appendix A) is the gold standard for measuring the professional quality of life and the Maslach burnout inventory is the gold standard for measuring burnout (Maslach, 2003; Maslach &

Jackson, 1981; Maslach, et al., 2018). The Maslach burnout inventory uses consistent terminology and that is often used in research. Researchers recommended that a conceptual analysis of the ProQOL should be done because the individual phenomena are difficult to understand and use due to the fluidity of the model's defining characteristics (Coetzee & Klopper, 2010; Drury et al., 2013; Killian, 2008). Terms like secondary traumatic stress, vicarious trauma, and second-victim syndrome can be related to the same condition and it depends on the profession that is studying the phenomena.

Figure 2

Professional Quality of Life



From "The concise ProQOL manual (2nd ed.)." B. H. Stamm, 2010.

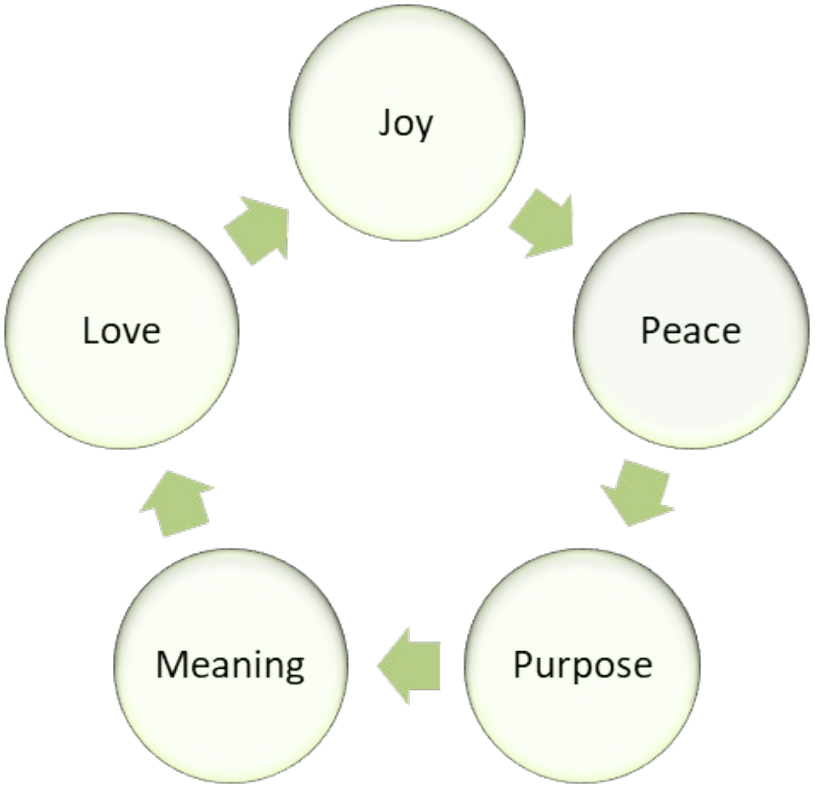
https://img1.wsimg.com/blobby/go/dfc1e1a0-a1db-4456-9391-18746725179b/downloads/ProQOL%20Manual.pdf?ver=1622839353725

The terminology used in the ProQOL has created confusion for researchers. A variety of researchers have recommended that conceptual analysis be performed to bring clarity to the study the phenomenon found in the ProQOL model (Sacco & Copel, 2017). Authors of the quadruple aim had the intent of collaborating with professional nursing. ANA was listed as being a collaborative team member with the IHI. Expansion and clarification of the four tenets to include traumatic stress, and the theoretical underpinnings of professional nursing may provide a more comprehensive approach to developing an environment that supports broader professional career satisfaction. In turn, professional career satisfaction may help healthcare systems to control healthcare costs. The American Nurses Association's Magnet® Recognition, and holistic nursing models have a history of bolstering professional satisfaction and reducing hospital costs as a result of reduced turnover rates (Lewis et al., 2014: McElligott et al., 2010; Shanahan et al., 2018; Stimpfel et al., 2016).

The IHI's quadruple aim, the IOM, and the Joint Commission recommend that leadership and management take responsibility for supporting safe work environments (IOM, 2010 & 2021); Joint Commission, 2012, Sentinel Event Alert, 2017; Perlo & Feeley, 2018; Sikka et al., 2015). They also recommend that healthcare organization leaders and managers support their staff's need for professional career satisfaction. Joy, peace, love, meaning, and purpose are necessary components to achieving professional career satisfaction (Gentry, 2012; see Figure 3).

Figure 3

States of Being Necessary to Assure Career Satisfaction



Adapted from. *Understanding Compassion Fatigue* [CD]. J. E. Gentry, 2012 International Association of Trauma Professionals. https://www.pesi.com/store/detail/7470/international-association-of-trauma-professionals-new

The alignment of one's practice with personal moral values is significant to practice with authenticity and integrity (Rushton et al., 2015; Watson, 2008, 2012). Nursing is based in caring science which is different than medical science. To bring about the safest and most cost-effective outcomes it is necessary for the two professions to work collaboratively.

Conceptual Framework: Quadruple Aim

The four tenets of the quadruple aim are meant to improve and humanize healthcare. The tenets are outlined as (a) safe quality patient outcomes, (b) population health, (c) cost containment of healthcare, and (d) improve healthcare providers' life and job satisfaction (Perlo & Feeley, 2018; Sikka et al., 2015). The fourth tenet of the quadruple aim is meant to help organizational leaders support healthcare staff. See figure 2. The focus of this research was focused on better defining professional nursing within the context of the quadruple aim. The research sample used acute care bedside nurses as research participants. The first and fourth tenets of the quadruple aim are interrelated in that nursing satisfaction has been shown over time to contribute to patient satisfaction (Lewis et al., 2014, Shanahan et al., 2018).

The quadruple aim was written to overcome physician burnout. Berwick et al. (2008) recognized while they were writing the triple aim that nurses also suffered the same conditions that physicians suffered. The driving force that guided McGuire's founding of the American Holistic Nurses Association in 1981 are congruent with the four tenets of the quadruple aim (Dossey, 1997; Perlo & Feeley, 2018; Sikka et al., 2015).

The exception to this is that the quadruple aim was written from a medical perspective and McGuire was focused on professional nursing, so her work is written from the perspective of nursing. Medicine and nursing though collaborative are two different and autonomous professions.

Holism

The philosophy of holism as a term began with Smut while studying at Cambridge University. Smut first wrote about the holism in *Holism and Evolution*. The scientific community overlooked the philosophy of holism and credited physicist Bohm as the one who first discussed holism (Erickson, 2006). Holism is unification of universal consciousness and a unified energy field. The term was derived from the Greek word *holos,* which means whole. However, the term appears to have a much longer history that originated in Indian Vedic culture and comes from Sanskrit vocabulary. In Sanskrit it means that the physical being is imbued with an all-knowing spirit or universal energy (Erickson, 2007). People are whole and intact beings and inextricably part of a greater whole with all other beings and the universal whole (Erickson, 2007; Rogers, 1992, Shields et al., 2016).

Holism contrasts reductionism, which reduces physical beings into parts and introduces a schism between humans and the universe and creates disconnection, which causes injury to the whole (Erickson, 2007). When taking into considering historical change in culture from ancient Greek, Indian, Roman, and pre-Christian Germanic linguistics one can extrapolate, “to be healthy is to have mind, body, and soul intact”

(Erickson, 2007 p 140). The key to health and well-being is when all parts together are in balance and harmony with the universe. Separation creates injury or ill-health.

Holistic nursing is rooted in Nightingale's theory and philosophy that nurses support clients so that they are able to gather their own ability to heal themselves and to become whole. The art of nursing based on Nightingale' teachings conveyed compassionate caring with comforting touch given in the context of a healing environment was at the foundation of nursing. In schools of nursing the student was taught to use eye contact, a caring voice, to use caring touch, and to employ massage to provide comfort to support healing. These are the art of nursing (Erickson, 2007).

The *American Holistic Nursing Scope and Standards of Practice* (ANA/AHNA, 2019) outlines the five core values and the scope and standards of holistic nursing practice. Quantum physics, traditional systems of care (ANA/AHNA, 2019), complex systems theory and behavioral change theories are used in Holistic Nursing (ANA/AHNA, 2019). Holistic nurses recognize that people hold their own healing solutions and that nurses' partner with clients to provide options that allow the person to clarify what they need to heal and achieve well-being. Nurses do not force solutions on the client (ANA/AHNA, 2019; Bannink, 2007; Erickson et al., 1983). Nurses co-create a healing environment with the client, rather than prescribing specific behaviors (ANA/AHNA, 2019).

Behavior change models are used in holistic nursing and nurse coaching to help patients discover their own healing solutions. Like the client, finding the solution though

their own healing and recognizing that illness in one creates ill health in the whole, improving nurses' professional quality of life improves the four tenets of the quadruple aim. Beginning from the individual and the local perspective the work moves toward a national solution (ANA Enterprises, n.d.; Lewis et al. 2014; O'Brien-Pallas et al. 2006).

Nursing departments often use nursing theory to guide and support patient care practices and nurses use theory to guide how they approach client care. Likewise, nurse researchers use philosophy and theory to support their research (ANA/AHNA Scopes and standards of Practice, 2019). Holistic nursing theory including modeling and role modeling (Erickson et al., 1983), Peplau (1997), Watson's theory of human caring science (2012 & 2015), was important to this study. Peplau's theories are theory of interpersonal relations in 1952 and in 1968 interpersonal techniques became the foundation of psychiatric nursing. Holistic nursing theory and philosophy guided the grounded theory method used to analyze the research data.

The primary conceptual framework of this research was the quadruple aim. Nursing theories including modeling and role modeling, theory of interpersonal relations, and the theory of human caring were also used in a more subtle manner as they guide my nursing and research practice. Social sciences have been used in nursing practice since early modern times to guide the nurse and client interactions. Since the time of Florence Nightingale, nurses were part of the healing environment for clients, so it subjects them to taking on other's wounds (Watson, 2018). Conti-O'Hare (2002) and Gentry (2012)

both discussed this phenomenon and related their findings to Jung's wounded healer theory.

Nature of the Study

Research Design

I used a synthesized grounded theory to collect and analyze the data and design the methodology. A synthesized grounded theory method may support the expansion of the quadruple aim (Amsteus, 2014; Chen & Boore, 2009; Zahourek, 2015). Chen and Boore used a synthesized technique that also met the requirements of this research. Choosing to synthesize multiple generations of grounded theory is congruent with the intent of the quadruple aim's goal to humanize healthcare. Grounded theory is used to either develop theory or expand theory. Synthesized grounded theory facilitates a deeper exploration of the data.

The participants will be a subset English speaking professional nurses. The acute care bedside nurses will be from the six regions of the United States that holistic nurses most often used in research. The acute care bedside nurses will have worked for one year in professional nursing and one year on the acute care unit where they practice at the time of interview. Participants will be asked to write a reflective journal guided by 11 prompts (see Appendix B). Once the data were collected, transcribed, and the first analysis was done I scheduled a clarifying interview which were coded before interviewing the next participant. I used a conceptual mapping method to code the data.

The question over all research question was, how does the environment of care support the professional nurses' provision of high-quality person-centered care and bolster a meaningful and purposeful career? My primary concern in choosing a sample size was to collect a corpus of saturated data from the six regions of the U.S. commonly used in nursing research (see Appendix C). The participants were proficient in written and spoken English and had at least one year of experience on the unit where they worked during the collection of data. I will expand the methodology in Chapter 3.

Framework Expansion and Refinement

IHI authors Berwick et al. first developed the triple aim in 2008 and later in 2014 Bodenheimer and Sinsky expanded it to the quadruple aim. The fourth aim focused on professional caregiver joy in caregiving (see figure 1). My suggestion was to expand and clarify the quadruple aim in a way, which would clarify nursing practice and include the sequela of burnout and career satisfaction. A comprehensive understanding of burnout and career satisfaction might better support staff and management in terms of their efforts to develop a more comprehensive approach to improving the environment of care.

Defining professional nursing would be a significant contribution and coupling that with expansion of what leads to burnout, and expansion of joy to career satisfaction may enhance the quadruple aim. This proposed expansion might better support collaboration among healthcare leadership, medicine, and nursing in their efforts to meet the four tenets of the quadruple aim.

Methodology

Theoretical coding took multistep synthesis that used Charmaz (2014), Glaser, (2008) and Strauss and Corbin (1990) approaches as a synthesized methodology. This method of data analysis was more in line with the original grounded theory developed by Glaser and Strauss in 1967. They developed grounded theory to facilitate the collection and analysis of complex nursing data. The idea of using this complex method served to remove limitations and allowed an "emergence [of theory] from the data" (Chen & Boore, 2009, p. 2252).

The grounded theory involves inductive reasoning and is useful for identifying patterns and processes based on the reported data. Participant data samples were collected from the six regions of the U.S. that are commonly used in nursing research (see Appendix C). Participants were asked to write a reflective journal using 11 prompts to guide their writing and follow-up interviews (see Appendix B). Multiple ways of collecting data and member checking were used to discern the internal validity of the saturated data and support the overall trustworthiness of the completed research.

Operational Definitions

The limited number of terms found in this section was meant to help the readers gain a rudimentary understanding of what they find in this research. The healthcare environment has a complex structure with multiple professionals who function under separate professional governing bodies. The professions that influence this work includes

healthcare and nursing administrators, medicine, and professional nursing as it is the focus of the research.

Burnout: Burnout is perceived as a sense of powerlessness (Whitehead et al., 2015) or hopelessness (Maslach, 2003). Burnout manifests as emotional and physical exhaustion that involves reaching beyond coping resources (Gentry, 2012). Burnout is related to toxic environmental conditions and it often sets the stage for secondary traumatic stress to occur. It is an external condition that shames a victim for their inability to overcome toxic environmental conditions (Dean et al., 2019; Gentry, 2012).

Conflate or Conflation: Conflate is melding or fusing of terms that make complex ideas difficult to understand and when applied to a discussion it can make clinical application confusing (Ng et al., 2014).

Co-Optation (co-opt): Co-optation is an appropriation and absorption into the creation and unequal power over and creation of a hierarchical utilitarian relationships. In the context of this research healthcare administration, medicine, and nursing logic and logistics are equally important. Co-optation is a way of defining the hierarchical power struggles found in healthcare environments to maintain power over (Andersson & Liff, 2020). Another term that may be used in place of co-optation is subsume. It is related to oppression of nurses who are being incorporated into the business model or the medical model in this case.

The Environment of Care: The environment of care includes peers, team leaders, and the nurses' perceptions of the institutional philosophy of managerial and executive

officers, administration, and physical layout of the unit on which one practices (Stimpfel et al., 2016). From a holistic nursing perspective nurses are an environment of care.

Heal or Healing: Healing is to make whole, and this is different than curing, which is the purview of the curative medical model (Seaward, 2018; Watson, 2018).

Health and Well-Being from the perspective of the science of holism health and well-being assumes a positive focus that promotes health. Health and Well-being is based on the client's perception of what the client believes health and well-being are. The disease state may or may not be a part of their perception. Health and well-being are states of being. (Erickson, 2017).

Health Promotion: The use of this term is found in the quadruple aim which is based in conventional medicine a disease management and cure focus. Nurses in this model focus on a return to maxim physical function based on a medical diagnosis, which copes with the disease or what is wrong. See health and wellbeing for further information.

Holistic: A person is greater than the sum of their parts (see wholeness).

Holistic Nursing Process: The holistic nursing process is more comprehensive than the conventional nursing process. It is inclusive of all aspects of human nature in addition to looking at disease management. The Holistic Nursing process is inclusive of the art and science of nursing. It includes tangibles (overt; what nurse does) and intangibles (covert; how nurse is) such as, presence, hope, support, caring and mutuality (Abdellah, 1960; ANA/AHNA, 2019; Rutherford, 2014). See also *Nursing Process.*

Hospital consumer assessment of healthcare providers and systems (HCAHPS): A Comprehensive survey that is used for measuring quality healthcare and solicits the patients' likelihood of recommending the facility from which they received care (McClelland, & Vogus, 2014).

Imposter Syndrome: Imposter syndrome is defined by Dzurec et al. (2014) as not being good enough and incorporates having a feeling of being ashamed (Brown, 2006).

Moral Distress: Studied in nursing for 4 decades. An umbrella term used to denote the suffering that caregivers encounter when they are not able to meet their deeply held ethical and moral values due to the constrains that are imposed by institutional, procedural, or social constraints [that] make doing the right thing nearly impossible. (Helmers et al., 2020; Jameton, 2017; Fowler, 2015a).

Moral Injury: Moral wrongdoing or the guilt and shame experienced when one's moral values are broken especially if the individual perceives that they had the power to avoid such behaviors (Dean et al., 2019*;* Litz et al., 2009). Brewer (2021) discusses moral injury in the context of violation of trust.

Moral Resilience: Learned response that increases one's ability to recover from distress and injury. …an ability to adapt to challenges in a way that helps with the restoration of one's integrity (Rushton et al., 2017).

The American Nurses Association defines specific components of nursing practice. One aspect is that nursing integrates art and science.

Nursing: Nursing integrates the art and science of caring and focuses on the protection, promotion, and optimization of health and human functioning; prevention of illness and injury; facilitation of healing; and alleviation of suffering through compassionate presence. Nursing is the diagnosis and treatment of human responses and advocacy in the care of individuals, families, groups, communities, and populations in recognition of the connection of all humanity (ANA, 2021b p.1; see also holistic nursing).

The American Nurses Association (ANA) along with the American Holistic Nurses Association (AHNA) use the nursing the process. It is the nursing process, which sets nursing apart from the disease management model used by medicine The nursing process addresses professional nurse's response to human needs.

Nursing Process: The nursing process outlines the steps of nursing care and includes 1) assessment 2) diagnosis, problem identification, or pattern recognition 3) outcomes 4) plan of care 5) implementation of intervention and 6) evaluation of the process. The nursing process used in education may appear as though it is linear but in practice it is circular in nature. (ANA, 2021b p.12).

Presenteeism: Presenteeism is being at work but unable to function at full capacity due to lack of health and well-being or distractions that precludes undivided attention (Letvak, 2013).

Public Communication Forum (Fora): Public communication fora included electronic communication, news articles, professional magazines, newsletters and letters to the editor.

Resilience: Resilience is the counterbalance to traumatic stress and burnout. A learned positive response to the challenge of distress and burnout (Gentry, 2012; Rushton et al., 2017; Seaward, 2018; Stamm, 2010).

Scope and Standards of Practice: The nursing scope and standards of practice as defined by the ANA (2021b) outlines the who, what, where, when, why, and how of nursing practices. Each specialty area within nursing defines specific criteria to meet the specialties' standard of care as noted in their scope and standards of practice that set their practice apart from other specialties. The document sets nursing as a separate profession aside from medicine and each specialty apart from one another. Each specialty still follows the generic conventional nursing scope and standards. Specialty nursing is an additional layer of expertise on conventional nurse that is highly encouraged by the ANA.

Secondary Traumatic Stress: Secondary traumatic stress is a subjective internal experience based on a caregiver's feeling. It may be an acute condition or historically accumulative (Coetzee & Klopper, 2010; Drury et al., 2013; Gentry, 2012). Figley (1995) described secondary traumatic stress as being one degree from PTSD.

Wholeness: The person is the sum of their parts as compared to holiness as contrasted with holism.

Assumptions

Nurses' work is grounded in a range of theories, some are nursing theories and others are based in other social sciences. Considering that I am a nurse and specialize in holistic nursing, holism and holistic nursing theory helped to guide this research in addition to conventional nursing. The research participants were acute care nurses who shared their personal perceptions when they provided the raw data, and those submissions were assumed to be correct as reported. Research participants partnered with the researcher to increase understanding between the various aspects of responsibility for the purpose of enriching the theoretic development of this research. This approach contributed to meeting the goals of the proposal to expand, clarify, and refine the quadruple aim in terms of professional nursing.

Limitations

Characteristically, qualitative research cannot be generalized to the larger population. Generalization pertains to a population that mirrors the original sample. Corbin and Strauss (1990) stated that grounded theory is only reproducible as it is limited to the study variability. Inability to replicate the same circumstances that were present in the original study limits reproducibility and verifiability in social or psychological research (Corbin & Straus, 1990). Theory applicability improved as the core concepts were noted and as the core category became more abstract.

A potential limitation of collecting data from public communication fora might challenge reliability because there was no demographic data in the one-way observation.

I vetted the participants in this one-way sample based on how they described their nursing activities. I purposefully chose participants who identified themselves as bedside nurses. Nurses working in COVID-19 units were assumed to be acute care nurses. I focused on collecting data from individuals who met the same demographic criteria as those who were two-way observation participants.

Generalizability to a larger population is limited do to using a one-way observation sample that was collected during the COVID-19 pandemic. Though the pandemic is not reproduceable, data validated what was collected in the two-way observations. Those who contributed data in the two-way observations provided information based primarily on pre pandemic experiences. The COVID-19 pandemic exacerbated the conditions found in work environments that occurred prior to the pandemic.

This data collection process was lengthy in nature. That might have prompted individual participants to limit their contributions to the reflective journal prompts. The participants provided short answer as if the prompts were essay questions. Reflective Journaling in addition to an online environment may cause participants concern about confidentiality. Reflective journaling can sometimes feel threatening to participants. Nurses have been known to not answer questions that were indicative of traumatic stress (Mullen, 2010; Neville & Cole, 2013).

Limitation and Transparency

My own educational and clinical experiences are significant to data interpretation (Harry et al., 2005; Higginbottom & Lauridsen, 2014). Professional nurses bring a broad perspective of knowledge and skill sets to healthcare environments. I am an experienced professional acute care nurse and respiratory therapist. Both positions are front line. My clinical experiences were in small rural, medium size community hospitals, and large metropolitan acute care hospitals. I was the administrative director of a respiratory care department prior to becoming a nurse.

My formal graduate nursing degrees focused on nursing and health education. Elective studies focused on executive and political leadership, business management, organizational change, and performance standards measurement. My nursing specialty is based on holistic nursing philosophy and theory, and I hold board certification as an advanced holistic nurse (AHN-BC). These professional interests lead me to formalize the holistic nursing specialization by choosing a terminal degree in health psychology where I focused on psychoneuroimmunology (PNI). This research is a synthesized reflection of participant data viewed through my broad and complex understanding of the value that professional nursing brings to healthcare.

Scope and Delimitations

The original research plan included a potential sample size of between 12 and 15 acute care bedside nurses. Participants needed to be proficient in written and spoken

English and were required to have at least one year of experience on the unit where they worked during the collection of data.

The scope of this research included observation of public communication fora, one career length reflective journal and interview for clarification, and four other reflective journal responses. I used member checking to clarify interviews of the acute care nurse participants. The sample covered the six regions of the United States (U.S.) commonly used in nursing research (see Appendix C). Outcomes of the research were limited by the perceptions of research participants and related literature. Demographic surveys served as a way of qualifying participants beyond the general requirements listed in the invitation (see Appendix C).

Participants partnered with me to help determine how the environment of care supported their provision of safe high-quality person-centered care, and bolster a meaningful and purposeful career? Examining the environment of care based on the four tenets of the quadruple aim may be a more beneficial exercise if professional nursing is more clearly defined in terms that are consistent with nursing ontology and epistemology. Nursing cannot be defined in terms of medicine because it is a separate profession.

Participants worked as acute care registered nurses. Acute care nurses are a subset of professional nursing. This designation is used to distinguish a registered nurse from a technical nurse who is also known as licensed practical nurse or licensed vocational nurse. The participants met licensing requirements including age and language skills.

There was no discrimination used for the selection of participants based on gender, religion, race, or nationality.

The participants self-selected using a convenience and snowball sample. The six regions of the United States were represented through either the one-way observation or through the two-way observation. Three of six regions of the U. S,, the Northeast, Southeast, and Midwest were represented by those who took part in the two-way data collection. The six regions were represented in the one-way observation so there was a small overlap of where the data were collected.

Nurses believe that stoicism is a valuable skill for the emotional work that they do and when they are vulnerable to their emotions it causes them to feel ashamed (Brown, 2006; Gentry, 2012). Nurses have been cautioned to not show their emotions in school and in the environment of care. Those who have been bullied or have experienced incivility fail to recognize their vulnerability and the ability of others to read their behaviors and feelings of not being good enough (Dzurec et al., 2014). They defined not being good enough as *imposter syndrome*, a feeling of being ashamed of one's perceived inadequacies.

Neville and Cole (2013) reported in one of their research projects that nurse participants avoided perceived shame as evidenced by the way those nurses answered a ProQOL survey. The nurses were believed to demonstrate their inability to cope with what they believed was vulnerability to the stress from thee work environment. Their

intentional skipping of the questions was believed to be indicative of compassion fatigue sequela.

The Magnet ® Recognition credentialing literature for hospital systems, noted that similar implications occurred in other front-line professionals who work alongside acute care nurses. Physicians and respiratory therapists work in the same conditions and as a result would likely suffer the same stress conditions (Stimpfel et al., 2016). Other professionals also suffer job related trauma and burnout, including veterinarians, emergency medical services, police, and others. This is not an all-inclusive list other profession also suffer secondary from the sequela of traumatic stress and burnout.

Significance of the Study

The forward in the *Core Curriculum for Holistic Nursing* written by McGuire discussed her purpose for developing AHNA (Dossey, 1997). McGuire's purpose was to encourage the use of selfcare to reduce the effects of stress and burnout and to increase compassionate caring (Dossey, 1997). McGuire's goals in developing the AHNA were to increase the institutional support of nursing staff and to encourage the respect of nurses.

The authors of the quadruple aim reiterate the need for institutional support of nurses and other staff members (Bodenheimer & Sinsky, 2014). The Magnet ® Recognition credential for nursing has a four-decade history and three decades of credentialing improved working conditions internationally (Stimpfel et al., 2016).

The IHI, parent of the quadruple aim, has developed ongoing educational programs to support the development of institutional management teams to teach unit

managers how to support nursing staff (Perlo & Feeley, 2018). Twenty years after McGuire started the journey to Holistic Nursing, Joinson (1992) a nurse researcher identified compassion fatigue in a sample of emergency room nurses. Joinson called it a type of burnout. Three years later Figley (1995) defined the term compassion fatigue as, "the cost of caring" (p. 1). Traumatic stress and burnout create a costly, unsafe environment of care that increases costs to individuals, facilities, and the national healthcare system (Bodenheimer & Sinsky, 2014; Jones, & Gates, 2007; O'Brien-Pallas et al., 2006). National healthcare costs are directly affected by the data in this research because 44% of healthcare is paid for by the government through Centers for Medicare and Medicaid Services (CMS; www.cms.gov).

Bodenheimer and Sinsky (2014) documented in their work that the U.S. spent 17% of the (GDP) on healthcare and reported that between 2010-2020 the expenditure would increase to 20% of the GDP. McHugh et al. (2011) said that 34% of hospital nurses, 22% of other nurses, and IHI said 37% of first year nurses left their positions. Yet other researchers have reported that annual attrition of nurses is believed to be close to 20% since 2006.

The IHI recommended that healthcare organizations take responsibility for improving nurse's professional quality of life and the Institute of Medicine (IOM) recommended that nurses' step into leadership roles to create positive changes in healthcare. AHNA core values have addressed these issues since 1981 (Dossey, 1997). ANA tried to address these issues with a variety of strategies, one of which was the use of

professional issues panels beginning in 2013. The goal of one such panel was to identify the barriers to (registered nurse) RN scope of practice in 2015.

Walden University's mission is to support and contribute to positive social change. The University developed a framework of positive social change and leadership guided by eight principles. Those principles are scholarship, systemic thinking, reflection, practice, advocacy, collaboration, political or civic engagement, ethics, and values. What these eight principles show is the complexity of social change and that the implications of social change are far-reaching. The quadruple aim, which is the primary conceptual foundation of this work is also far reaching. The quadruple aim seeks to humanize and improve healthcare. That improvement starts local to the client and providers of care, moves outward to the facility, the community, and influences the U.S. healthcare system (Berwick et al., 2008; Bodenheimer & Sinsky, 2014; & Perlo & Feeley, 2018). What occurs at the local level of care influences the healthcare system at the national level because 44% of health care is paid for by CMS. These CMS hospitals reimburses will continue to grow as more people continue to retire (CMS, 2014).

Systemic Thinking

Multiple organizations inform this body of work. As an example, the Joint Commission, Institute for Healthcare Improvement, and the National Academy of Science, Engineering, and Medicine (NASEM), formerly the IOM prior to 2015 are national organizations that focus on healthcare quality and safety improvement. Professional nursing organizations that focus on nurses' well-being include the American

Nurses Association, the American Holistic Nurses Association, and Magnet ® Recognition which is a program under the auspices of the American Nurses Association (ANA Enterprises, n.d.).

Complex system theory justified the inclusion of information from multiple organizations and entities. Additionally, multiple professionals that have different practice guidelines and authority interact with individuals who have markedly unique needs. The meaning of research will not be consistent with reality unless one examines the topic through an encompassing and holistic lens.

Reflection, Practice, Collaboration, Ethics, and Values

The American Holistic Nursing Association (AHNA) has focused on the improvement of nursing care through transformational leadership since its founding in 1981. *The Scope and Standards of Holistic Nursing Practice* (2019) includes the five core values of Holistic Nursing (ANA/AHNA, 2019; See Appendix D). Nurses, in general, are client care advocates. The American Nurses Association and the American Holistic Nursing Association are advocates for care at the national level. Health psychology: psychoneuroimmunology (PNI) and traumatology also have a leading role in this research and are informed by the principles of American Psychological Association (APA).

Scholarship and Social Change

The principles of scholarship focus the Walden University population of scholar-practitioners on positive social change and allowed me to focus on my mission and vision

by providing additional scientific research that influences nurse's health and as an extension, healthcare (ANA Enterprises. n.d.). The research questions focus on the perceptions of acute care bedside nurses in acute care healthcare organizations. The participants discussed their perceptions about how the environment of care supported their efforts to give safe and purposeful client care. I also queried the nurses about how the environment of care supported their self-care, personal healing, and how that influenced systemic healthcare.

Improved communication enhances the environment of care (Gourley, 2008). The university's mission and vision support the integration of the principles of multiple professional organizations missions to potentially engineer cost-efficient and safe high-quality care in acute care facilities. The primary focus of this research is to improve the acute care nurse's professional quality of life and improve professional career satisfaction by building more collaboration between healthcare management teams, medical colleagues, and peers. By addressing the identified barriers to practice research has shown that these factors improve, career satisfaction, client care is increased that result in financial stability (ANA Enterprises, n.d., Lewis et al., 2014).

Background

Several researchers, including McHugh et al., 2011 and Romano et al., 2013 state that a balanced professional quality of life promotes wellbeing for nurses and clients. The research by Jones and Gates (2007), Kovner et al. (2014), and O'Brien-Pallas et al. (2006) showed a significant connection between nurses' wellbeing, patient safety,

retention of staff, and the financial stability of healthcare organizations. When the health and wellbeing of nursing staff was imbalanced, and nurses lacked a sense of professional satisfaction and meaning it increased healthcare costs. These staff imbalances created environmental safety concerns including absenteeism, presenteeism, increased nurse turnover rates, and reduced patient satisfaction (Jones, & Gates, 2007; Killian, 2008; Kovner et al., 2014; O'Brien-Pallas et al., 2006). Nurse's health and the cost of private healthcare insurance increased due to the stress under which nurses practice (Kovner et al., 2014). This increases the cost to the healthcare organization as they must provide more services to the employee.

Summary and Transition

In Chapter 1, I identified negative aspects of caring and discussed the need for collaboration between leadership, management, and nurses to improve the environment of care. An introductory discussion described turnover rates and the cost of turnover to healthcare organizations and the need for improved safe communication in healthcare environments. A summary of the literature related to the scope of the discussion, the overall research question, the four specific research questions, and an outlined of the prompts that were used for the reflective journal. Introduction of the theoretical and conceptual framework of the research also took place in Chapter 1. The operationalization of terms peculiar to this research took place here.

The discussion in Chapter 2 included nursing and traumatology literature, factors that may contribute to the cause of burnout and traumatic stress, development of first the

Triple Aim and its expansion to the quadruple aim. The discussion of nursing theory and philosophy covered the period from1860 to the present.

Discussion about the monetization of healthcare is important to understand because it has a significant role in creating an environment that influences safe, high quality person-centered care, and that supports professional career satisfaction. Monetization strategies of health care became more commercialized in the early to mid-1970s (Romano et al., 2013). The era of the 1970s is also when McGuire began her journey to developing the American Holistic Nurses Association (Dossey, 1977). Romano et al. described this monetization as the McDonaldization of healthcare and that was further influenced of the Disney Institute for Healthcare (Austin, 2011). The financial discussion that has historically influenced healthcare was developed further in Chapter 2 as one way of contextualizing the historical aspect of this research. The Disney Institute for Professional Development teaches a customer service model that promotes business excellence by exceeding the customers' expectations. This does not promote safe, compassionate, and high-quality healthcare.

The concepts of bullying, shame, oppression, imposter syndrome, and how these contribute to the negativity found in a nursing professional's quality of life were discussed in Chapter 2. The five core values in the AHNA Scope and Standards of Practice (2019) contribute to building resilience, meaning, joy, purposeful caring, and professional career satisfaction in the context of the quadruple aim. The AHNA's five core values (see Appendix D) and for quadruple aim tenets (see figure 1).

Chapter 3 was devoted to the discussion of the research design and justification of the research methods. Tools used for collecting the research data, the background survey, the reflective journal, and the follow-up interview were described in this chapter. I justified the use of the recorded follow up interview with the participants once they completed the reflective journal.

Chapter 2: Literature Review

Introduction

The literature review described tools and organizations, which have influenced this research study. Tools that have been used internationally to help improve nursing and healthcare included the quadruple aim written and administered by IHI. The ProQOL came from traumatology a subset of psychology was an integral part of the discussion as was the Magnet® Recognition Credential, which was developed by the American Nurses Association (ANA Enterprises, n.d.). I included a brief discussion about nursing history, culture, and the specialization of holistic nursing. The Joint Commission, NASEM previously known as Institute of Medicine (IOM) prior to 2015 influence this work because they offer direction for safe high-quality care. PNI though subtle was also significant to this discussion because it contributes to the provision of safe high-quality healthcare. I will discuss specific factors that influence healthcare expense.

Nursing turnover rates have been consistently at least 20%, according to Jones and Gates (2007). Repeated research by authors like Aiken et al. (2012) showed that nursing dissatisfaction reduced the quality of care, patient satisfaction rates, and increased healthcare costs (Stimpfel et al. 2012). Bodenheimer and Sinsky (2014) also discussed the effects of provider burnout and dissatisfaction on the provision of healthcare. IHI recommended that healthcare organizations take responsibility for improving the professional quality of life within healthcare organizations in a way that supported meaningful and professional satisfaction (Bodenheimer & Sinsky, 2014; Perlo

& Feeley, 2018; Sikka et al., 2015). IHI uses the quadruple aim as a model that would lead to healthcare improvement.

The U.S. spent 17% of the GDP on healthcare and expected that between 2010-2020 that 20% of the GDP would be spent on healthcare. Townsend (2012) found that up to 70% of nurses left their employer, and 60% of the brand-new nurses left within six months of taking a position. In 2012 new graduate nurse turnover rates were 30% the first year and during the second year the turnover rate was as much as 57% (Twibell et al., 2012) and one-third of newly graduated nurses left their career in nursing. Jones and Gates found in 2007 that training a new nurse cost between 22 and $145,000. The cost depended upon the salary of the nurse in the position.

NASEM subsumed the IOM in 2015. In 2010 the IOM recommended that nurses' step into a leadership role to help remediate the dissatisfaction experienced in healthcare. The American Holistic Nurses Association, whose primary focus is on health and wellbeing as the underlying components to health promotion is also a proponent of selfcare and supports nurses in their achievement of leadership roles (AHNA/ANA, 2019; see Appendix D).

IOM (2010) recommended that nurses take a leadership role in the healthcare transition, but without personal health and wellbeing, they are unable to withstand the demands of leadership (Gentry, 2012). Personal health, wellness, and wellbeing are requisite to taking on other demanding roles. The demands of the profession are emotionally intense, and the workloads create an exacerbation of the emotional and

heavy load that nurses currently work under (Kravits et al., 2010; Trinkoff et al, 2000) Weston (2010) and Trinkoff et al. (2000), discuss nurses' need for professional autonomy and control over their professional careers. McGuire noted when she was an inspector of the 19 facilities in her charge, that nurses did not portray behaviors that were indicative of feeling safe nor of having professional support (Dossey, 1997). Plaisier et al. (2007) also emphasized the psychological, environmental, and sociological demands put on nurses cause chronic stress that leads to burnout. Burnout diminishes one's connection to their work. Researchers have shown that intent to leave one's job or career was reduced when the nurse had a sense of autonomy and career satisfaction (McHugh & Ma, 2014; Stimpfel et al., 2012).

The IOM (2004) suggested that healthcare organizations improve the nurses working environment as a way of letting nurses know that they were valued as part of the healthcare team. Research by Kelly et al. (2012) showed that healthcare organizations must respond to safe staffing needs (Stimpfel et al., 2016). Authors of the quadruple aim suggested that by creating joy, that it would improve the since of meaning, and purpose for working professional caregivers (Bodenheimer, & Sinsky, 2014; Perlo & Feeley, 2018).

Professional nursing and psychological trauma-based organizations, government agencies, health improvement organizations, certifying bodies, and social sciences were instrumental in designing and researching potential solutions that helped to remediate patient and healthcare professional dissatisfaction, which resulted in healthcare turnover

rates. The work by these organizations has brought about significant changes that have been effective in reducing turnover rates (Lewis et al., 2014; McElligott et al., 2010; McHugh & Ma, 2014; Stimpfel et al., 2016).

Even though the programs have been successful, they have not been fully implemented to the advantage of the professional acute care bedside nurses, healthcare organizations, nor healthcare costs and expenditures. The more prominent organizations that have been part of these efforts to improve the environment of care were included in the literature review following the discussion of the four tenets of the quadruple aim. I asked the participants to discuss, how the environment of care supports their ability to achieve professional career satisfaction.

Institute of Healthcare Improvement

Multiple groups of authors from the IHI either authored the quadruple aim or contributed to the original document, the triple aim in 2008 and was expanded to the quadruple aim in 2014. These authors included Berwick et al. (2008), Bodenheimer and Sinsky (2014), Perlo and Feeley (2018), Sikka et al. (2015), and others may have also contributed to the document. Bodenheimer and Sinsky, recommended that healthcare organization leadership take responsibility for the reduction of burnout and suggested that they also support nurses and other professionals to achieve a passion for caregiving. Bodenheimer and Sinsky discussed physician burnout primarily but noted that nursing staff also fell victim to burnout.

Quadruple Aim

The quadruple aim is rooted in the triple aim. Berwick and colleagues developed the U.S. healthcare quality improvement model in 2008. Since that time, the framework has been used globally to improve healthcare, and in 2014, developers added the fourth aim (Sikka et al., 2015). The four aims include 1) improved patient care experiences 2) improved population health 3) reduction of per capita healthcare costs and 4) that healthcare providers enjoy the caregiving experience (Berwick et al., 2008; Bodenheimer & Sinsky, 2014; Sikka et al., 2015).

The quadruple aim called on healthcare leadership and organizations to take responsibility for their role in providing safe environments of care that also created joyful work experiences for professional caregivers (Bodenheimer, Sinsky, 2014; Perlo & Feeley, 2018). The healthcare professions must also address predisposing factors, identify what in the environment activates the infective agent that causes burnout and traumatic stress (Gentry, 2012).

The primary aim of this research is to support collaborative, cost-effective, safe, high-quality care that facilitates the development of a meaningful and professionally satisfying career. The IHI developed recommendations that support and promote health via healthcare organization support (Berwick et al., 2008; Bodenheimer & Sinsky, 2014; Perlo & Feeley, 2018). The Centers for Disease Control and Prevention said that disease is the absence of infective antibodies, not the presence of a toxic environment (Gentry, 2012). The magnet ® Recognition program was developed to help nurses achieve the

needed autonomy and self-efficacy that creates professional satisfaction for nurses staff members as well (Stimpfel et al., 2016).

Both the environment and a predisposition can lead to secondary traumatic stress, burnout, and a lack of resilience (Gentry, 2012; Harr, 2013). The NASEM announced in December 2016 a collaborative effort with the American Nurses Association and American Nurses Credentialing Center, "to promote clinician well-being and combat burnout, depression, and suicide in healthcare workers" (NASEM, 2016, Dec 22). ANA convened a national task force to examine nurse suicide prevention in 2019 and the task force completed its work in 2020.

Improve Patient Care Experience

Patient-centered and person-centered care are two ill-defined terms that are often used interchangeably (Clarke & Fawcett, 2016). Both terms came into vogue in response to the IOM 2001 publication, *Crossing the Quality Chasm*. However, person-centered care was historically based on Nightingale's model of nursing and focused on the person for whom nurses care. Whereas the medical profession focuses on disease management and patient-centered care (Morgan & Yoder, 2011).

Healthcare organizations were designed architecturally to create organized and systemic environments where disease processes could be managed in a standardized and efficient manner (Clarke & Fawcett, 2016; Morgan & Yoder, 2011). Morgan and Yoder also pointed out that healthcare organization, environment, and culture of care are antecedents to either promoting or repressing individualized care. Acute care settings are

built for the convenience of sick care or disease management, according to Morgan and Yoder rather than focusing on personal care needs.

The National Cancer Institute developed the six measurable criteria of client-centered care as, "fostering healing relationships, exchanging information, responding to emotions, managing uncertainty, making decisions, and enabling self-management" (Epstein, & Street, 2007, p. 3). Lewin et al. (2001) showed that client-centered care was more cost efficient, as this is important to the way healthcare organizations are reimbursed for services through the Centers for Medicare and Medicaid Services (CMS, 2014).

To overcome the medical influence on the way acute care settings are designed, Morgan and Yoder (2011) chose to use a post-acute care setting in which to conduct their concept analysis. In contrast, Epstein et al. (2010) tried to define better client-centered care from a medical perspective and Epstein et al., also used the term to enable being "directive and to challenge the patient's beliefs" (p. 2). As a result, this provides fractionated care. Fawcett (Clarke & Fawcett, 2016) pointed out that this model was used in the provision of patriarchal and hierarchical and depersonalization of care where patients were passive recipients of care rather than participants in their care. Fawcett (Clarke & Fawcett, 2016) explained the systemic objectification and disempowerment of a person.

The term client-centered care is rooted in Nightingale's work, according to Lauver et al. (2002) and Morgan and Yoder (2011). Carl Rogers, a psychologist, coined the term

person-centered care in the 1940s and Balint coined the term patient-centered in 1968. Clarke interviewed Fawcett, in 2016 on behalf of the Nursing Science Quarterly with the intention of clarifying the terms patient- and person-centered caring in the context of nursing.

In 1984 Lipkin et al. wrote that a nurse needed to adhere to necessary interviewing skills that encouraged people to tell their story. Peplau (1997) described the interview process as participant observation, a two-way process to differentiate it from spectator observation, a one-way observation. The nurse, through a mutually trusting relationship, facilitate interactions with the client that promote open sharing of biopsychosocial aspects of one's illness. Nurse coach training helps nurses to further develops their communication skills. This training helps to facilitate better healing outcomes for clients and for improving communication skills with other professionals.

Nurses focus on human response to illness and potential health concerns and develop a nursing diagnosis and treatment plans based on the patient's story. They develop the nursing care plan and document based on nursing process rather than using the hierarchical medical model that focuses on lab testing data collection as used in the biomedical model. Nurses are essential to creating positive changes as they are recommended by the IOM in 2001, 2010, and the NASEM 2020.

When the healthcare organization’s focus is on nurse driven care, nursing theory and philosophy must ground the nurses practice rather than trying to control nursing through the medical model. By using the theory and philosophy of nursing it would

support the 2010 and 2020 recommendations that nurses lead health behavior changes. Morgan and Yoder (2011) credited Peplau with describing person-centered care as being "the crux of nursing" (p. 7). The researchers in the medically focused model, discuss patient-centeredness, while, in holistic nursing care, the focus is on person-centered care (Erickson, H. personal communication, 2015).

The intent of person-centered care is to provide holistic care, which appreciates the unique values and history of the whole person-- "the biological, social, psychological, and spiritual aspects" (McCormack, & McCance, 2006; Morgan & Yoder, 2011, p. 7).

Person-centered care allows the provider to understand not only how the individual's illness affects that person in their entirety but how the psychospiritual and cognitive aspects of the person influences their health in a way that enhances the caring relationship (Mead & Bower, 2000).

Improve Population Health

The Canadian Institute for Advanced Research was the forerunner of population health used as a research strategy and the U.S., and the United Kingdom joined the discussion later (Kiefer et al., 2005; Kindig & Stoddart, 2003). The social determinates of health research is ongoing across the country. The Florida Institute for Health Innovation researches the social determinates of health in the state. The social determinants of health in the U.S. are zip code, income, and education, among other factors, played a role in health and well-being (Florida Institute for Health Innovation, n.d.). Without addressing

the social determinants of health, the incidence of repeated admissions results in reduced healthcare organization reimbursement (Berwick et al., 2008).

Population health studies the determinants of health outcomes to identify patterns and policies of influence that link among other factors genetic predisposition, social circumstances,, environmental conditions, behavioral patterns, medical care, and political factors to the available interventions for groups of people (Kindig & Stroddart, 2003). These authors postulated that population health is different from public health, health promotion, and social epidemiology. Berwick et al. (2008) further discussed this matter by addressing the politics of population health by including multiple organizations, which had an interest in the phenomena. He included those with a medical focus including. the NASEM and gathered physician groups and organizations like the Accreditation Council for Continuing Medical Education, AHA. Berwick and his colleagues also included nursing focused organizations like the Association of Colleges of Nursing, American Association of Critical-Care Nurses, and American Nurses Association to address the four components of the quadruple aim through collaboration.

IOM (2010) recommended that nurses' practice to the full extent of their education to model good health practices for the communities in which they live and work. With the advent of first the triple aim and then the quadruple aim the IOM champions discussions of burnout in healthcare providers (National Institute of Health, 2018). The nursing professionals are collaborating with others in healthcare to meet the goals of the quadruple aim. The most recent discussion about the *Future of Nursing*

2020-2030 states that the population of nurses has reached 4 plus million. Nurses as a group are the largest number of professionals in the U.S. healthcare system and are the largest segment of care providers in hospital settings. Nurses have been rated the most honest and ethical profession consistently since Gallup began the public survey that asked what profession one would rate as the most trustworthy and ethical (Riffkin, 2014). The only year since 2001 that nurses were not named to the first position was when firefighters were rated in the first slot for their response to 9/11. Considering the size of the profession and their professional esteem nursing would have the ability to influence the health status of a large population in diverse ways and circumstance.

Thacker et al. (2016) reported that the (AHA) asked hospitals to become leaders in creating a culture of health in their organizations and the communities based on the Healthy People 2020 agenda. This is in keeping with the health promotion tenet of the quadruple aim and the IOM's 2010 recommendation. One way of promoting a culture of health is by using nurse coaches® who are board certified through the American Holistic Nursing Credentialing Center and maintain that practice over time. Nurse Coaches® are licensed registered nurses who can work within hospitals and in communities as health and well-being proponents (Letvak et al., 2011). Thacker and colleagues of the AHA went on to reiterate the necessity of sustainability in the health promotion paradigm. Health promotion is significant to reducing the cost of healthcare and having a financially sound healthcare organization. In some instances, hospitals have expressed concern about health promotion models cutting into their profit margins (Allard, 2019).

Literature often uses health promotion and disease prevention interchangeably, and to complicate matters, health is often defined as an absence of disease, which can be found by risk assessment and screenings. Health is defined as having an elevated level of energy, an ability to have focused thinking and happiness based on good habits and a solid foundation (Stimpfel et al., 2016). Disease prevention is solution-based avoidance of disease states like diabetes, obesity, and heart disease. Health and well-being (health promotion) is based on the building of a solid foundation and begins long before any sign of disease process can be recognized. Health and well-being are based on an abundance of hope, aspirations, and peaked interests in the life journey. Health and well-being increase control over one's lifespan, according to Bandura (2004).

Terminology used by ANA/AHNA (2019) is "Wellness and wellbeing" from a positive perspective, which promotes health. The goal of wellness and wellbeing in the context of the science of holism is the promotion of health. On the other hand, health promotion in the context of medicine is based on disease management or what is wrong with the client (Erickson, 2017).

Reduction of Per Capital healthcare Costs

The Framingham Nursing Studies often identified as the "Nurses' Health Study" perpetuated the belief that the nursing population mirrored the general population. Recently the research has begun to show that those who experienced traumatic and chronic stress have higher rates of life-threatening illness and that because nurses are chronically stressed, they face far greater health issues than do the general population.

Psychoneuroimmunology research conducted by Glaser and Kiecolt-Glaser (2005), Gouin and Kiecolt-Glaser (2011), and others support the hypothesis that chronic stress markedly challenges immune function and creates higher rates of life-threatening illnesses. Registered nurses are more prone to disease states than the public because nurses experience higher levels of acute and chronic and traumatic stress due to their work.

Kiecolt-Glaser and Glaser's 1989 seminal research showed that dysregulation of the immune system increases disease states like diabetes, alcoholism (Kindig & Stoddart, 2003), depression (Melnyk et al., 2013), and suicide (Feskanich et al., 2002). Other disease states include cardiac health, elevated blood pressure, and some cancers including increased breast cancer risks, divorce rates, and relationships are common problems experienced by those who have compassion fatigue, a form of traumatic stress (Gentry, 2012).

Smoking rates were 15% higher for nurses, more than three times the number of physicians, 25% of nurses reported being obese, which was more than twice as many as physicians who report obesity (Han et al., 2011); and 55% to 65% of the nursing population is overweight or obese. Feskanich et al. (2002) further asserted that social relationships such as divorce and separation adversely affect marriage and reported that 5% of those participating in the Nurses' Health Study were either divorced or separated. Kiecolt-Glaser et al. (2002) discussed the consequences of proinflammatory cytokine production that influences disease states such as those discussed here. Kiecolt-Glaser and

Glaser (1989) pointed out that up to 85% of disease is precipitated by chronic stress or repeated acute stress.

Humphreys (2007) in a white paper, said that in one eight-hour shift, a nurse may lift as much as 1.8 tons. An average sized woman can lift 46 pounds. In addition to lifting, nurses are subjected to infectious diseases like Ebola, tuberculosis, HIV/AIDS, toxic chemicals, and needle sticks (Letvak 2013). Davidson (2020) also said that the stressful work environment causes depression and general physical health was at substantial risk as was musculoskeletal injuries. The research in psychoneuroimmunology showed that when individuals tried to cope with increased stress executive function was compromised, and people were more prone to succumbing to viral infections.

Nurses who work rotating and night shift have 11% to 44% higher rates of developing type 2 diabetes than those who work the day shift (Vetter et al., 2018). The rate of increase is dependent on the number of nights one works per given month. Nurses suffer increased rates of depression and suicide, according to Vetter et al. One study showed that 35% of the 150 nurses studied were depressed;18% were severely stressed in their home environment, and 21% said that they had severe work stress. Fourteen percent of the cohort used diazepam. Increased alcohol, coffee, smoking, and divorce were associated with high stress loads in the study which is also congruent with Gentry's 2012 work and the research leading up to 2012. Relationship issues are consistent with compassion fatigue and found to be in the list of signs and symptoms (Stamm, 2010).

Seven percent of the cohort had died, and of those deaths, 166 were attributed to suicide, according to Feskanich and colleagues (2009).

Healthcare Providers Caregiving Satisfaction

Personal satisfaction, feelings of fulfillment, and meeting one's purpose, creates a sense of meaning and purpose to a caregiver. Lack of hope and inability to achieve a sense of meaning are independent predictors of burnout (Rushton et al., 2015). Nurses thrive when they have a sense of professional satisfaction for doing their job well (ANA n.d.; Gentry, 2012; Lewis et al., 2014; Stimpfel et al., 2016). Three key concerns need to be met to have a meaningful and purposeful provider experience.

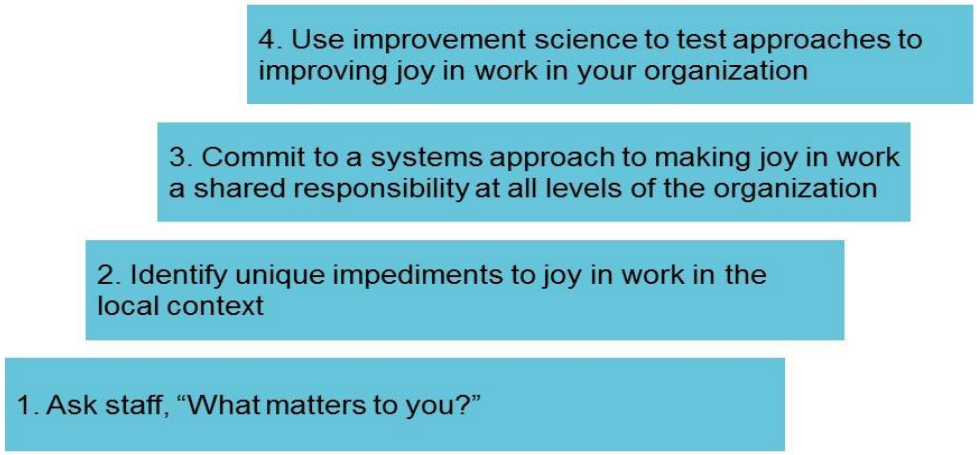
1. The nurse must have a sense of being respected without regard to race, gender, religion, ethnicity, or station in life and work culture.
2. Nurses need to know that the necessary supplies and tools are accessible.
3. Nurses need to know that those in their practice environment recognize their contributions and express appreciation for those contributions (Perlo et al., 2017; Sikka et al., 2015).

The nurse must believe their education and training is adequate to do the job, that financial support is available, and that they have the needed backing, and encouragement from their peers and leadership otherwise they are in jeopardy of suffering from imposter syndrome (Dzurec et al., 2014; Haney et al., 2018). According to the IHI (2018), creating joy at work is a systemic issue that healthcare organization leaders must address.

Perlos and colleagues identified four steps to facilitate the creation of joy at work and stated that leadership is an instrumental part of this (see figure 4).

Figure 4

Four Steps of Leadership



*Adapted from "*Why focusing on professional burnout is not enough," by Perlo, J., & Feeley, D. (2018). *Journal of Healthcare Management, 63*(2). https://doi.org/10.1097/JHM-D-18-00003

Peplau's (1952 & 1968) theory of interpersonal relations is most useful in understanding a nurse's desire to connect with patients in such a way that the relationship facilitates healing. A disconnection between one's calling, and one's daily work can contribute to distress, creates feelings of alienation and isolation, elevates levels of depersonalization, cynicism, causes emotional exhaustion, and burnout (Dyrbye et al., 2017; Gentry, 2012; Ommaya et al., 2018). Nursing professionals like others, are susceptible to shock, guilt, feeling stressed, and are frustrated with large caseloads, long

hours, and when they are unable to meet their personal moral obligations, the nurses feel distressed.

Watson began developing human caring science in 1979. In 2012 she wrote in *Human Caring Science: A Theory of Nursing* that when nurses are immersed into the medical model, it destabilizes their perceptions about nursing practice. Separating nurses from their professional philosophy and the foundation those underpinnings of professional nursing leads to chronic stress disorders such as compassion fatigue and career dissatisfaction. Nurses are unable to meet professional expectations when they are pulled away from their theorical and philosophical roots (Watson, 2008 & 2012). Watson's on-going message in each iteration of her theory is that heart-centered care changes the nurse and client in lasting ways and influences nurses healing partnerships with those for whom they care.

Perlo et al. (2017) described burnout in public health terms as epidemic in proportions. Data focused on the medical model but recognized that burnout was also evident in nursing. Holistic nursing leaders like Lewis et al. (2014), Potter et al. (2015), and Neville and Cole, (2013) noted the epidemic proportion of chronic and complex traumatic stress conditions in nursing.

Numerous researchers identified a lack of understanding, awareness, and misconceptions surrounding compassion fatigue (Figley, 1995; Gentry, 2012; Neville & Cole, 2013; Potter et al., 2013; Potter et al., 2015). Researchers have called for clarification of the terms found in the ProQOL model (Neville & Cole, 2013; Potter et al.,

2013; Potter et al., 2015). Multiple public service professions have studied the same general condition or sets of related conditions and they each use different terminology, which leads to further confusion.

When nursing staff experience a lack of purpose, meaning, traumatic stress and are burned out, it creates safety concerns for staff and patients, because individuals are distracted and disengaged (Gentry, 2012; Sikka et al., 2015). Organizational efficiency may be improved, by the recognition of the symptoms leading up to compassion fatigue in nurses and other healthcare professionals (Jones & Gates, 2007; O'Brien-Pallas et al., 2006; Palumbo et al., 2013). Remediation based on the recognition of traumatic stress sequalae, and burnout helps to build a more resilient workforce (Gentry, 2012; Sikka et al., 2015).

Nurse turnover rates create more expensive healthcare costs related to retraining, to make up for nurse's absence from work, increased mistakes, and lead to poor communication between team members (Gourley, 2008; Jones & Gates, 2007; O'Brien-Pallas et al., 2006). Toxic environments of care create safety concerns and distract nurses and other care providers from their work and reduce career and patient satisfaction (Gentry, 2012 & Gourley, 2008).

Bullying, Incivility and Shaming

Incivility or bullying, horizontal violence by a peer, or lateral violence by a superior are similar terms that are pervasive in nursing (Christie & Jones, 2013). Bullying may be outspoken or subtle (Dzurec et al., 2014). Incivility of any form is often a

percipient to burnout, and lateral violence is "the strongest predictor of burnout" (Maslach & Leiter, 2008 p. 57). The primary message that the bully's victim receives is that they are not good enough (Dzures et al. 2014) nor in the case of an inexperienced staff member, that they cannot adjust (D'Cruz & Noronha, 2010). Incivility is in opposition to a safe healthcare environment for hospitals and the national economy (Gourley, 2008) and a predictor of depression and nurse suicide. American healthcare expenditures in 2012 were 17.9% of the gross domestic product (GDP) or $8,953 per Capita (Florida Hospital Association [FHA] website, n.d.). Thirty-one and a half percent of healthcare dollars was spent on hospitals (FHA), sick leave, individual healthcare costs.

Turnover rates are increased in healthcare facilities where incivility or bullying is part of the accepted culture (Jones & Gates, 2007; O'Brien-Pallas et al., 2006). Bullying is difficult to recognize because of behaviors are subtle, which may be silent, conveyed through a look, intonation, and word choice (Dzurec et al., 2014). Spence-Lashcinger et al. (2010) found that 34% of Canadian nurses planned to leave nursing because they felt so disempowered in their professional role. Jones and Gates (2007) and O'Brien-Pallas et al., (2006) found that replacing a nurse costs between $22,000 and $145,000 dependent on a nurse's salary, position, and location.

O'Brien-Pallas et al. (2006) found a 500-bed community hospital saved $800,000 annually if they could reduce turnover rates by only 3%. Taking into consideration that

nurse turnover rates in 2000 were over 21%, a 3% reduction still leaves a substantial financial burden on the organization (O'Brien-Pallas et al., 2006).

When patients are unhappy with care, the Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey show lower patient satisfaction scores. The Centers for Medicare and Medicaid Services (CMS, n.d.) began to reward healthcare facilities based on patient satisfaction scores by reimbursement in October 2012. The instability of staffing in healthcare organizations taxes the facilities and the national budget. Creating stability of these entities depends on personal and institutional health and well-being. Patient satisfaction scores throughout modern nursing history have been tied to environments where nurses thrive (Lewis et al., 2014; Neville & Cole, 2013).

The IOM (2010) appointed nurses to assume leadership to influence the health status of the broader population. However, nurses cannot lead into the future unless they are healthy and model health-promoting behaviors. However, when physiological and psychological health reduces neurocognitive function, it threatens one's ability to solve problems, ability to make decisions, and reduces communication skills and that in turn reduces the efficacy of care, and patient safety (Potter et al., 2015).

Safety, quality of care, career satisfaction, and the financial stability of a healthcare provider, a healthcare organization, and national healthcare spending is affected by what happens in healthcare environments. If professional nursing staff as providers and managers of care are distracted by gossip, name calling, eye rolling,

taunting, and sabotage, refusal of answering questions, and inequitable assignments (Alspach, 2007) it makes the patient care environment toxic and unsafe (Hutchinson et al., 2006). These behaviors are known as bullying or shaming and interfere with cognitive abilities.

Healthcare environments are assessed by the HCAHPS. When the scores are low, it reduces reimbursement for services according to information found on the Centers for Medicare and Medicaid Services (CMS, 2014). An example of how decreased HCAHP scores can affect hospital reimbursement, a four-day stay for pneumonia may be billed at $40,000, but a 2% reduction in reimbursement would reduce the hospital payment reduce by $800 for that one patient.

Townsend (2012) found that up to 70% of nurses left their employer, and 60% of the brand-new nurses left within six months of taking a position. One-third (33%) of new graduates left their career in nursing. Jones, and Gates (2007) found that training, a new nurse cost between $22,000 and $145, 000 per year (Fuller, 2012). In 2012 new graduate nurses' turnover rates were 30% the first year, and during the second-year turnover rate increased to as much as 57% (Twibell et al., 2012). O'Neill, and Morath (2010-2011) and the Lucian Leape Institute (2013) found that 33% of RN sought new jobs within their first year of employment. The AMN Healthcare 2013 survey of RNs found that 51% of the nurses believed that their jobs caused them poor health, and 35% wanted to leave their job.

The 2013 survey by AMN Healthcare showed that of more than 3.1 million nurses, 500,000 were not working in their profession; the field of nursing is the largest profession in the country. Dawson et al., 2014 found that doing non-nursing tasks, low morale, management problems, and workload due to inadequate staffing causes nurses to leave their jobs as did burnout and exhaustion. Conditions that inhibit the quality of care creates nursing disaffection that leads to job turnover and has been a long-known reason for nursing dissatisfaction and causes increased turnover rates (Townsend, 2012; Jones, 2008; Dawson et al., 2014).

Carpenter and Dawson (2015) documented other nurse stated concerns in the recent American Nurses Healthy Nurse's Initiative; workplace violence 21%; indoor air quality18%; elevated levels of disinfectants 11%; indoor air quality18%. Sprang et al. (2007) suggested that supporting staff included providing a more ergonomic environment, providing a less physically demanding work environment, and reduction of environmental confusion.

Historical Development of Nursing Practice

The practice model of nursing in the U.S. has undergone significant shifts from1898 when the Daughters of Charity first arrived in Florida to the present. The work of nurses in the United States in the 1870s was considered women's work and altruistic (Rutherford, 2007). The order of nuns first ran the school of nursing in Jacksonville, Florida, and later, their students staffed the hospital once graduated from 1870 to 1920s (Rutherford, 2017). During the time up to the Great Depression in the late 1920s, nurses

placed their names on registries, and private clients hired them from the registry. The nurses were independent practitioners (Rutherford, 2007). Schools were hospital-based up until the Great Depression.

Nurses began formal training outside of hospitals and hospitals hired them once they graduated in the 1930s. The hospitals charged for nursing care but paid the nurse not much more than the stipend they earned during clinical training. This set an altruistic precedent of giving care when students served as nurses during their training (Rutherford, 2007). Hospitals replaced homecare based on the need to more closely monitor clients who required more care than they could receive at home.

Hospitals bought physician's technical equipment as it was developed, and pharmaceuticals began to make their way into sick care. Hospitals, as a result required more skilled nurses to monitor patients according to Rutherford, 2012. Physicians were given professional privilege and authority to judge the quality of their own contributions to healthcare based on the special knowledge and their profession, which was thought to be beneficent (Berwick, 2016; Freidson, 1970). The public deferred to physicians when they needed care because they did not have the same knowledge as did the physicians (Berwick, 2016; Freidson, 1970). This period in medicine has been recognized as Era 1, the first of three eras discussed in holistic nursing education and by Berwick and Freidson. Era 2 is based on accountability models manipulated by the pay for performance schemes that keep healthcare in the state of constant flux of change. Three

eras of medicine are discussed in the literature, I will discussion factors that illustrate Era 3 in chapter 5.

Between 1945 and 1965, the American Nurses Association pushed for national healthcare. Medicare and Medicaid passed legislative hurdles in 1963 (Rutherford, 2012). The Centers for Medicare and Medicaid began to fund healthcare for a part of the population and reimbursed for hospitalizations. Private insurance approvals helped to boost nurses' salaries during this time (Rutherford, 2012).

Nurses began to focus on the technology and pharmacology that paralleled the curative medical diagnostics and disease management model found in medicine (Rutherford, 2012; & Silveri, 2002). Nursing education began to emphasize acquisition of education in disease management or the biomedical model (Abdellah,1960; Erickson, 2007; Watson, 1979). During this time Abdellah (1960) wrote the original nursing process as 21 problem categories to distinguish between nursing and medicine.

Medical tasks are a necessary part of what nurses provide. But nurses are expected to care in more subtle or covert way that set clients in the most suitable state to heal, (to make whole; Nightingale,1860/1992). Nursing supports bio-psycho-social needs of clients. Clients need both curative and carative factors to recover fully. Rutherford (2014) referred to these as intangible assets of nurses. It is these covert skills that patients expect when they are vulnerable and in the hospital.

In the 1960s and 1970s, a division of philosophical beliefs occurred in nursing, but the desire for autonomy remains a consistent factor of nursing practice. These

philosophical beliefs occurred because of the changing climate in healthcare. Some nurses focused on medical and pharmaceuticals use while others focused on the roots cause for ill health. This is also when the McDonaldization of healthcare and the discussion of education of business executives at the Disney Institute began to change the face of healthcare in 1990s. Later in the 2000s business consultants began to script nursing and patient interactions as though the nurse was a server in a restaurant.

During the 1970s a part of the nursing profession further embraced medicine's influence and part of the nursing profession chose to maintain their Nightingale roots while at the same time they supported their medical colleagues (Abdellah,1960; Erickson, 2007; 2010; Watson, 1979). Nurses who were influenced by nursing theory and philosophy found in Nightingale's work felt disenfranchised from their foundation of practice (Abdellah, 1960; Erickson, 2007; 2010; Erickson et al., 2015).

The progressive loss of autonomy and control over practice led to what McGuire witnessed in the 1970s as burnout and managerial disrespect for nurses (Dossey, 1997). That loss led McGuire and 70 plus colleagues to develop the American Holistic Nurses Association in 1981 (Dossey, 1997). McGuire's goals in developing the American Holistic Nursing Association were to increase institutional support of nursing staff and encourage respect of nurses.

Nearly 20 years after McGuire started her journey in the hope of rectifying nurse burnout and stress, Joinson (1992), a nurse researcher witnessed what she identified as a type of burnout in emergency room nurses. Three years later, Figley (1995) defined the

term compassion fatigue as, "the cost of caring" (p. 1) because that was the least offensive term to those effected by this phenomena.

In the classroom, students are often taught to protect themselves from the negative aspects of caring by distancing themselves from their clients (Gentry, 2012). Conventional nursing education teaches nurses to distance themselves from their work in multiple ways. One way that unintentionally teaches distancing is by using simulation models in skills laboratories, so the student is not aware of learning the subtle caring skills (Kapucu, 2017). Kapucu lists the positive psychomotor skills but does not address the need for the nurse creating the environment of care which are the subtle skills for which nurses are responsible (Rutherford, 2012; 2014). Durham and Alden, on the other hand pointed out that nursing schools teach the complex technical aspects of nursing and internships fill in what the nursing students did not learn in school. These task trainers teach students to avoid medical errors and develop clinical decisions and critical thinking skills.

Using simulation models though a necessity due to a lack of clinical sites with live patients promotes separation or an inability to build relationship while learning to care for the client. Using the simulation labs for skills development has positive as well as negative aspects. One of the negative aspects of this necessary skill building technique is the unintentional enforcement of distancing behaviors. Presence of that attitude in caregiving often creates a top-down approach at the expense of the caring relationship (Durham & Alden, 2008).

The provider of care cannot conduct their personal or professional mission if disconnected from themselves due to experiencing burnout and traumatic stress or moral distress (Gentry, 2012). The aversion behaviors found in these conditions destroy self-worth, and disables one's ability to achieve health and wellbeing, and interferes with achieving self-actualization (Gentry, 2012). It also leads to demoralization or loss of meaning for the healthcare provider "infected with compassion fatigue," according to Gentry (Premier Publishing & Media, 2013, track 1). The authors of The Future of Nursing: Leading Change, Advancing Health redefined one segment of the nursing profession and further divided the profession based on the medical model rather than on the nursing model (IOM, 2010; Summers & Bickford, 2016).

Exposure to emotional work without a way to disburse excess and troubling emotions causes a chronic state of increased stress that may lead to burnout. Burnout increases the likelihood of a nurse developing secondary traumatic stress (Gentry, 2012; Neville & Cole, 2013). Secondary traumatic stress is more acute than is burnout, according to Gentry and Stamm. Chronic and heightened stress leads to chronic disease burden which increases personal and national healthcare spending due to the underlying inflammation caused by stress (Glaser & Kiecolt-Glaser, 2005 & 2009). Those exposed to victimization from traumatic events, loss of loved ones, accidents, and those diagnosed with life-threatening diseases, requires a nurse to make an emotional investment if they are to provide empathetic and compassionate care (Watson, 2002, 2005; Watson & Browning, 2012).

Holistic Nursing: Nursing Specialization

McGuire called on a group of nursing colleagues to develop the American Holistic Nurses Association (AHNA) in 1981 based on her observation of nurses' working conditions during the mid to late 1970s (Dossey, 1997). The reason McGuire developed the organization is reflected in the fourth tenet of the quadruple aim. Research shows that when the nurse is happy that the patient is happy (Lewis, 2009; Lewis et al., 2014; Shanafelt & Noseworthy, 2017). Joinson (1992), a registered nurse researcher, identified secondary traumatic stress in a sample of emergency room nursing staff during a study she was conducting.

Watson (2015), a holistic nurse theorist began to develop the theory of human caring in the 1970s and attributed the work to Nightingale's vision of nursing. As a proponent of heart-centered care, Watson said that heart-centered care changes the nurse and patient in lasting ways and influences nurses healing partnerships with those for whom they care. Gentry (2012), a traumatologist supported the same philosophy of caring recounted Jungian philosophy that uses nearly the same terminology that Watson used but she used Nightingale as her resource of wisdom.

The IOM (2010) published the Future of Nursing: Leading Change, Advancing Health. The authors of the publication recommended that nurses' step into leadership roles to help remediate healthcare organizational issues like nurse turnover rates, impaired communication skills, providing safe work environments, and reducing errors in healthcare systems. The IOM initiative recommended that nurses become leaders in

implementing a paradigm shift in healthcare. The Institute of Medicine (IOM; 2004, 2010) suggested that healthcare organizations improve nurses working environments in such a way as to let nurses know they were valued as part of the healthcare team.

Historic Monetization and Value of Nursing

President T. Roosevelt (1858-1919) when president of the U. S. suggested that individuals invest in insurance to protect themselves, but the idea of a national plan was not popular. The public, AHA, and insurance companies favored the idea of such a plan (AHA; Stevens, 1999; Rutherford, 2012). The Great Depression (1929-1930) caused financial shortfalls for hospitals, and they asked the government to help with healthcare organization solvency so that healthcare organizations could meet public needs for healthcare.

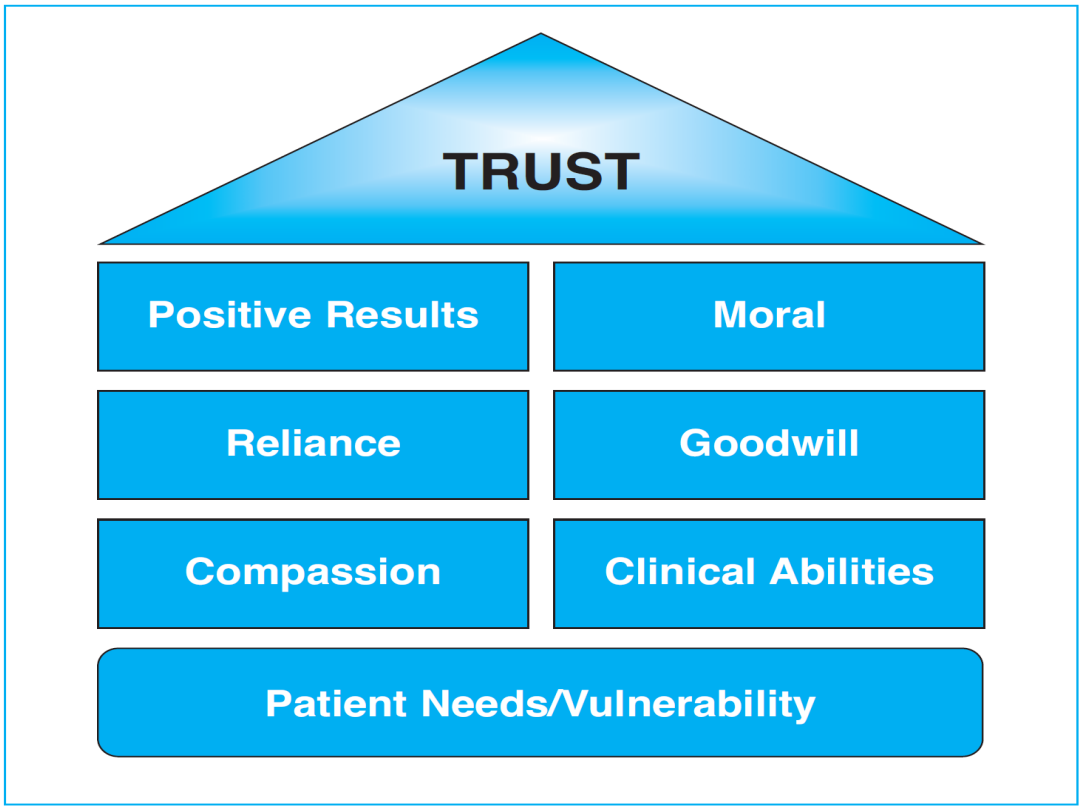
Nursing care is an expensive service, but when the care by nurses is judged to be high quality the care goes unnoticed by constituents (Rutherford, 2014). She said that nursing care is only noticed when it does not meet constituents' expectations. The perception of not meeting shareholders expectations makes it a necessity for nursing administration to be astute in their assessments and explicit in their communication with financial executives in order to justify required investments to improve care. Nursing has a long history of meeting the public's trust according to the annual Gallup poll.

Welton (2006) noted that when economic circumstances required nurses to sidestep their enterprising spirit and take acute care positions within healthcare organizations, they gave up their financial relationship with clients. In turn, hospitals

gave nurses a wage and charged for their services as if they worked in a hotel. Social circumstances during the depression years forced nurses into hospital work to gain financial stability for themselves and their families. Once nurses gave up their original entrepreneurial roles after graduating from nurses training, they did not capitalize on their multifaceted assets (figure5). Trust facilitates patients' ability to build healing relationships that increase healing outcomes. Both tangible and intangible value examples are illustrated in see figure 5.

Figure 5

Imperative Components: Nurse Patient Relationship



From "The value of trust to nursing." by Rutherford, M. M. (2014). *Nursing Economic$*, *32*(6), p. 284. https://link.gale.com/apps/doc/A394997190/AONE?u=anon~9be1e418&sid=bookmark-AONE&xid=13a2b899

Diagnosis Related Groups

Welton and colleagues (2006) compared the present system of billing for nursing services with a nurse intensity billing model and found that by using the nursing intensity billing model charges for nursing services increased 32.2% in the Medical University of South Carolina (MUSC) research. According to the figures found, using this scheme, increased daily revenue would have been $4.9 million for the 12 units that were used in the proposal (Welton et al., 2006). "The variability of nursing cost to charge was reduced from 0.34 to 0.80 for room and board to 0.33 to 0.45 for the nurse intensity billing method" (p. 181) this amounted to a 32.2% increase over the room and board charge scheme.

Creating a reimbursement policy taking into consideration nurse intensity billing criteria supports increased nursing services rather than cutting the nursing to patient care ratios as is vogue. Using the nurse intensity billing model would set a more equitable revenue stream for healthcare organizations in addition to supporting the value of nursing. Welton's goal for revisiting the nurse intensity billing model as it was outlined in Thomas and Fetter's 1983 Diagnosis Related Groups **(**DRG) model was to expose the clinical and economic contribution that nurses made to healthcare and to justify increasing nurse to patient ratios rather than creating a do more with less attitude that would increase safety and medical error concerns. Reducing nursing staff is creating less safe environment of care and more stress for the care givers (Cimiotti et al., 2012).

Recognizing the worth of nursing care has the potential to improve the safety and quality of care by increasing the nurse to client ratios (Rosenthal, 2007). The present way of funding incentivizes heavy workloads that reduce the quality of care (Welton, 2006). Welton (2008) postulated that by changing to the nurse intensity billing system, it would incentivize a pay for performance model. Using the nurse intensity billing model may also contribute to IOM's recommendation that nurses take a leadership role in changing healthcare organizations culture of caring. It would increase the nurse's level of autonomy by requiring them to understand the economic impact that they have on healthcare and require that they be accountable for their professional actions.

Though these data were estimates based on a formula developed for research, it shows a large discrepancy between the room and board-based charges and nurse intensity billing charges. Room and board-based charges lump housekeeping, maintenance, physical plant, and etcetera into one charge and do not recognize the levels of skilled nursing care that are required of various kinds and acuity of patients. When nursing care was lumped in with room and board, the value of nursing care goes unrecognized and undervalued. Nurse intensity billing would also create challenges during the change process. Before computerization, the cost of implementing this type of charge system would have been challenging, but with the evolution of technology using nurse intensity billing model of charging would be more easily implemented, according to Welton et al. (2006). Nursing is a cost center in healthcare organizations, rather than a revenue-

producing center, and unless nurses can articulate their worth stakeholders will not be inclined to invest in the nursing workforce (Rutherford, 2012).

The monetization of healthcare fueled a change of focus from the original mission of a moral public service focus to be a profit-driven commercial business interest, according to Sikka (2015). Romano et al. (2013). named this phenomenon the McDonaldization of healthcare, which was based on *The McDonaldization of Society* by Ritzer (1983). The corporate healthcare focus fuels the need to turn a profit, and as the government tightens the requirements for repayment options, chief financial officers require care providers to do more with less Romano et al. (2013); and Austin, (2011).

In turn, the business attitude of corporate healthcare creates negative consequences for nurses and clients. The business of healthcare is essential for nurses to understand because it has a significant role in the creation of environments that contribute to compassion fatigue (Sikka, 2015; Romano et al., 2013; and Austin, 2011). Business management administration in this era of healthcare sees and measures caring in terms of tasks rather than seeing caring in terms of being a person-centered relationship. This creates professional and client dissatisfaction (Aiken et al.,2012; Austin, 2011; Lewis et. al., 2014; Morgan and Yoder, 2011; Watson, 2008 & 2012).

Aiken et al. (2012) asserted that staffing reflected proportionally high budget expenditures and that healthcare costs exert pressures on hospital business management teams to reduce nursing staff because of budget constraints. The quality of care suffers as a result. Aiken et al., (2012) surveyed 1105 acute care hospitals in the U.S. and Europe.

The sample included 61,168 professional nurses and 130,000 patients, to measure patient and nursing satisfaction scores. The nurses reported quality care deficits, burnout due to job dissatisfaction, and intention to leave when the nurse to client ratio was high in hospital that had work environments which were lacking. Client and Nursing satisfaction mirrored each other (Aiken et al.,2012; Lewis et al., 2014; Shanahan et al., 2018).

The Value of Nursing

Nursing's value, as depicted in figures 5 and 6 must be recorded in the EHR based on the nursing process. However, if nurses' chart in a way that is not specific to nursing process, they are not recording nurse "tangible and intangible assets," (Rutherford, 2010 p.115). Abdellah (1960) wrote the first phase of the nursing process that led to the use of nursing diagnosis to document client response to nursing interventions. She said the same thing that Rutherford did by calling nursing skills either overt or covert.

If nurses use the present EHR system to document they chart medical care, and that leads to a devaluation of nursing assets and in effect that makes the nurse invisible. The invisibility of nursing work has led to nursing being a cost center rather than a revenue center. Rutherford noted that the Daughters of Charity also called the Sisters of Charity were educated as nurses and in finance, which enabled them to own and run their institutions from 1916 to 1990 in Jacksonville, Florida.

Defining one's economic worth is paramount to being paid for one's services at this time in history. Historically nursing was delivered by religious orders as a free service. Not having terminology for intangible and difficult to measure services can

undermine the ability to measure and chart the art of nursing. Nursing aesthetics or the art of nursing is intellectual and creative in nature and intangible. These services are in large part how patients measure their satisfaction with nursing care. Aesthetics of nursing is the foundation of relationship-centered care and helps to build personal connection.

One way of defining and measuring a nurse's worth is through their use of the nursing process. This process is used in nursing documentation, but if it is difficult to find the nursing language the work may not be documented in a way that it can be captured for reimbursement. Nursing care cannot be documented when conventional medical documentation is used (Rutherford, 2010). When the chart is audited for payment purposes medical documentation is visible, but nursing service is not.

The imperative is using the nursing process to document nursing care. This is exceptionally difficult to accomplish in an electronic medical record (EMR) because the incorporated terminology is medical rather than nursing-based language. The nursing process uses nursing diagnosis and therapeutic interventions to provide the nursing language to guide nurses charting (Rutherford, 2010). In medically oriented charting systems, whether called electronic medical record (EMR) or electronic health record (EHR) it challenges the ability of nurses to chart nursing care (Pagulayan et al., 2018; Rutherford, 2010). If the program does not use nurse specific language nursing tasks go unrecognized and care is often missed (Pagulayan et al., 2018; Rutherford, 2010).

Diagnostic Related Groups (DRG). During the early 1970s, Thompson and Fetter both R.Ns. and professors at Yale University developed the DRG based on Thompson's

research of Nightingale's work, which was related to mortality rates in London based hospitals (Thompson et al., 1979). The Health Care Financing Administration, which later became the Centers for Medicare and Medicaid Services (Mullner, 2009), assisted the researchers in creating the DRGs. The original DRG model included nursing related parameters for each medically based DRG.

The CMS implemented the DRG model in1983 by stripping the model of the nursing charge criteria (Buerhaus et al., 2010; Welton et al., 2006). This elimination further supported the reason to reimburse for nursing's services as part of the room rates. Politics devalued what nurses contributed to the care of patients and reduced payment for services to hospitals based on that devaluation (Welton et al. 2006).

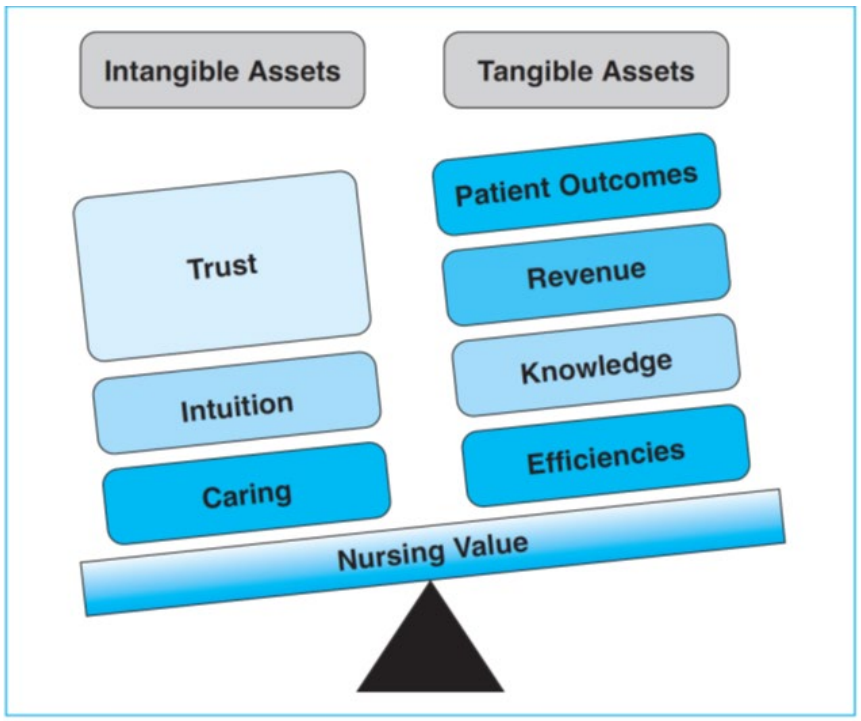
The provision of nursing care is more than medically driven tasks. Nursing practice is driven by, client and nurse relationships, and the need to provide care based on the scope and standards of practice of nursing (ANA, 2015b). Nurse's work follows high moral and ethical standards as mandated in the code of ethics for nurses with interpretive statements (ANA, 2015a). Nurses also have a social contract and covenants with the public. They are morally bound to that contract just as physicians are bound to their covenants and social policy with the public (Fowler, 2015b).

Determining reimbursement for disease processes in this way allowed the CMS to control hospital reimbursement costs and served to overlook the required nursing linked individualized criteria required in nurses' work. This has caused, hospitals to reduce staffing ratios that are averse to safety and quality control issues, which have the power to

further reduce healthcare organizations profitability (Cimiotti et al., 2012). Nightingale and later Thompson's and Fetter's work revealed the economic value of nursing services to society and is depicted by Rutherford (2014) as demonstrated in figures 5 and 6.

Figure 6

The Balance of Nursing's Tangible and Intangible Asset



From "The value of trust to nursing." by M. M. Rutherford, 2014. *Nursing Economic$*, *32*(6), p. 284.

https://link.gale.com/apps/doc/A394997190/AONE?u=anon~9be1e418&sid=bookmark-AONE&xid=13a2b899

Welton (2006), noted that nursing the largest profession in the U.S. is also the largest workforce in the hospital setting. Furthermore, 30% of the total operating budget and 44% of direct care costs can be attributed to nursing, but nursing is ignored by third-party payers (Thompson et al., 1979). The cost of nursing is based on average unit cost rather than on the care of each patient. Costs assume that cost of caring are fixed and similar for similar units throughout a hospital the same as housekeeping, laundry, and maintenance; they are billed as room and board. To further compound the discrepancy there is no mechanism in the system that allows for the individuation of billing. Charges are based on medical diagnoses and not on nursing diagnosis, which would document the nursing care provided to patients.

The pharmaceutical and medical industry along with reductionistic nursing education (Erickson, 2007) coupled with the rapid changes in technology that occurred in the 1920s to 1930s and periodically after that contributed to the dysfunctionality of the present health system (Sikka, 2015; Romano et al., 2013; Austin, 2011). During the sixties, these same issues contributed to the industrialization referred to as the McDonaldization of healthcare (Romano et al., 2013; Austin, 2011). In the late 1990s and 2000, Disney created the Disney Institute to train healthcare managers to become customer-service managers to improve patient satisfaction scores.

There has been no incentive to provide health promotion. The government attempted to put reform into the hands of hospitals and physicians by the pay for service

models (Rosenthal, 2007). CMS based its payments on the discharge diagnosis, a medical judgement.

Lawmakers limited repayment by CMS by selecting two conditions that cost more because of being assigned to a secondary diagnosis when the case was managed less than adequately and reduced payments to the point of what would have been expected had the case been managed correctly (Thompson et al.,1979; Rosenthal, 2007; Welton & Dismuke, 2008). An illustration of how two cases of a pneumonia diagnosis might be reimbursed follows: Uncomplicated pneumonia might be reimbursed at the rate of $3705 under the simple pneumonia DRGs code while the same case of pneumonia with complications that could have been avoided would have a different DRGs and potentially be reimbursed at the rate of $6,253 (Welton, 2008). What occurred as a result is that certain populations were at higher risks of having secondary complications that Centers for Medicare and Medicaid Services would not pay, so healthcare organizations chose to avoid those kinds of clients (Rosenthal, 2007).

McDonaldization Influences on Healthcare

The McDonaldization of healthcare refers to the business model of healthcare that is contrary to moral practice (Austin, 2011). Hospitals were originally run by physicians but in 1970 that changed to the present business model. Nurse and physicians find that this model contributes to moral distress and is alienating because it undermines the reason providers become healthcare providers in the first place (Austin, 2011).

Ritzer coined the term McDonaldization in 1983 as a social symbol of how modern society has changed. McDonalds was designed to produce the principles of efficiency, calculability, predictability, and control. However, no boundaries were set to counter these. Consequently, a loss of individualized and relationship-based care was lost when hospitals instituted that business model, according to Ritzer, Sikka (2015), Romano et al. (2013), and Austin (2011). Personalization of care or using person-centered care is essential to caregivers (Aiken et al., 2012; Berwick et al., 2008; Lucian Leape Institute, 2013). Various others and professional specialty organization like the AHNA support the need of person and relationship centered care is their primary professional message. Scripting a healthcare provider is the equivalent of depersonalizing and commercializing the caring process and goes against the moral ethic of nurses (Austin, 2011). Hospital consultants advised nurses to use scripts for interactions with clients.

Disney Influence on Healthcare

The Disney Institute perpetuated the McDonaldization or commercialization of healthcare by turning a moral act of caring into leadership excellence, people management, quality service, brand loyalty. Another issue was innovation to remodel caring behaviors in the provision of care by constantly exceeding the clients' expectations ("Disney Institute Announces," 2011). The goal was to increase customer satisfaction scores. This emphasis on customer satisfaction creates a barrier between clients and nurses that interferes with open and honest sharing in a caring relationship in a way that engenders trust, caring, and comforting.

Nursing relationship centered care requires time to engage with clients that are vulnerable and sensitive when in hospital. Nursing care is not task oriented (Dinkins & Sorrell, 2006; Austin, 2011). Austin said that client engagement creates bottlenecks but for a nurse to do otherwise can create moral distress, and that leads to burnout and compassion fatigue (Gentry, 2012). When nurses do not take time to engage with clients, they also are unsatisfied with their care. Commercializing healthcare has the potential to create moral distress for providers who came to the humanistic caregiving role as part of a social contract rather than to sell a commodity (Austin 2011).

Nursing and Healthcare Organizations

The forerunner of the American Nurses Credentialing Center (ANCC) developed the Magnet Nursing Services Recognition Program in the 1980s and named a hospital in Seattle, Washington as the first ANCC Magnet® Recognition recipient in 1994 (ANA Enterprises, n.d.). The program has been used internationally to improve healthcare work environments in much the same way as the quadruple aim has been implemented internationally (ANA Enterprises, n.d.; Whittington et al., 2008).

Nursing leaders, researchers, and theorists have a long history of promoting selfcare beginning with Nightingale. Nightingale (1860/1992) cautioned nurses to use selfcare in *Notes on Nursing: What It Is, and What It Is Not*. Nurse theorists, Erickson et al. (1983), Orem (1959), Walker et al. (1987), and Watson (1979) wrote theories based on selfcare. Erickson and her colleagues discussed specifically the need for nurse's

selfcare, holism, and relationship-centered care. Morgan and Yoder (2011) credited Peplau with describing person-centered care as being "the crux of nursing" (p. 7).

The tradition in healthcare has been to make nurses responsible for their own well-being without recognizing that organizations have a role in staff support (Shanafelt & Noseworthy, 2017). Blaming is a shaming action that in this case does not take into consideration that burnout is created by a toxic environment (Gentry, 2012). The American Holistic Nurses Association *Scope and Standards of Holistic Nursing* (2019) makes holistic nurses responsible for their own selfcare as does the ANA in the *Scope and Standards of Nursing Practice* (2021) as does Fowler (2015a). The Magnet® Recognition credential was developed in the 1980s to improve the support for nursing staff and to improve the environment of care by the ANA Enterprises (n.d.). Self-care is important but it only partially addresses the issue and does not resolve the environmental toxicity.

Magnet® Recognition Credential: Best Practices

Hospitals that are recognized as Magnet® Recognition credentialed facilities have a reputation of having better work environments, more support of the nursing staff and better patient outcomes (Kelly et al., 2012; Stimpfel et al., 2016). Lower rates of job-dissatisfaction and burnout have been consistently reported in Magnet® Recognition credentialed hospitals (Kelly et al., 2012; Stimpfel et al., 2016). The credentialing process has resulted in better physician and nurse collaboration, communication, and in safer

work environments (Armstrong et al., 2009; Stimpfel et al., 2016; Tourangeau & Cranley, 2006).

The American Academy of Nursing, which has since become part of the ANA Enterprises developed the Magnet® Recognition credentialing program during the 1980s to improve support for nursing staff, improve the environment of care, and provide recognition by the American Nurses Credentialing Center for quality patient care (ANCC; ANA Enterprises. (n.d.). Magnet® Recognition facilities support nurse autonomy, and control over one's own practice, satisfaction is improved, and a decreased turnover rate has been reported (Stimpfel et al., 2016; Tourangeau & Cranley, 2006). The consistent outcome that makes the difference is that clinical nurses have autonomy and control over their own practice (Rafferty et al., 2001; Weston, 2010).

Joint Commission: Creating a Safe Work Environment

The Joint Commissions a healthcare certifying body helps healthcare organizations address safety concerns. The Joint Commission (2012) recommends ways of achieving compliance based on National Patient Safety Goals. Safety issues are discovered when an organization self-reports a life threating or near miss sentinel event. Compliance is measured when inspectors make site visits (Gourley, 2008).

The Joint Commissions began to identify and report sentinel events in 1996 to develop cultural and environmental safety within healthcare organizations. The sentinel events important to this work include sentinel event alert 40 (2008; 2016), 48 (2011; 2018), and 57 (2017). Joint Commission reported in *Sentinel Event Alert* issue 59 (2018)

that burnout contributes to turnover as it relates to chronic high stress in work environments. The lack of professional engagement creates safety concerns (Gentry, 2012; Gourley, 2008). Sentinel event 57 (The Joint Commission, 2017) called for healthcare leadership to employ a culture of safety and specifically addressed burnout and lack of managerial focus on the prioritization of safety (ANA Enterprises, n.d.).

Social Sciences and Healthcare Organizations' Perceptions of the Research Problem

Brown (2006), a sociology researcher first exposed the influence of shame in one's life and her second-generation work exposed the influence of vulnerability. The work of Brown (2006), Jung (as cited by Gentry, 2012), and Watson (2018), may explain why some succumb to traumatic stress, burnout, and others do not. A variety of predisposing traumatic life events accumulate to increase susceptibility to traumatic stress (Gentry, 2012; van der Kolk, 1994 & 2014). Gentry suggested that burnout predisposes one to traumatic stress but van der Kolk (2014) said that traumatic stress predisposes one to burnout.

Nursing has been said to be an oppressed profession for decades (Roberts et al., 2009). According to Roberts et al., oppression reduces the quality of nurses' performance, professional career satisfaction, and increases turnover rates. Oppression often leads to imposter syndrome, manifests as self-doubt and emotional paralysis, and an inability to practice self-advocacy (Haney et al., 2018). Oppression and imposter syndrome may precipitate bullying, an exacerbated level of stress, and burnout when one is a newly graduated nurse (Christie & Jones, 2013).

Brown's 2006 work on shame and vulnerability showed how the two emotions contribute to the phenomena of imposter syndrome. Primary shaming triggers for female nurses include, "mental and physical health, speaking out, and surviving trauma" (p. 46). Shame is also prevalent when people feel that they cannot keep up with what they believe is their duty and responsibility (Neville & Cole, 2013). Brown (2006), and Gentry (2012) emphasized the importance of selfcare for the modulation of shame, vulnerability, traumatic stress, and burnout sequelae.

Health Psychology: Psychoneuroimmunology

Psychoneuroimmunology (PNI) is the scientific basis of holistic nursing according to the authors of the (AHNA) and American Nurses Association/ANA Scope and Standards of Practice of Holistic Nursing 3rd Edition (2019). Glaser and Kiecolt-Glaser (2005), Kendall-Tackett (2010), McEwen and Gianaros (2010), and other PNI researchers found that dysregulation of biopsychosocial, emotional, and spiritual balance occurred when people are under chronic high stress.

Long term dysregulation of one's system as occurs in traumatic stress and burnout leads to chronic disease states like chronic inflammatory conditions including autoimmune diseases, metabolic syndrome, and cardiac disease (Kiecolt-Glaser & Glaser, 1989). Traumatic stress and burnout also cause a deterioration of relationships, mental health and may lead to suicide (Feskanich et al. 2002; Gentry, 2012; National Academies of Sciences, 2016, Dec 22). The National Academies of Sciences (2016) states in their work that suicide is under reported or in the case of nurses the incidence of suicide is

invisible. Poor emotional intelligence contributes to negative interpersonal relationships (Gentry, 2012). Traumatic stress symptoms also produce unsafe working environments, increased cost of personal, institutional, and national healthcare, and creates an environment of poor communication and safety (Gentry, 2012; Gourley, 2008).

Constraints on executive function related to staffing and chronic stress cause a breakdown in communication when healthcare providers are overly tired and stretched beyond their capacity. This leads to depersonalization and reduced quality of care of both the staff and the clients (Mayers, 2006). Acute and chronic stress creates an environment fraught with opportunities for misjudgments, medical errors, reduced client, and staff safety which Joint Commission addresses in multiple sentinel events.

Traumatology: Psychology Specialization

Figley (1995), while studying post-traumatic stress disorder (PTSD), noted that secondary traumatic stress was one degree from PTSD. PTSD is primary and related to the self, whereas secondary traumatic stress is related to witnessing another's distress. During Figley's early tenure in the mid-1990s as a professor of trauma care, he and later Stamm developed what became the ProQOL model or scale (see figure 2). Gentry et al. (1997), students of Figley developed a method to help insulate and remediate caregivers from the negative aspects of professional caregiving.

Figley (1995), Gentry et al. (1997) and others pointed out the negative consequence of caring. Figley, a traumatologist, stated that compassion fatigue was a combination of secondary traumatic stress and burnout. He described it as being one

degree from post-traumatic stress disorder (PTSD) and defined PTSD as a personal exposure to trauma. PTSD was Figley's research focus. Gentry et al. 1997 and those who studied with Figley during the late 1990s contributed to the development of trauma remediation programs and Stamm upon Figley's suggestion further developed what became the ProQOL model and scale (Stamm, 2010).

Gentry, 2012 when consulting in healthcare uses the ProQOL scale (Flarity et al., 2013; Potter et al., 2015) to help identify and rectify the negative aspects of caring. The ProQOL scale identified secondary traumatic stress and burnout as the negative aspects of caring (Flarity et al., 2013; Potter et al., 2015). The positive aspect of caregiving in the ProQOL is compassion satisfaction of which resilience is the subcategory (Flarity et al., 2013; Potter et al., 2015).

Gentry (2012), Mesnikoff (2013), and others identified secondary traumatic stress and burnout as negatively affecting a range of healthcare professionals and first responder's physical health, mental health, professional communication, and provision of safe care. Acute care nurses are the focus of this research. Others who suffer from secondary traumatic stress in the same environment of care include physicians, and respiratory therapists (Sorenson et al., 2016). Though not the identical environment, veterinary service providers also suffer from secondary traumatic stress (Figley & Roop, 2006). First responders also suffer the similar consequences (Gentry, 2012). This list is not an all-inclusive list of those who experience secondary traumatic stress, from here forward traumatic stress.

Burnout and Traumatic Stress

Care providers who suffer burnout often distance themselves from their work (Coetzee & Klopper, 2010, Gentry, 2012). Traumatic stress creates a sense of hyperarousal and a need to be overly involved (Gentry, 2012). Burnout and traumatic stress sequalae cause unsafe working environments and increase staff turnover rates related to the maladaptive behaviors used as coping mechanisms (Gentry, 2012). The maladaptive behaviors that Gentry and research colleagues discussed were addictions to drugs, alcohol, and sexually explicit behaviors, among others. Symptoms of burnout include depression, excessive absence, presentism, and a lack meaningful purpose driven caregiving (Coetzee & Klopper, 2010; Gentry, 2012).

Traumatic stress occurs because of unresolved wounding earlier in life (Gentry, 2012 & van der Kolk, 2014). Unresolved traumatic life experiences early on often motivate people to follow caregiving and community service careers. This model is an illustration of Jung's archetype of the wounded healer (Christie & Jones, 2013 & Gentry, 2012). Childhood traumatization is a common part of growing up (Gordon, 2019).

***Suicid*e**

The American Foundation of Suicide Prevention states that there is no single cause for suicide but that it occurs when one's coping capabilities overwhelm their coping skills for dealing with mental health issues. Davidson et al. (2020) said that suicide of nurses is increased in comparison to the public, and that it can bring about

much mental distress for the survivors including nurse colleagues. Major depression, PTSD, suicidal behaviors, and prolonged grief disorder occur as a result.

Organizational response to a nurse's suicide can and does exacerbate nurse's ability to deal with a colleague's death by suicide when managers stifle the cause of death and tell nurses that they cannot discuss the issue. Nurses have been threatened with loss of job if they discussed a colleague's death by suicide. Healthcare organizations may not have standards of how to respond to a nurse's death by suicide. This leads to each nurse manager having to oversee the response to suicide in their own way. However, Physicians do have available protocols for dealing with physician suicide. Part of what makes it so difficult to develop consistent science-based strategies to help nursing colleagues deal with loss of their peers by suicide may be based on the tendency of society to deny mental health issues and therefore death by suicide has been "shrouded in silence, avoidance, and denial" (Davidson et al.,2018, p. 2). Under reporting is bound to occur because each district reports deaths differently.

Gap in Literature

The gap in the literature was determined by reading a range of literature including the ProQOL of nurses' work engagement, Joint Commission sentinel event alerts, the Magnet® Recognition credential, nurses well-being, the quadruple aim, and literature about what influences nursing turnover rates. The ProQOL is based on nurses being responsible for their own selfcare (Gentry, 2012). The quadruple aim in contrast to the ProQOL scale is based on healthcare organization's executive, management, and leaders

accepting responsibility for their part of the problem and being willing to collaborate with the nursing staff (Bodenheimer & Sinsky, 2014; Perlo & Feeley, 2018; Sikka et al., 2015). Stress management, an integral part of PNI research sparked my interest to further explore this topic as it pertains to nursing and the healthcare environment. I also read multiple articles on bullying or incivility, imposter syndrome, and other nursing literature that discussed major contributions to nursing turnover, absenteeism, presentism, and mental health issues such as depression and suicide.

McClelland and Vogas (2014) published a quantitative article that suggested scholars follow the research of hospital executives to determine how "frontline employee's perceptions of compassionate practices influence [nurses] caregiving" (p. 1679). The Magnet® Recognition sets out governance requirements that an organization must follow to earn the credential. Institutions that become Magnet® Recognition credentialed meet the highest national standards hospital wide (Stimpfel et al., 2016).

When nursing flourishes hospitals flourish, as do clients, and other staff who receive the benefit of the improved standards (Stimpfel et al., 2016). Facilities that have used holistic nursing practices to improve client and nursing satisfaction have shown a marked reduction of turnover rates and improved both patient and nursing satisfaction scores (Lewis et al., 2014; McElligott et al., 2010).

I wanted to examine how professionals and organizations could collaborate with each other to improve a system that is not meeting the needs of the population and is depleting financial resources for people, healthcare facilities, communities, and the

national healthcare system. The problem is multifaceted and complex, so the problem needed to be examined from a broader perspective than it has been previously explored.

This study was based on examining how acute care bedside nurses could provide care that meets the four tenets of the quadruple aim developed by IHI. The authors of the quadruple aim recommends that healthcare can be improved by developing collaborative relationships between health organization executives, managers, leaders, and acute care nurses (Berwick et al., 2008; Bodenheimer & Sinsky, 2014; Perlo & Feeley 2018; Sikka et al.,2015). By asking acute care bedside nurses what matters to them it requires that those asking the question to understand what professional nursing is to be able to address the nurses' concerns.

Additionally, burnout is the end point that has severe consequences and can include traumatic stress, moral distress, and moral injury. It may be more beneficial to prevent burnout rather than treating the extreme end point. Joy is one of five parts to the broader concept of professional satisfaction. Measuring only one of the five parts of professional satisfaction may limit the ability to understand the broader concept of professional satisfaction.

The goals of the quadruple aim may be better served if healthcare leadership had a clearer understanding of what brings nurses into the profession, how nurses' ethical responsibilities and the nursing scope and standards of professional practice (Fowler, 2015; ANA, 2019) differ from the disease management or curative medical model. Social policies of nursing speak to the sacred contract that professional nurses have to the public

(Fowler, 2015b). Joy is one of five components needed to experience professional satisfaction (Gentry, 2012, figure 3). The quadruple aim served as the conceptual framework of this research.

Summary and Conclusion

The authors of the American Nurses Association 2014 Professional Issues Panel: Fatigue recommended that nurses take self-responsibility to remediate and avoid fatigue. The panel identified the problem as fatigue, but participants on the advisory panel defined fatigue by enumerating symptoms of compassion fatigue. The ANA also called for employers to address fatigue and support nurses to remediate fatigue (ANA, 2014). Managers and educators call on nurses to take self-responsibility in remediating compassion fatigue, but when individuals experience compassion fatigue, one of the symptoms is that they are incapable of identifying their own sequalae (Gentry 2012). Additionally, nurses are known to exhibit shame based on their inability to manage the stress of their jobs and so they will deny the influence of job stress (Brown, 2006; Neville & Cole, 2013).

Neville and Cole (2013) found that since its 1981inception as an organization, the ANA (2019) has emphasized selfcare and self-reflection as one of the five core values of the organization. When endorsing holistic nursing schools, the AHNCC assesses the schools for the inclusion of specific criteria found in the Scopes and Standards Holistic Nursing Practice (see Appendix D). The criteria for conventional nursing are found in the generic document that outlines the scope and standards of nursing in general terms and

that applies to nursing as the whole body of professional nurses. Each specialty follows its own scope and standards of practice layered over the generic document. Every nurse must start with the conventional foundation upon which the specialty was added. Each specialty requires an additional two years of practice after taking the registered nurses licensing exam to qualify for a specialty board.

Communicating one's needs by advocating for policies that support the use of selfcare protects nurses, patients, and the organization; it increases communication between multiple professional levels within a healthcare organization. This research also supports nursing leadership by helping them to develop, implement, and support dynamic professional growth. Research has shown that selfcare is instrumental in providing safe, quality patient care. The research, based in psychology, is reflective of the health promotions model suggested by the national health care system. The IOM (2010) recommended that nurses take a leadership role in health care transition, but without personal health and wellbeing, nurses are unable to withstand the demands of leadership.

The needed institutional changes that support those in the work environment cannot occur until executive and leadership teams understands the influence that a healthy and compassionate staff means to the cost of caring, both physically and fiscally. Leon et al. 1999 cautioned organizations and caring professionals in 1999 to collaborate to reduce compassion fatigue symptoms. The ethical codes of the APA in 2010 and the ANA in 2015 have come to support this position. Both professional organizations state

that organizational leadership has a responsibility to provide education and support to those exposed to traumatic stress, and burnout.

Chapter 3: Research Method

Introduction

I discussed the research methods used in this chapter so that others would be able to reproduce the study if desired. I also justified using reflective journaling with a clarifying interview in the collection of data. Conducting the pilot study allowed me to find the least difficult and most secure way of collecting data by way of software packages in an online environment. The purpose of this study was to determine if an expansion of the quadruple aim would better facilitate cost-effective, safe, and quality care provision by professional nurses. Career satisfaction in professional nursing occurs in conjunction with client satisfaction. Research has shown that nurses were better able to serve the needs of clients when they have autonomy and control over their careers.

I discuss the rationale for conducting the research and explain my role as the researcher. Triangulation methods were used to improve the trustworthiness of the results. Researchers have come to realize that they cannot bracket or separate themselves from their participants nor environment. Data coding included an explanation of the synthesized grounded theory and why the data collection method and analysis were suitable to use. I discussed ethical handling of the data sets, how I planned to protect participants' data, and how I would secure the corpus for 5 years.

Demands on acute care bedside nurses have increased exponentially due to COVID-19. COVID-19 demonstrated underlying weaknesses in the healthcare infrastructure. As such, public communication fora were used for observational data

collection to contribute to understanding how nursing is valued by the public and organizations for which they work. This provided additional depth that might improve the health care systems understanding of the work that acute bedside nurses do and illustrate the value of nursing work

Qualitative Research Question

The overall guiding question for this qualitative research was how did the environment of care support the professional nurses' provision of high-quality person-centered care and bolster career satisfaction? I coded the qualitative data to determine if adequate support existed to propose an expansion of the quadruple aim based on participants' responses. The specific research questions were.

Research Question 1: Based on the experience of acute care nurses can burnout be expanded to include traumatic stress.

Research Question 2: Based on the experience of acute care nurses could joy be included as part of the larger context of professional satisfaction?

Research Question 3: How did the environment of care support the acute care nurses' provision of high-quality, safe, and person-centered care?

Research Question 4: How did the environment of care bolster the acute care nurses career satisfaction?

Research Design

I first used a reflective journal and followed up with interviews to collect nurses' perceptions of how the working environment supported their need to provide safe, high-

quality care. Nurses' need for professional autonomy to achieve professionally satisfying careers by having control over their practice is also of primary importance. Professional autonomy and control over practice is important to meeting and documenting client's needs. Once the data were collected, I coded them by using the synthesized grounded theory.

I used a demographic survey to qualify participants who placed their names in Research and Me to register as research participants. Once qualified, five acute care nurses contributed data to what was meant to be a reflective journal. The purpose of the journal was to determine how participants believed that their work environment supported them in providing safe, and high-quality person-centered care. Each participant took part in a follow up intensive interview to confirm my understanding of their reflective journals which allowed me to collect richer sets of data (see Appendix B).

One participant used prompts to reflect on their career. The other four individual participants when writing their reflective journals used prompts as short answer essay questions rather than writing reflective journals. Because of this and the COVID-19 pandemic, I expanded data collection to public communication fora. I followed the same analysis coding strategy with all of contributions. The public fora were conducted as one-way observations and the individual contributions were two-way observations. One-way meant that I had no interaction with the participants and two-way observation meant that I had conversation with the individual participants.

The COVID-19 outbreak at the end of 2019 and in the U.S., the outbreak carried over into 2020 and 2021 and continues to be a problem in late 2021. The original data collection plan was modified to include a large one-way observational study to supplement the smaller than intended individual participant sample. Acute care nurses were identified via public communication fora which facilitated collection of data from a nationwide sample. One-way observations allowed me to expand the data by collecting a national sample.

Though I expanded the study to include nurses who worked the frontlines during the COVID-19 pandemic this research should not be construed to be a study of acute care nursing conditions based solely on the COVID-19 pandemic issues. These issues were prominent prior to the pandemic. COVID-19 created an exacerbation of an ailing healthcare system with automated systems that have been used to manage restaurants, theme parks, and automobile manufacturing.

Grounded Theory: Rationale

A quantitative research model that uses grounded theory is markedly different from a qualitative model that is used to contextualize phenomena (Higginbottom & Lauridsen, 2014). Qualitative research is used for contextualization of phenomena, but this methodology does not offer the generalizability of quantitative research (Corbin & Straus,1990; Higginbottom & Lauridsen, 2014).

This study required a qualitative approach to explore acute care nurses' feelings about their work environment. The purpose of quiring acute care bedside nurses was to

determine their perception of how the work environment supported or contradicted a potential expansion of the quadruple aim. Synthesized grounded theory was an appropriate way of studying this phenomenon because it is congruent with nursing philosophy and synthesizing the theory is useful when asking if theory expansion would be appropriate (Chen, & Boore, 2009; Zahourek, 2015).

The synthesized grounded theory research may help to identify patterns within the work environment that illustrates how leadership and staff may collaborate to facilitate a healthier and safer work environment. The remediation of burnout is a cooperative effort between management teams and staff (Bodenheimer & Sinsky; 2014; Perlo & Feeley, 2018). Health is not the absence of disease, nor is the lack of having compassion fatigue equivalent to being resilient or achieving professional career satisfaction (Gentry, 2012; Perlo & Feeley, 2018). Collaboration between leadership and staff has been discussed at length by Joint Commission (2012; 2008 & 2016; 2011 & 2018; 2015; 2017) in multiple directives and sentinel events by the organization.

Reality is based on the perception of those participating in the research and cannot be measured by using quantitative methods (Heath & Cowley, 2004; Mills et al., 2006). This knowledge has led to the selection of an inductive methodology. Charmaz (2014) approaches grounded theory from a constructivist perspective that is in line with the theoretic and philosophical perspective of nurse researchers (ANA/AHNA, 2019). The beginning of constructivism began with Straus and Corbin (1990). Grounded theory developed into three or four iterations depending on the reference and expressed different

interactions as a response to societal change (Higginbottom & Lauridsen, 2014). They cautioned as have Charmaz (2014), and others, that the researcher must consider the world view and their own view when choosing a research method. The world view in this body of work is the viewpoint of professional nurses and those of the leadership team in the environment where the nurse practices.

The first grounded theory iteration and generation was that which Glaser and Straus developed for a California school of nursing in 1967 (Heath & Cowley, 2004). Strauss and Corbin published their work in 1990 according to Heath and Cowley, and Charmaz (2014) published her first constructivist work in 2006. Charmaz is a second-generation grounded theory researcher as she was a Glaser and Strauss student. Constructivist grounded theory would be considered a second-generation style of grounded theory while Strauss and Corbin are still first-generation grounded theorists.

Charmuz (2009) assumed that people made their own reality (Higginbottom & Lauridsen, 2014). Charmaz is of similar mindset as those who practice holistic nursing. She said that one, in this case nurses cannot separate themselves from the data and stated that the analysis is more subjective.

Further, Charmaz believed the views are influenced by the researcher, the world, and the participants interactions (Charmaz, 2009; Higginbottom & Lauridsen, 2014). In 2009 Charmaz stated that interpretation was grounded in “perspectives, privileges, positions, interactions. and geographical locations” (Higginbottom & Lauridsen, 2014, p. 11). A marked difference occurs between grounded theory and constructivist grounded

theory (Higginbottom & Lauridsen, 2014). Grounded theorist believes the data is rigorous enough that the theory is made, while constructivist grounded theorist proposes a theory (Glaser, 2002; Charmaz 2014). Though Glaser believes Charmaz has misunderstood she believes her work responded to the complexities of the world (Higginbottom & Lauridsen, 2014).

Nurses are of more value to the organization for which they work when they can provide safer, and higher quality cost-effective care (Lewis et al., 2014). An autonomous practice supports nurse's ability to practice at their highest level of education, a goal of the IMO (2010) criteria. Institutions benefit from respecting what nursing practice means and that it is different from what medical practice contributes. Both nursing and medical practice can enhance each other to improve professional and client satisfaction. Meeting these IOM goals contributes to the development of a more stable workforce (ANA Enterprises, n.d.).

Zahourek (2015) used synthesized grounded theory to expand her original study of Intentionality: Matrix of healing (IMH), a holistic nursing theory. Zahourek was further expanding the IMH by studying 12 male nurses to determine if men in nursing also used intentionality in their healing work as do female nurses (Zahourek, 2015). Zahourek looked to researchers Chen, and Boore (2009) and Amsteus (2014) for guidance on synthesizing grounded theory.

Synthesized grounded theory will allow the greatest flexibility to code the qualitative data as demonstrated by Amsteus (2014), Chen and Boore (2008), Rieger

(2018) and others. Chen and Boore recommended using synthesized methodology because it provided the flexible range of data gathering and coding by using the three primary grounded theorist's works. Charmaz (2014) constructivist grounded theory researcher and author is consistent with conventional and Holistic Nursing. Strauss and Corbin (1990) recommended that researchers use memos and mapping to make the researcher more aware of their own thoughts and actions when interviewing and coding data. Field memos and mapping were used as techniques to help me guard against forcing an interpretation of data rather than letting the theory emerge as Glaser (2002) and Higginbottom and Lauridsen (2014) recommended. The synthesized grounded theory leads to a multi-step coding process by using theoretic iterations of grounded theory (Chen & Boore, 2008). In this research the goal is focused on a subjective experience of acute care nurses.

Research Ethics

The participant consent was integrated with the letter of introduction to the study, and the participant were instructed to print a copy for their records and return the demographic form as a consent to participate. The participants were not known personally to the researcher. The writeup did not use full names nor identifiers that connected the person to a workplace in the data interpretation. The participants chose a pseudonym when writing Chapters 4 and 5. Participants were free to drop out of the research at any time they believed it was necessary without repercussions. I further

provided a numerical coded to better protect confidential of region, person, and institution for which the individuals worked.

Letters: Research Introduction, Participants Consent, and Appreciation

The IRB approved of my research and consent to participate. The IRB assigned the approval code number 10-02-19-0234721. The reason for conducting the research was posted to those who made inquiry. My research explanation was included in the consent form. The participants were assumed to have given consent once they filled out the demographic survey and returned it via secured email. Individual participants were filtered through Research and Me so there was evidence of meeting participation criteria.

Recruitment

The sample was to include 12 to 15 registered nurses, and one longitudinal observation. Participants were to write a reflective journal using the same prompts that were later used for the 30–60-minute follow-up interview. The follow up interview was used to member check and clarify potential misconceptions on my part. The multiple ways of collecting the reflective data, using member checking, and collecting data to saturation had the potential to provide a rich source of data.

Recruitment Procedures

The participants were purposefully recruited and sampled throughout the six regions of the U.S. as described in the demographic survey (see Appendix C). Sampling continued until the data was saturated. Sampling began with one participant and analysis started with that sample one at a time as is standard practice when using grounded theory.

Though the sample represented a broader swath of the U.S. population, the information was not in the strictest sense generalizable in terms of statistical research because this grounded theory study is qualitative.

The institutions from which participants came was not restricted by the size or location of the organization and was not used for inclusion or exclusion criteria. Participants came from a variety of worksite examples that included a community, private for-profit, and nonprofit hospitals and was identified in the demographic survey. The worksite was not used as inclusionary nor exclusionary criteria unless the facility did not address acute care needs or unless the site was a held Magnet ® Recognition or was Pathway to excellence ® credentialed or if Holistic Nursing in any iteration was a part of the way nurses practiced in the facility. The research was based on acute care RNs in the U.S.

Sample Demographics

Social media, snowball, and Research and Me were used to find research participants who wished to partner with the researcher in the synthesized grounded theory study. Those who wished to participate needed to copy the consent to participate for themselves and return the demographics form via secured email. After the participants returned the demographics form, and I sent them the reflective journal prompts.

The survey helped the researcher to determine if the potential participant met inclusion criteria. Though the demographic survey was linked to the person to symbolize a signature, pseudonyms were used during the write-up process and names were assigned

numerical codes to identify the individual's demographics. Participants were only linked to the region as defined in the demographic survey rather than a facility within a region

The participants came from acute care units within healthcare organizations. Nurses that worked on rehabilitation units did not meet the standard set for this study. Magnet® Recognition and Pathway® facilities did not meet criteria because documented outcomes of those facilities met the desired outcomes identified in this research and would not provide helpful data (Stimpfel et al., 2016). Participants had to have full command of written and oral English and have an acute care bedside practice of one-year minimum as a nurse on the unit where they worked at the time of the research. The region of the country in which participants practiced is found on the one-page demographic survey in (see Appendix C).

Sample Selection Criteria

Participants held a registered nursing license, had an active acute care practice of at least one year on their unit. English proficiency in spoken and written form was requisite for participation in this research. The levels of education included the Associate Degree Nurse (ADN), Bachelor of Science Nurse (BSN), or a diploma of nursing and potentially MSN or doctorate if the nurse served as an acute care bedside nurse. The student population included RN to BSN or BSN to MSN and BSN to a doctorate if they had an active acute care practice. No exclusionary criteria based on sexual orientation, race, color, or creed took place. Male and females registered nurses were equally recruited. The collection continued to the point of saturation of the data (Leung, 2015).

The demographics used in this research were supported by other researchers such as Kowitlawkul et al. (2018), and Zahourek (2015). The demographic data was necessary to determine if the participants met the criteria to partner with the researcher as a participant in the synthesized grounded theory study.

Data were collected to the point of saturation with the reflective journal and clarifying interview, which was used as a member checking method. The variety of the data collection resources was meant to contribute to the reliability, validity, and improve the research trustworthiness as it is a requirement of grounded theory (Strauss & Corbin, 1990). Data were collected via reflective journals with a 30-to-60-minute follow-up interview. The final study used five acute care nurses who were fluent in English communication, contributions from public communication fora including printed media were used as samples. One of the five individual participants submitted a career length reflective journal.

Participants

The nurse participants came from acute care units within healthcare organizations. Nurses that work on rehabilitation units did not meet the standard set for this study. Magnet® Recognition and Pathway® facilities did not meet criteria because their documented outcomes met the desired outcomes identified in the quadruple aim and provided no viable data (Stimpfel et al., 2016). Participants were required to have full command of written and oral English and had an acute care bedside practice for a minimum of one year on the unit where they worked. The region of the country in which

the participant practiced appear in the demographic survey used to qualify participants. The demographic survey was based partially on the works of Kowitlawkul et al., (2018), Steege et al. (2015), and Zahourek (2015) see Appendix C).

Participant Safety

Safety of Participants was essential to consider during this research. Participants discussed sensitive data that had the potential to bring up past unpleasant memories, and for their wellbeing, it was essential to remind participants that they may stop at any time if they were uncomfortable writing the reflective journal. During the interview participants were able to request a break or stop the interview without any repercussions. I encouraged participants whether they chose to withdraw or not, if they felt overly distressed to consider calling a mental health help line at 1(800)-994-9662. I also informed participants that they may text 741741 at the Crisis Text Line. Other options would include sharing with someone they trust in their local area. If the participants experience an emergency, they were reminded that 911 may be the best option for them to call upon.

Researcher Role

A researcher cannot be separated from the participants as one has an influence on the other from a constructivist view and an energetic perspective (Charmaz, 2014; Erickson, 2007; Peplau, 1952 & 1968; Rogers, 1992, Shields et al., 2016). Charmaz (2014) follows a constructivist philosophy which is congruent with holistic nursing as the specialty is outlined in its philosophical underpinnings (ANA/AHNA, 2013).

Constructivism, pragmatism, and symbolic interactionism offer grounded theory its philosophical underpinnings (Corbin & Strauss, 1990; Charmaz, 2014). I was an integral part of the data collection as Brown et al., (2002) discussed in their work.

Synthesized grounded theory is a way of examining the underpinnings that answer the research questions, what is the reality of those taking part in the research. Pragmatism, symbolic interactionism, and constructivism are ways that theorist have used to interpret the question, what is a reality (Corbin & Stauss, 1990). Madzia (2013) used his understanding gleaned from the Chicago philosophers Mead and Dewey to define pragmatism as the transition between perception and action. Symbolic interactionism focuses on the relationship or the interaction between small components of society and that, in turn, helps a researcher to understand society at large (Aksan et al., 2009). Symbolic interactionism in this research is based on the multiple realities of the research participants (Higginbottom & Lauridsen, 2014.

The purpose of grounded theory was to develop theory rather than to evaluate theory (Glaser & Strauss, 1967; Higginbottom & Lauridsen, 2014). Society is evolving as is the way society understands a reality, so it seemed reasonable that the methods used to interpret the question of what reality is would also change as society matures. Personal perception informs one's sense of reality, and few people have the same perceptions even though people's perceptions may be close enough to provide continuity of communication.

The researcher's role is to measure the conditions, reactions, and the interplay between those caught in the flux of change and to support evidence and theory-based growth. This research was intended to support the development of a more collaborative work environment where acute care bedside nurses will be able to achieve career satisfaction. My intent is to help other colleagues to better understand the professional nursing role within the healthcare system. The use of synthesized grounded theory will provide a systematic, replicable, and a rigorous way of conducting this study in a way that is congruent with personal and professional practices (Bryant & Charmaz, 2009; Higginbottom & Lauridsen, 2014).

Data Collection and Analysis

Data collection and analysis of grounded therapy research was interwoven and began when the I received the first reflective journal. Strauss and Corbin (1990) created the foundation for the constant comparative method that Heath and Cowley (2004) recommended one use in grounded theory. Constant comparative is a process of moving back and forth among data and coding for conceptual categories that become theory in the final stage the analysis (Harry et al., 2005). Stage one of the analysis was open coding where the process begins to establish codes and moved to conceptual categories and finally to theory development (Corbin & Strauss, 1990).

Pilot Study

The primary purpose of the pilot study was to refine the data collection process and to evaluate the software packages that were to be used in the data collection process.

(Thabane et al., 2010). One pilot participant was used to evaluate and potentially adapt the way the reflective journal and clarification interview was conducted. This prior modeling of the process in full, allowed me to determine if the line of questioning or reflective journaling needed to be modified (Dikko, 2016; Majid et al., 2017). The interview prompts were constructed to address the research questions (Castillo-Montoya, 2016). Dikko (2016) said that by using a pilot study, the researcher could gauge ambiguities and increase awareness of challenges. The pilot took place in the same online environment that the full research project took place. The three participants were chosen to be pilot participants because they brought various levels of computer skills to the project and met the other demographic criteria. The interviews took place over a confidential recorded audio connection. No video was used to assure participants' confidentiality and so that they would feel safe. An electronic transcription was made of the audio recording, which I converted into a series of concept maps and coded according to the outlined method.

I pilot tested the data collection process to build an effective computer aided data collection processes for people who were least comfortable in computer use. Easy and intuitive data collection strengthens the quality of the collected data. Using a pilot study allowed me to find and edit potential weaknesses in the software choices and replace those which were cumbersome to use.

Methodology

I wrote and discussed a reflective statement based on my perspectives of the research questions prior to data collection. This approach supported Glaser and Strauss's (1967) theory that the researchers must be sensitive to the collected data Higginbottom & Lauridsen, 2014; Strauss & Corbin 1990). According to multiple researchers, sensitivity to the collected data occurs based on the research's previous experiences with the related types of data collected (Glaser & Strauss, 1967; Higginbottom & Lauridsen, 2014; Strauss & Corbin 1990.

Some in the research community identify researcher sensitivity or intuition as a weakness of qualitative research, but Glasser and Strauss (1967) identified it as a necessary strength. Glaser and Strauss believed that researchers need to possess phenomena sensitivity so that they can understand the social situations or the phenomena of research focus (Harry et al., 2005; Higginbottom & Lauridsen, 2014).

To overcome the weakness or to identify the researcher's knowledge of the research phenomena Strauss and Corbin (1990) and Corbin and Strauss (1990) suggested that field notes be used during the interview and coding. Both sets of authors were of a mind that field notes might temper potential negative influence on the way data was collected and interpreted. What occurs is dependent on the perception of the individual or individuals involved who are experiencing a situation.

Charmuz (2014) interpretation of the grounded theory is based on constructivism. Grounded theory is a circular process of alternating collection and analysis and was

conducted one set of data at a time. This allowed for an intensive exploration of the data and for one data set to build on the previous until data saturation was reached (Charmaz, 2014; Corbin & Strauss, 1990.

Researcher Process

While writing the study, I reflected on my own perspective of the research questions. In that same journal, I registered memos while performing analysis of the data and theoretical notes as recommended by Strauss and Corbin (1990). These memos and theoretical notes were meant to help me link developing concepts to core concepts and theory as they were revealed (Miles et al., 1994). I discussed ideas and the data with my mentor to further help develop the coding, doing this helped me maintain a sense of balance and perspective.

Data Collection

Once potential participants expressed interest and they returned the completed demographic survey, the researcher posted the prompts used for the reflective journal via email. I asked the five participants to use 11 prompts to guide them in writing a reflective journal. The constant comparative method of analysis required me to begin the open coding process as each set of data was returned (Strauss & Corbin, 1990.

The guidelines suggested how to complete the reflect journal in a way that conserved the person's time and allowed them to complete a small amount of journaling at a time. I gave specific guidance on how to write the reflective journal and said that the

prompts should not be used as essays or short answer questions. The sample of the reflective journal prompts (see Appendix B).

The follow-up interview served as a form of member checking, to help clarify the reflective journal entries, and contributed to the validation of data accuracy (Leung, 2015). It also allowed the researcher to probe deeper to obtain completed sets of data with each successive interview. This method is said to contribute to accuracy in coding and creates a more trustworthy study (Leung, 2015). The data and coding were an integrated process and alternated between data collection and coding of the data. A significant part of the coding was used to maintain a reliable audit trail, which required me to keep a detailed record of the analysis process and the ideas as they arose.

Confidentiality of Data

The consent to participate was integrated with the study description. Participants were instructed to copy the form an keep it in their records and to return the demographics form as acknowledgement that they read and consented to participate. Additionally, the participants were informed that they could drop out of the research for any reason and agree to all terms of the consent to participate. The participant summary will use a numerical code that cannot be identified in any way. The participants chose their initials as identifiers, but once I began to report the results in Chapters 4 and 5 it was clear that by using participant's initials that would compromise their identities, so I chose a numerical coding strategy that would prevent outside identification of the participants.

Data Analysis

Grounded theory research analysts write memos during the analysis process to provide an audit trail and seek clarity of thought while coding. Memoing keeps the researcher focused on coding of the data and sensitive to the interpretation of the data. Common characteristics that are necessary to grounded theory coding include: Theoretical sensitivity, theoretical sampling, treatment of the literature, constant comparative methods of coding, the meaning of verification, identifying the core category, memo writing, diagramming or mapping, and measurement of rigor through the use of field memos (McCann & Clark, 2003). All data were put into coding maps also called mind maps, or concept maps.

I wrote my own reflective perceptions before collecting data and maintained a memo log while analyzing the data so that I was aware of the potential influence my own experiences had on the way the data was interpreted. Constructivist grounded theory is a way of data interpretation that has been common in nursing research. Additionally, Holistic Nursing by its nature does not recognize boundaries between entities (Rogers, 1992; Shields et al., 2016). What occurs in research is dependent on the perception of the individual or individuals involved in the experience. Interpretation of the grounded theory is one based on Constructivism Charmuz (2014).

Constant Comparative Coding

The constant comparative an open coding form of data analysis was used by the researcher to identify meaningful concepts (Glaser, 2002; Hood, 2007). Patterns were

identified and grouped into like concepts when identified while gathering the research corpus or the grand total of the data sets from the participants in the opening coding phase of the research. This method allowed the researcher to formulate the interview used for member checking, clarification, and further development of data collection. Reading the participants reflective journals and listening to their interviews facilitated development of the core concepts. Glaser (2002) and Strauss and Corbin (1990) were proponents of the constant comparative method as it established a systematic structure that contributed to potential replication and rigor that was necessary for quality research (Bryant & Charmaz 2009; Charmaz, 2014; Higgenbottom & Lauridsen, 2014). The coding process was a comparison of concepts with each step revealing a more refined data analysis (Scott & Howell, 2008).

Open Coding

Open coding was a loose process of grouping collected data from the reflective journals. Related items were grouped under one conceptual label (Scott & Howell, 2008). Open coding was conducted by engaging with the reflective journals and by listening to the interviews as they were collected. Further engagement took place while transcribing the interviews (Braun & Clarke, 2006). It was helpful for me to make notes and reflect on the data in mentoring session during the time while I was identifying potential concepts as suggested when working with data sets in grounded theory.

Axial Coding

Axial coding identifies relationships between previous categories. Scott and Howell (2008) interpreted Strauss and Corbin's 1990 work to mean that relationships were revealed by asking the questions "who, when, why, how, and with what consequences…to relate structure with the process." (p. 127). Scott and Howell developed tables to help novice researchers and combined those concepts with the mapping recommended by Strauss and Corbin. I used a computer application called XMind 2020 to map coding strategies. This technique allowed me to build relationships between open coding and axial coding and axial coding and the development of patterns where relationships were constructed based on the evidence as to the final coding stem (Scott & Howell, 2008). Open coding, and axial coding prompts the development of a central theme specific to the relationships found coding process.

Relationship of Categories

Relating categories is the decisive step of data analysis in grounded theory (Higgenbottom & Lauridsen, 2014). The relationship categories were built around a central core or the primary reason for the research.

Trustworthiness

Synthesized grounded theory allowed for the greatest flexibility and creativity to code the qualitative data sets as was demonstrated by Chen and Boore (2009). Chen and Boore recommended using synthesized method based on the broadest range of data gathering and coding methods. Strauss and Corbin (1990) recommended that the

researchers use memos and mapping to make them more aware of their thoughts and actions when interviewing and coding data sets. This technique helped to guard against an interpretation of the data that would lead to forcing data rather than letting the theory emerge as was recommended by (Glaser, 2002). The synthesized grounded theory leads to a multi-step coding process by using at least the three major generations of the grounded theory (Chen & Boore, 2009). The trustworthiness of the research occurs because those who are experienced in the method are willing to trust their sensitivity and creativity as it is part of their learned acumen of the grounded theory methods (Scott & Howell, 2008).

Generalizability

Generalizability depends on how "systematic and widespread the theoretical sampling" is and how closely related the actions and interactions are between circumstances will influence "generalizability, precision, and predictive capacity." (Strauss & Crobin, 1990, p. 15). Variation in the findings and abstract core concepts also add to a wider range of similar situations.

Reproducibility

Reproducibility requires an audit trail and can only occur if the original researcher is transparent in all aspects of collecting and analyzing the research data. The original researcher must document the conditions under which the research took place to facilitate reproducibility by later researchers (Strauss & Corbin, 1990).

Corbin and Strauss (1990) found that grounded theory had limited reproducibility because it depends on the variables found in the original study. Inability to reproduce the same circumstances as were present in the original study limits replication potential (Corbin and Straus, 1990). Researchers have no way of designing studies with a control for variables when the study is carried using a qualitative method. Theory applicability improves as the core category become more abstract. The conditions under which the research was conducted influence its limitation because there is no way to replicate the same conditions in two different sites or in different circumstances (Strauss & Corbin, 1990).

Validity

Multiple ways of validating and checking for the reliability of collected data from the participants were necessary to provide quality research. Once the initial coding of the first reflective journal took place, a follow-up interview of 30 to 60 minutes was scheduled to clarify the data. Each reflective journal was coded and compared to the previous reflective journal and interview coding. Successive coding followed the transcription of each set of data and entry into the concept map. Multiple rounds of coding are common in synthesized grounded theory as it is important to allow the theory to emerge rather than to force an interpretation according to Glaser (2002).

Dissemination Plan

I will launch of the dissemination plan once the study has been completed and published. My aim is to present the finished product to one or more professional nursing

organizations. Once the proposal is accepted, scholarly publishers may be interested in the literature review. The study is complex so that increases publication options. Journals that may my interested in publishing the work include the *Journal of Occupational Health Psychology, Journal of Holistic Nursing, and The Qualitative Research Nursing Journal*. Other journals that may be interested in publishing the research results include Policy, Politics, and Nursing Practice or Nursing Management. The IHI expressed interest in the research when I asked for permission to use figures and adaptation of the quadruple aim illustrations. Once published I will share the abstract with the as a thank you for their contributions.

Summary

The major sections of Chapter 3 that I discussed include research design, method, confidentiality, and safety of the participants and the data they contributed, where the data was collected and the demographics of those who were suitable participants. Chapter 3 also included the discussion of the introduction to this research and consent to take part. Demographics of the study participants to included participant safety ethical handling of their data was also a significant part of this chapter.

One of the requirements for quality research is to lay out a plan that is transparent enough that it will encourage other researchers to reproduce the research. Writing this section of the proposal helped lay out a plan that I could follow and a way to analyze the quality of my work as I engage in the circular collection and data analysis process. A researcher must be ever present to the quality and trustworthiness of the work they

produce. Part of achieving a quality research study is first to collect a smaller set of data to engage with as a pilot to the larger project, and that was laid out in chapter 3 to complete the proposal.

The last section of the proposal addressed in chapter 3 was the dissemination plan. This study includes healthcare administrators and professional care takers. This document includes discussion about acute care bedside nurses, national nurse professional groups like the ANA, and AHNA. Two versions of the *Future of Nursing* research publications were used in this research. The *Future of Nursing 2020-2030* focuses on healthcare diversity and how nursing can be involved in meeting the report's goals.

I developed this work to influence the way hospital executives, hospital-based nursing executives, nursing departments, and educators understand the importance of professional nurses' contributions to healthcare organizations. My intent was to offer a clearer perspective of what professional nursing entails as an autonomous but collaborative profession and to enhance the understanding of what nurses can contribute to the quadruple aim model. This cannot be done without understanding what nursing is and what it is not.

I used the quadruple aim, an IHI document, as the framework of this dissertation and they gave me permission to use the figures that are found in their working papers. The figures included in this document are illustrative of the quadruple aim. The goal of authors who wrote the triple aim and the expanded version to the quadruple aim remains

to help professionals regain a sense of professional satisfaction and to humanize healthcare by providing compassionate care by providers who are fully engaged.

Chapter 4: Results

Introduction

I provided an overview of the study, review of the literature, and discussed related literature. The research corpus was fully saturated after collecting data from five individual participant's reflective journals. The use of five two-way observation participants allowed me to reach data saturation. An additional 39 participants in the one-way observation allowed me to collect data from the six most commonly used regions when doing nursing research in the U.S. These regions are Northeast, Southeast, Midwest, Southwest, Central and Western (see Appendix C). This method of data collection increased the depth and breadth to the research. It also contributed to developing trustworthiness (dependability, credibility, and transferability.

The COVID-19 pandemic began during the data collection phase. Development of public communication fora allowed me to collect a relevant and rich source of data from the perspective of acute care bed side nurses across the U.S. This one-way observation of acute care bedside nurses in these fora allowed me to meet the goal of collecting data from the six national regions of the U.S. Acute care bedside nurses are professional nurses who work in an acute care setting rather than for instance rehabilitation. I will discuss the results and summarize Chapter 4 and transition to Chapter 5.

Purpose

The purpose of the research as stated in the overarching research question was to determine how the environment of care supports the professional nurse's provision of high-quality person-centered care and bolster a meaningful and purposeful career. The Chapter 4 discussion will include the pilot study, setting, demographics of the participants who chose to take part in the study, and potential limitations. The influence of COVID-19 expanded the importance of collecting additional current data.

Pilot Study

I designed the pilot study to reduce potential technical issues that might occur and to help decide which data collection tools were easiest for participants and me to use. Using software applications for recruiting, and communicating with acute care bedside nurses, and recording interviews have the potential to be confusing and difficult to use. Nurses are often averse to using computers after work hours, especially when they are overwhelmed by computer charting, which pulls them from direct patient care. The recruitment, data collection, and transcription platforms required adjustments to use them accurately. If participants were too challenged by software, it might have reduced the participation in the final data collection.

The pilot participants had more significant interactions with software changes to enhance the electronic research capabilities, than those who were the research participants. Three people who had varying levels of computer skill took part in the pilot study and worked through software package changes with me. One of the software

applications needed to be exchanged because it was too cumbersome to use, and I changed out the mapping application and learned a new software application. I also discovered a data transcription application during the pilot study.

The pilot participants went through the full data collection process from registering at Research and Me, to setting up the secured email communication package. Once the software application glitches were solved, I began to qualify those registered with Research and Me as either recruited by Research and Me or recruited by me via social media and snowball sampling. Those whom I recruited were funneled through Research and Me so that participants went through the identical screening process, and I was able to track the collection statistics.

Data Collection Modification

Due to the changing work environment perpetuated by the COVID-19 pandemic, which began early in 2020 in the U.S. I modified the way data collection took place to better fit the circumstance and the desire to meet the full research criteria. I used one-and two-way observation as defined by Morgan and Yoder (2011). Using the two-way observation allowed participants and me to give each other feedback. The two-way observation included the reflective journal and the follow up interview, whereas the one-way data collection was observational and provided no route for feedback. Modifying the data collection method allowed me to take the normal work environment into account and to take into consideration how the pandemic influenced the work environment.

History: Sars CoV-2 and the Covid-19 Pandemic in the United States

Late in 2019 in Wuhan, China the country's health authorities confirmed the discovery of a novel coronavirus sometime written as 2019-nCoV2. By January 20, 2020, the U.S. reported its first death from the virus. The Chinese celebrate the Chinese New Year in February each year wherever they live. January 30 the World Health Organization (WHO) declared a state of emergency. The United States State Department warned travelers against traveling to China and Chinese officials suspended travel departing from China on January 31. The cases totaled 9,976 in 21 countries by the end of January 2020.

On February 11, the disease that was caused by the Sars-CoV-2 virus was named the novel COVID-19. The total number of cases confirmed in 24 countries was 44,653. Europe experienced the first major outbreak in Italy and the disease spread to the East coast of the U.S. from Europe. The U.S. West coast outbreaks of COVID-19 came primarily from East Asia.

Widespread testing for COVID-19 began in March and by that time internationally 90,000 people had been infected. The U.S. disallowed entry form European travelers except those from Britain and the number of cases of the virus continued to spread. The country hardest hit by the virus by the end of March 2020 was the U. S. (Taylor, 2020, June 20).

Setting

Though this research took place online, the conditions under which acute care bedside nurses have been practicing since COVID-19 became a pandemic made it difficult for them to consider being a research participant. One potential participant wrote to me for over six weeks saying how much they wanted to participate, but as the time for data collection ended they had not responded. Months later they sent me a message that read, “the emotional investment of the job during COVID-19 and the research was just too much to bear” (potential participant).

Demographics

The acute care bedside nurses’ demographics were diverse across categories of gender, race, age, hospital size and type, hospital location, years in practice, role responsibilities, and overtime requirements. Three people worked in metropolitan areas of varying sizes and two people worked rural areas. One of the rural hospitals was less than 100 beds but the hospital was not critical access.

Acute care bedside nurse participants ranged in ages between 31 and 69. The five participants who completed the study included three women and two men. The two men were between 31 to 39 and the three women were between 31 and 69. One participant held a BSN and three of the participants held MSN degrees. Two participants were at two distinct stages of completing MSN as advanced practice registered nurse (APRN). One nurse was starting the APRN and one MSN was taking a certification program to be a APRN as well as an MSN in a non-clinical role that is not considered as an APRN. One

participant had no interest in education beyond a BSN and said that they wanted to retire as soon as possible, and they hoped they would be able to maintain their health long enough to retire. The participant who held a BSN considered a MSN for a brief amount of time but believed it would serve no purpose. One of the people who identified as male further identified himself as African American.

A potential limitation of collecting this data in the public communication fora was to collect from a reliable sample that would meet the individual criteria without asking them to provide demographic criteria. I vetted the bedside nurses by how they described their nursing activities and purposefully chose participants if they identified themselves as acute care bedside nurses. I focused on qualifying participants so that they would be following the individual participant demographics survey (see Appendix C).

Generalizability to a larger population would be difficult due to a lack of transparency of the specific sampling used in the one-way observations for the public communication fora. The severity of the pandemic would not be present in most circumstances. The pandemic background should not invalidate the outcomes because the public fora reiterated what individual participants shared.

The data sets were difficult to analyze because participants chose the prompts that they responded to and used the prompts as if they were short answer or essay questions. The Directions were clear in the consent and terminology was consistent throughout the process. This is not an unusual phenomenon for nurses, another researcher had the same

issue in a survey using to ProQOL. The nurses in that ProQOL survey skipped the questions that identified compassion fatigue (Mullen, 2010; Neville & Cole, 2013).

This collection process was lengthy in nature. Due to the length, it might have prompted individual participants to reduce their contributions to the reflective journal prompts by answering the prompts as short answer or essay questions. Reflective Journaling in addition to an online environment may cause participants concern about confidentiality. Reflective journaling can sometimes feel threatening to participants. Nurses have been known to not answer questions that were indicative to traumatic stress conditions (Mullen, 2010; Neville & Cole, 2013).

Limitation and Transparency

The overwhelming workloads of the acute care bedside nurse may have limited my ability to collect a nationwide sample of acute care nurses for the two-way observation participants who partnered with me to provide reflective journals and clarification journals. One participant stated that she was not participating based on her limited ability to further invest time after working long and emotional exhausting hours. This may have also been the reason that over 2,000 people clicked into Research and Me. This online tool is an online research participant recruiting software package. Even though more than 2,000 people clicked into the study description only one person came to the research and completed it through the recruiting tool.

Data Collection

Research and Me tracked the number of people who explored the research. Six of those were approved for researcher-imposed inclusion criteria one of those dropped out and that left five participants. Once approved, I sent the participants the email address where they could access a free account to find the consent to participate in the demographic survey (see Appendix C). This email account is where they would communicate with me and pick up the reflective journal prompts once they returned the demographics, which symbolized a positive consent to participate in the research.

Acute care bed side nurse participants in the U.S. were recruited and screened via Research and Me. The individually recruited participants were funneled through Research and Me where they were screened for the predefined criteria. Individual data collection took place remotely in a secured email client. Public communication fora were used for the one-way observation. Once the journals were returned interview sessions were scheduled one at a time. Interviews were transcribed by an electronic transcription agency that collaborates with Zoom. I recorded the data in electronic concept maps where I identified several iterations of themes.

Six participants completed the demographic study, one of whom chose not to complete the rest of the data collection procedures even though they returned their demographic form. Recruiting participants through Research and Me was not a successful endeavor in that only one participant came through the site. otherwise, participants were volunteers found in social media or via snowball sampling. The licensed acute care

bedside nurses were U.S. citizens from the six regions of the U.S. that are most used by professional nursing organizations when doing or reporting researcher.

Research and Me recorded 2139 clicks to view the research, seven potential participants applied to take part in the research. Six people qualified to participate in the research and five of those completed the research. One of the five participants who completed the research came directly from Research and Me. Four of participants who I recruited completed the project came through social media or snowball recruitment.

Like bullying, which can be overt or covert and as nursing uses overt and covert skills in their surveillance of clients, I have done the same thing while collecting data. I used listening skills for intonation among other differences in voice and used interviewing skills to make sure I understood responses at a deeper level than listening to the words alone. In the one-way observations this took on a unique way of hearing by looking at the contest of the conversation both before and after the comment, which I captured taking into account the context of conversations. Some terms like burnout, selfcare, and holistic are misused because they have been popularized without a real understand of what each term means and it makes the interpretation of some conversations challenging.

Nurses are experts as concealing their feelings and interpreting question that expose their feelings. Nurses are experts in reading between the lines. This also applies to assessment for stress and burnout (Neville and Cole, 2013). Nurses are required from a professional perspective to not be reactive to client issues or presentations. Additionally,

It is seen as shameful when one is unable to tolerate job stress. Neville and Cole discussed a survey administered to assess for secondary traumatic stress and found that the nurses skipped the questions, which revealed secondary traumatic stress.

I also got considerable overt and covert push back. It took several months to collect data, the sample was small, one participant took part in the demographics survey, and two others told me for several months running how much they wanted to participate but never completed the participant process. Each of the five participants chose which of the prompts intended to guide the reflective journal chose to answer the prompts as though they were short answer or essay questions. One participant wrote an historical reflection of their career by including information from the 11 prompts. The other four participants responded as if answering essay or short answer questions. But even when the participants used the prompts as short answer essays, they chose which of the prompts to which they would respond. One participant responded to my interview prompt by saying, “you know how it is, I’m not going to say it.” Later that participant said, ‘it’s just internal frustration,” when I asked them about not sleeping well, they would not say more.

I made minor changes in the data collection method by including a one-way observation of the public communication fora. The discussion was in the public domain with or in response to other comments. I identified the areas of the country where the discussion originated. I did not identify any of the 39 observation participants whose responses I used, nor did I identify specific facilities. I used regional identification only

where it was necessary or where it was written in printed materials. The observations included the six regions of the U. S. The regions from which the individual participants came included the Northeast, Midwest, and the Southeastern regions of the U.S. (see Appendix C).

Data Collection Variance

The participants completed the research to the best of their ability. The participant who wrote a historical reflection of their career worked in four of the six regions throughout their career. Four participants used the reflective prompts as if they were answering short answer essay questions. Those same four participants chose which of the prompts to which they responded. Their approach was tantamount to skipping survey questions, which often occurs in research studies without invalidating the research.

However, in grounded theory and other qualitative research incomplete participation creates difficulty during data analysis because it circumvents the researcher's intention and interferes with a researcher's ability to identify patterns. When there is insufficient data transparency, it is difficult to analyze the data sets.

The initial number of participants described in the proposal was 12 to 15 or until saturation of data occurred. My intent was to recruit two participants from each of the six regions of the U.S. to obtain saturated data. Five participants contributed reflective journals and follow up interviews. Saturation of the data occurred in what the five people who provided the two-way observations contributed, but the sample did not include the six intended regions of the U.S. However, by using the one-way observational study from

the public communication fora, I was able to access a data set from the six regions of the country when both samplings were combined. The one-way observation participants did not take part in the demographic survey.

Individual Data Collection

I used Research and Me to maintain statistical records for the research project. The breakdown included the source of recruited participants, the number of potential participants who viewed the study, and how many registered for the study. Additional Research and Me participant data included the percentage of those who registered, how many of those were approved, rejected, and completed the study. Other data showed the percentage of those who opened and clicked through to open the research study and a broad discussion of these statistics has been discussed earlier in this section.

The research participants reported that they took about 10 to 15 minutes to respond to the demographic survey and submit it via the secured email account. Once the participants returned their demographics implying that they understood the consent to participate I sent them the reflective journal prompts. I recorded the follow up interviews via a secured audio file connection after which I used a secured electronic transcription service. The participants reported having taken between 30 minutes to four hours divided into multiple segments to finish their reflective journals.

Participants who took between 30 minutes and an hour to construct their reflective journal provided data that was challenging to analyze based on the prompts that they responded to and the format they used to record their perceptions. The participant who

took four hours to record the reflective journal shared their career as a longitudinal data collection. Those who were part of the one-way observation often shared their perceptions based on full career exposition and discussed how nursing has changed over the years. The one-way observation participants used the term “do more with less strategy” as difficult to deal with on multiple occasions.

Practice Site Location

One-way observation took place in public communication fora and contributed a potential sample of over 200,000 participants. I recorded comments that were consistent throughout the observation. Participants who identified themselves as frontline nursing professionals and worked in the acute care setting were observed but I had no interaction with them. These acute care bedside nurses were easily identified as most said they were bedside nurses, and it was understood that anyone caring for COVID-19 patients was an acute care bedside nurse.

Data Analysis

Data Analysis Strategy

I began to identify patterns in each data set during the open coding stage of analysis. That allowed me to begin identifying potential patterns of relationship as they began to appear between and across the data sets. The second step in this coding process was to use Axial coding. The third step of analyzing the qualitative data required me to identify the central core codes. Once I was able to identify the central core codes I moved into the selective coding and finally to identify the core categories or themes.

Qualitative Research Questions

The overall qualitative research question that guides the research is how does the environment of care support the professional nurses' provision of high-quality person-centered care and bolster a meaningful and purposeful career? The three specific research questions are:

Research Question 1: Based on the experience of acute care nurses can burnout be expanded to include traumatic stress?

Research Question 2: Based on the experience of acute care nurses could joy be included as part of the larger context of professional satisfaction?

Research Question 3: How did the environment of care support the acute care nurses' provision of high-quality, safe, and person-centered care?

Research Question 4: How did the environment of care bolster the acute care nurses career satisfaction?

Theme Identification

I developed two citation schemes to differentiate between the two-way observation participants and the one-way observation participants. The two-way observation participants wrote reflective journals and took part in the follow up interview. These participants' quotations are cited by using the formatting scheme 2020-000. The one-way observation participants and I had no interaction. I found their data in a variety of public communication fora. I will cite their contributions by using OBS #0 to

00 numbering scheme. I developed these citation schemes to afford the most secure level of protection for those who took part in the research.

Theme: Professional Nursing Identity

2020-001: Family lineage generationally. I became a nurse due to a familial background of nursing, there are five generations of nurses in my family. I'm highly motivated.

2020-002: I grew up knowing I was going to be a nurse. I never even considered another career choice.

2020-003: multi-generational line of nurses and caretakers, Stable and honorable occupation [that also has] reasonable monetary gain.

2020-004: Helping people not only felt good – it felt right. I did not question my desire to be a nurse. As a youngster I was patching up everything from pets to anyone that would sit still long enough to allow me to work on them. I was an advocate for siblings and classmates, and it was not until later that I realized people could be something other than a nurse. No one in my family was a nurse. Helping seemed like the right thing to do. Even though I wanted to marry, my education had to come first.

> 2020-006: It’s a burning passion of mine to help people. Family lineage of doctors…I wanted to be a doctor originally…life happens, and I didn’t. There wasn’t much clarity in what I’d do in the future. I’ve been a nurse for a few years and things are coming together. I became a nurse honestly because it was the quickest and easiest career I could get after already having a degree, with original

> hopes of becoming a doctor. I like making the emotional connection with the patients and stuff that's a priority for me. That's my favorite part about nursing is just that, connections that I do make with patients. When I work night shift and they were all alone that's really when their anxieties and fears come through when their visitors aren't there and it's quiet and so I really enjoy spending that extra time with a patient. I enjoy it, but it's a very frustrating career. And I was like, how do I get to be with patients so that kind of drove me to go to nursing school. […] so I'm fully immersed.

Theme: Professional Philosophy of Nursing Practice

2020-001: I like to […] spend time with the patients and talk with them and make sure that they are doing OK in regard to their own mental health.

2020-002: My personal mission and vision is to provide high quality care to all of the patients and their families who I come in contact with. The mission and vision of the hospital is similar however much wordier. […] Nursing is not task driven. It requires relationship and patients are unhappy when they cannot have time with their nurse.

2020-003: we're being called to meet deeper meanings absolutely or less tangible aspects of the human experience.

> 2020-004: […]career experiences have helped me delineate my own personal mission. […]seek to improve the clinical outcome. […] focus on finding solutions to problems encountered. […] I strive for clinical excellence […] believing I can always do more to improve the level of care I deliver by controlling variables.

> […] improve patient satisfaction. […] to decrease the cost of care. […] improve the efficiency of care delivered by streamlining processes. […] I looked to results being generated by national healthcare quality-focused groups and initiatives. […]I have a personal mantra with every touch – teach.
>
> 2020-006: My number one driving factor while at work, especially on the difficult days, is remembering that each patient is a human that has walked a vastly different life than me. They are currently in a vulnerable state and have no intentions of being hospitalized. I am going to find out about this person's story throughout the day and even when they get on my last nerve, realize they didn't want to be here and it's my duty to make them feel comfortable and safe. […] it's so important to treat each patient more than a room number, more than their comorbidities, and more than a diagnosis. […] My patient comes first, from safety to advocating, to ensure the best possible outcome. […] The primary mission of the hospital where I currently work at is 'patient first.' This aligns with what I believe, sometimes their methods don't. seem to think about staff because they are always putting the patient first.
>
> OBS #17: I LOVED my career but today it's extremely hard.

Theme: System Barriers to Practice

Barriers to practice include such topics as uncivil behaviors like eye rolling, lack of supplies, role conflicts, fractionated care, redundant charting, excessive auditing, lack

of mutual respect, lack of nursing autonomy. Lack of support from nurse leaders and managers, staffing shortages and dehumanization of clients and professional nurses.

Nurses need to be included on important decision-making teams that influence their role and ability to provide compassionate and meaningful care. Joint Commissions (2011; 2018) showed that spending insufficient amounts of time with patients increases complications and readmissions which reduces a healthcare facilities reimbursement from CMS.

> 2020-001: **[**…]but in reality, there is so much more that could be done for these patients at the time of admission […] to reduce the number of readmissions. […The] prescriptive authority and I don't even talk to each other unless something serious is happening.
>
> 2020-002: Stopwatch timing [time management studies] of professional nursing [creates] dehumanization of patient care. […] order entry poor communication [physicians] asking nurses to make [consultation] calls for them. It seems like the computer has actually added more stress. And so, they'll put in a preliminary note [work around], and you don't know if they've been around, or if they just put it in, note so that then when they see the patient, they can quick add to it. So, there's that challenge, because then you have to ask the patient, have you seen your doctor today, and they lose a little bit of faith [in you as their nurse] because you're the one there, you should know whether the doctor has been around. But so there's a little bit of that. And then also with the electronic medical record, and the

expectation on the physician, there's much less communication at all between any department. Right. [...] Sometimes it's hard to communicate with them [in] specific positions because they don't stay around. They come through like ghosts and evaporate […] I mean, you still have to acknowledge them [the orders]. A lot of the physicians still want to give verbal orders, which is not great. Best practice, Right? And so they still a lot of them have their own challenges with the computers. And so a lot still like to […] give verbal orders and orders over the phone. The electronic medical record [was] supposed to have helped quite a little bit but it brought new challenges right. So technically, they should be able to put in orders from wherever they are, and nurses should never have to take a verbal order or a telephone order to be able to order and for our facility and these physicians, there's still quite a little bit of that happening. But they'll put in their daily orders when they come and round. A portion of them will put in all of their own orders. The majority of them know, they've kind of gotten to put in all of their own orders, or now they have a nurse practitioner that will do it for them. But um, there's still a few that are learning how to use the electronic medical record. So there's that, but along with it, there are lots of physicians now who will put in a preliminary note. So, in the past and at the bedside, you know, physicians had to stay long enough at least to write their orders.

2020-003: In the context of my work environment there is a high level of excessive and redundant charting that takes nurses away from the bedside and from providing the necessary patient care and attention.

2020-004: Unhealthy work environment […] uncivil behaviors toward other workers and generalized disengagement (i.e., no interest in participating in meetings or unit-sponsored activities) nurse encounters role conflict with other healthcare providers on a regular basis. I collaborate with clinical pharmacists, nutritionists, physical and occupational therapists, speech therapists, palliative care nurses, case managers, chaplains and of course physicians. The American Association of Critical Care Nurses identified lack of control over work processes as a barrier to creating and sustaining a healthy work environment. (lack of nursing autonomy). […] Nurse to patient ratios, patient proximity, Inability to adequately address the educational needs of patients. Inadequate time to provide educational needs of patients. Inadequate time to provide educational needs of family. Improper patient staff mix—staff cannot meet the needs of the patients due to lack of time, limited time. […] nurses don't have the education to meet patient needs critical care nursing staff and my perceived consequence of lowered quality of patient care and patient safety. […] There are additional situations that remove the nurse from delivering direct patient care and compound the time-pressure experienced by nurses occurring each shift. Some of these situations were overseen by support personnel before staffing changes were implemented by

my manager others are *system issues*. Most of the issues encountered are the *system issues*, however a few are physician driven. Physician-driven issues may relate to physician availability and the timing of their on-unit rounds and the timing of their orders for medical care. These impact the 7a-7p shift more than the 7p-7a shift. Another physician-driven system issue is physician's circumventing the requirement that they put in their own orders rather than expecting the nurse to do it for them. Physicians are only one set of the healthcare provider groups that the nurse encounters while delivering nursing care. Additional, discussion about the impact on patient care delivered by the nurse while collaborating with other disciplines follows under role conflict. […]Two *physician-driven* issues that result in role conflict are that of circumventing the requirement to put in their own orders and one I recent requested that I received from a physician[was] to contact other physicians and communicate messages to these physicians with the additional request to share the response(s) back with the requesting physician. 2020-006: Inadequate resources and materials and equipment to conduct the job. Expansion does not take into account for needed supplies and resources. Having a manageable workload allows you to be safe with the patient and build trust and rapport, really look at labs, notes, medications, and notice when things are going in the wrong direction, turn the patients that need and ensure your patient gets a bath or shower. When you don't have enough staff, a lot of crucial things can be missed, resulting is poor patient outcomes. It's great to work with the variety of

colleagues I do, but it's frustrating when they don't have the same work ethic as I do. I should be comfortable asking everyone to do something or help, but unfortunately, a lot of times, I do it on my own because of the eye rolling that I know I will receive. This is a particular problem with the PCT's, who are protected by the union and rarely willing to go above and beyond their written duties.[…] I did learn, however, that the previous manager fought for his staff, but higher up didn't approve of it and made him transition to another position.[…] It's tough in a corporate world when your voice isn't heard, but if it was, there would be a lot of nurses that would have a smile on their face when they came to work.

OBS # 4 Staffing [...] like running during "season" without seasonal staffing. Holds in ER are over 24 hours due to r/o creating a bottle neck. Ambulances are diverting and on bypass. Anxiety mounting.[,,,]no overtime pay for extra hours worked [...] No raise. No sick time. And they took our PTO away.

OBS #18: When asked what a nurse's biggest struggle is during donning and doffing PPE by an engineering student who was attempting to design process improvements for PPE one of the responses read, there would be no problem donning and doffing if one was utilizing UNUSED (i.e.: clean) PPE. That is my biggest concern.

OBS #25: Started w/ 3:1 ratio increased ratio went to 5:1 with Bipap/ventilated patients on 100% O2—critical patients.

Theme: Cooptation of Nursing

Acute care bedside nurses describe their jobs in terms that one participant termed as co-optation of nursing into medicine and another spoke of non-nursing business types managing nursing or the act of systemic co-optation of the professional environment of care. Subsuming or reducing the value of another by suggestion. These terms are illustrative of hierarchization (Andersson & Liff, 2018). In this circumstance it is another way of devaluing a professional nurse.

Co-Optation is often connected to oppression an issue that is connected to nurse bullying or incivility. Anderson and Liff (2018) discussed co-optation in the context of power struggles, which are related to the cooptation of nursing by medicine and the necessity of clarifying nursing in the terms of nursing professional documents rather than attempting to define nursing in terms of medicine.

2020-001**:** […]in my current role as a nurse I feel very under-appreciated, my opinion is not taken into consideration when providing care for patients. Because I'm not a provider [b/c I don't prescribe] they don't listen to me.

2020-002: Non-nursing business types design nursing professional workflow and manage nurses time without any understanding of what we do with patients.

> 2020-003: […]others that thought we just […] do what doctors say and follow the doctor's plan.[…] recognize that the role of nursing has been co-opted into the medical model.[…] We have forgotten the primary role of nursing is to provide care, be attentive to bio-psycho-social needs […] We are not mini doctors, nor are

we the physician's hand maid. We are co-equal care partners in the tending of our patients.

2020-004: System issues [to] take nurse out of providing direct care and this compounds time pressures. Physician circumventing order entry and expecting nurses to do order entry.

2020-006: It's just so much change that's happening. And nobody from our department had input including the managers. So, a lot of us are frustrated with that too, because it's corporate making decisions without coming down to the nursing level and asking for input.

Sub Theme: Systemic Cooptation

OBS #11: For years hospital administrators have dictated how we do our jobs, where we work, and if we work.

OBS #16: We are floated to places we feel inadequately trained to work in or do not feel comfortable working in without any options.

OBS #20: Nurses make decisions that save lives when the docs have gone to the office or home to be with their families. Yet we are the ones too often blamed if anything bad happens. They are abusing us.

OBS #36: Large hospital systems and Congress encouraged rolling back of CDC's recommendation that would protect healthcare workers by withdrawing safety standards that are normally in place.

OBS #37: The American Hospital Association called on its supporters in an alert to urge Speaker Nancy Pelosi, D-Calif., and other Democrats to withdraw workplace safety standards from a second package in response to the coronavirus pandemic. CQ Roll Call obtained a copy of the alert.

OBS #38 Occupational safety and health director of AFL-CIO 1990 until 2019 described the Nation's coronavirus response as the biggest safety and health failure that has ever occurred in this country. The toll on working people is already enormous.

Theme: Nursing Role Devaluation due to Lack of Respect and Support.

2020-001: I do not feel supported or identified as a resource that should/could be utilized in practice but rather [I'm] seen as an individual […] used as a crutch and a scapegoat for other problems. […] I feel very underappreciated. [I'm] completely underutilized for my skills and my practice as providers do not uphold the professionalism of nurses and we are seen as just nurses. […] I applied for the new position here. They totally overlooked me and hired someone that has only been a nurse for a year and has no nurse educator background. […] because I'm not a provider [because I don't prescribe] they don't listen to me.

2020-002: non-nursing business types design nursing professional workflow and manage nurses' time without any understanding of what we do with patients. When nurses are put on a stopwatch, they are required to fulfil tasks rather than providing compassionate care.

2020-003: [I] often have no time to connect with my patients in any real and meaningful ways. Whenever I have sought expansive services for my clients nearing transfer or discharge, I am placated, but no following orders are usually received. My patients are often not empowered, as the physicians often feel that they know better than the patient and rather than taking the time to talk and explain things to them they frequently avoid it at all costs. […] So, I had three patients when our normal was two. And I said, hey, can you, do you mind watching my patients really quick while I go to lunch? And she said yes. […] and I turned to go grab some items […] I turned back around, and she had left the station. The lack of staffing partnered high acuity, and virtually no support, reduces the work of nursing to mechanistic equipment focused technical work. We have lots of nice equipment that assists us in being effective in providing life-saving care, but I do not have the support to provide meaningful connection, time, and attention to my patients. […] I had my evaluation. Um, and yeah, and so during my evaluation, I said, oh, you know, I had received one DAISY Award, directly. And then she said, Oh, well, here, let me give you these and she turns to my files and she pulls out [more than a half-dozen] Daisy awards. I think it was that she had been keeping for about the span of I think maybe eight months to a year, and I had never gotten [them]. She said, these are for you. She didn't say she was proud of me or happy that I had received them. But she said your patients really like you. Your patients love you. And they're very grateful for you.

2020-004: Threats are made in emails to the staff. […] Nursing staff freely blatantly disrespected. […] Disrespectful communication: written, spoken, and non-verbal […] Lateral intimidation and bullying behaviors […]Unilateral decision making that does not include those who it will affect. […] Employees regularly report feelings of invisibility and undervalued and staff are leaving as a result.

2020-006: team leader seems to be minion of higher management. […] Inappropriate patient assignments for unit just emptying the emergency room demoralizes the staff […] I don't feel like I have a future role in this organization, but education is encouraged. […] Many resources and employee benefits but staff are not encouraged to use them, and they are not communicated to the staff. …[I] received no feedback from management [and] No 6-month review.

OBS #1: Essential Workers are Disposable? Not eligible for Workman's Comp, no sick leave nor disability.

OBS #2: Hospitals want to kill a policy shielding nurses from COVID-19 because there aren't enough masks.

OBS #3: AHA says surgical masks are an adequate substitute when a supply of N95 respirators not available, citing the Centers for Disease Control and Prevention's recent decision to relax its own guidelines.

OBS # 4: Staffing ...like running during "season" without seasonal staffing. Holds in ER are over 24 hours due to r/o creating a bottle neck. Ambulances are

> diverting and on by-pass. Anxiety mounting. […] no overtime pay for extra hours worked [...] No raise. No sick time. And they took our PTO [paid time off] away.
>
> OBS #18: When asked what a nurses biggest struggle is during donning and doffing PPE by an engineering student who was attempting to design process improvements for PPE one of the responses read, There would be no problem donning and doffing if one was utilizing UNUSED (i.e.: clean) PPE. That is my biggest concern.

OBS #21: Too many administrators aren't concerned about their personnel on the front lines. They are concerned about their BOTTOM LINE.

> OBS #22: I've never felt so unvalued as an employee as I have since March. Constant policy changes. Loss of some benefits. No raises. And we have to use our PTO if we get COVID-19. If we don't have enough PTO, we are just out of luck.

OBS #33: More than one system in the country did not want nurses wearing masks at all because it contributed to shortages and promoted fear of the public.

Theme: Negative Aspects of Caring

> 2020-001: Some of our nurses just want to come to work, do what they need to do, give their medications, and go home. They just do not have a will to gain more experience or knowledge at this time. […] Burnout and fatigue in nursing is a real thing, hence why I believe in self-care.

2020-002: I think that the light at the end of the tunnel is retirement. Hopefully, I'm healthy and able to enjoy it. […] that's [many] years out, [I'm still young] you know. and honestly, I don't think it's just this system. I know it's the healthcare system, [it] is broken, you know, changing jobs might help, briefly, but it's all going to be the same no matter where else you go, you know what I mean? Yeah. So, I don't know what the answer is. I'm still trying to figure it out. But I would not if it didn't require me to be a nurse, um, to continue to Well, I mean, honestly, I don't know how people afford to live in this area without making… with making less than I make, and I don't, you know, I'm not rich by any means... But um, yeah, I don't know what the answer is, and I don't really have one. Right? I speak to several nurses who are good nurses and are leaving the bedside, because of all the things we've talked about. And they're in nurse practitioner school and one of them said to me last week, she said, I don't know why I'm doing this to myself, because the person that she does clinicals with, they see 30 patients a day in the office, they come to the hospital and do rounds on lunch. They eat lunch, as they're doing rounds at the hospital, go back to the clinic see the rest of their patients. You get 15 minutes with the patient, you know, that's not enough time they want to talk about everything, you know, you have to only focus on what their appointment was made for. Again, it's a broken system. And I said, there's not lots of options. And I said to my [spouse] the other day. I said, Maybe I should go back and work on my masters. And [they] said, why, what is it going to

get you? And I didn't have an answer to that it was just going to get me a reprieve from doing what I do, possibly. And then I'm going to be in debt for my masters and still dissatisfied. So really, it's the same thing that I've been saying for several years. And [they] just said it to me because [they] are a good spouse. And that's what I would have expected, not because [they] would ever talk me out of education, but because, honestly, you know, people have told me I should go back for education like a master's in education, but you don't want somebody with my perspective on nursing, teaching new nurses, I'm going to probably talk them out of being a nurse, you don't want me to be their educator. You know, I, I know that there's lots of knowledge that but, um, I don't have the answer to how to safely and appropriately work as a bedside nurse in this environment because I don't know what it is. And that's what educators need to be. I don't know. And that's a whole other thing. The educators don't spend time with their students anymore, either. That's a whole other topic. But um, yeah, I don't know. I don't know. I certainly would never want to be a nurse practitioner. Never ever. I looked at MSN in holistic nursing. But there's not a lot of options with that unless you are a nurse practitioner. I don't feel like you find when you find a little right, so then what, what would that do? As far as fulfillment for me and as a career, you know, so I don't really know.

2020-003: I could see the passion and compassion in them in their work they were doing. …many of them were eventually, you know, they kind of just kept settling

in my opinion, they kept settling for being tripled all the time. … I would say that she was definitely burned out. I can say that for certain. […] you know, when you're in that fight or flight kind of stay for 12 hours I would barely eat. And so, I would be, you know, hungry, and that would cause brain fog and feelings of fatigue, but then I couldn't stop because it wasn't, you know, the environment just wasn't conducive to really taking good quality, self-refreshing breaks, and lunches. […] I would get home […] I would just be tired and exhausted, and you know, and I have a child that needs time […] I still needed to decompress from work and, you know, and having a spouse that was also frustrating and it was exhausting to have to attend to that when I really needed to attend to myself after work.

2020-004: Here I learned to put my feelings aside in order to give the kind of care that may help these little ones. Blaming their parents or families or the "system" would have only stolen precious time from that which I could use to help them. I began to learn emotional distance to protect the professional relationship I had with these children, their families, the therapists, and doctors. (Oh […] and to help protect me, of course!). This is when I learned to stand up for myself. I went on to learn many other valuable lessons while working in this community hospital Unhealthy work environment […] Uncivil behaviors toward other workers and generalized disengagement (i.e., no interest in participating in meetings or unit-

sponsored activities) nurse encounters role conflict with other healthcare providers on a regular basis.

2020-006: I enjoy what I do, and I love my patients, but I want to do so much more. The healthcare system is set up to fail immigrants, uninsured, low-education, low-income, non-English-speaking patients, to name a few. Translators are always an option, but it's impossible (or providers just don't take the time) to have the emotional connection and build rapport with patients. Burnout is present on the floor but I'm just bored.

OBS #6: Nothing is worth this! I don't know what I'm gonna do with the rest of my life, but I'll never be a nurse again! And I don't even think I'll miss what nursing had become.

OBS #7: It's not what it was when I started, a decade ago, and this pandemic has given me new strength to move on to a new career path. Now to choose what?

OBS #8: The day I walk away will be incredibly hard

OBS #9: Today we delegate, administrate, document, CYA, and barely have time to make patient eye contact let alone hold their hands.

OBS #10: I have seen a consistent deterioration in nursing and medicine that ironically parallels the advancement of medical science. Staff ratios were 5 to 1 back then and we actually delivered nursing care.

OBS #12: We are shamed if we don't come in on a day off then cancelled with no compensation for lost hours if the census is low. We are shamed if we don't come

> in on a day off then cancelled with no compensation for lost hours if the census is low.

OBS #13: It's sad and demoralizing to watch my colleagues get sick and die unnecessarily.

OBS #15: As nurses we don't leave our patients and administration takes advantage of our nature.

OBS #19: Sterilizing PPE/masks that are single-use. We are changing regulations every time we turn around. Wearing trash bags for gowns. Wearing the same masks all day long.

Theme: Selfcare at Work

The participants in this study would have been grateful to eat, drink, and take bio-breaks. The participants had selfcare routines that they used at home.

> 2020-001: I called them out on it. I said, you need to understand about your student's mental health and you're not respecting it. I had a nice little email management mind was, you know, like tongue in cheek, mine was very underlying, like, they got my point. […] I did call out to a physician in regard to that because I have not slept right for like eight years but more so lately. It's not. It's not nurse proactive. If you're not nurse proactive, you're really not patient, proactive. If you take care of your staff, especially the nursing staff and the frontline staff actually the patient will be better cared for, so they obviously don't even really care about the patient. […] Um, I actually did seek out some help in

regard to my sleeping pattern. I did call out to a physician in regard to that because I have not slept right for like eight years but more so lately. Probably like three hours of sleep at night. Almost, just because of how busy […] I can't shut off my brain. So, I've lost a lot of weight, I'd focus more on my health. […] focus more on eating healthy, better eating habits better eating style. Since January, that decline, I still maintain my weight loss, but I'm with like, I've just noticed with school with work and my other job is just a lot. Hence, why I got super sick.

2020-002: Selfcare is very important. It has been taught many times that you can't pour from an empty cup, or you must take care of yourself before you can care for others. I believe, however that nurses are probably some of the worst professionals to actually practice selfcare.

2020-003: but then I couldn't stop because it wasn't, you know, the environment just wasn't conducive to really taking good quality, self-refreshing breaks, and lunches. And I said, hey, can you, do you mind watching my patients really quick while I go to lunch? And she said yes. […] I turned to go grab some items […] I turned back around, and she had left the station.

2020-004: did not practice self-care in early career. […] It did not come natural to me, but I started taking small steps at practicing self-care. […] I have learned over the years to engage in activities that I enjoy, to accept my imperfections and that it is acceptable to have a larger "to do" list than there is time to achieve the tasks on that list. **…**[I] leave work 1 to 2.5 hours late; that reduces my personal rest

time/time away from the job. [I'm] Often not eating until 10 or 11 at night going to bed on a full stomach and having to get up at 5 am to start over. […] often pick up takeout food on the way home. […] first job I learned to put my feelings aside in order to give the kind of care that may help. […] began to learn emotional distance to protect the professional relationship. Oh and to help protect me, of course! …as time went on, every job I took at each transfer they ramped up the do more with less rhetoric. Now well, we've talked about that.

2020-006: I feel guilty because I'm caring for myself, but I shouldn't everybody needs to put yourself first. And where that guilt comes from, I have no idea. I guess I feel like I'm such a strong people person and giving myself to others that if I'm not giving anything to anybody, I feel like I should be. But I was definitely not in a healthy state before because I ignored myself in any sort of self-care. So now I definitely prioritize myself when it comes to decisions. I mean, I can now. I used to not be able to say no, like, oh, we're short staffed. Great. Find someone because I'm too tired. I guess work doesn't really bother me anymore. Especially where I am now like it's just a chill job even though it's not, I mean, people wouldn't people don't think it's chill but to me compared to where I came from. When I walk through the hospital doors, I shut off my outside life and give it all to my patients and colleagues.

Emerging Theme: Moral Distress

2020-002: You get 15 minutes with the patient, you know, that's not enough time they want to talk about everything, you know, you have to only focus on what their appointment was made for. Again, it's a broken system […] I don't have the answer [as] to how to safely and appropriately work as a bedside nurse in this environment because I don't know what it is.[…]The educators don't spend time with their students anymore, either. That's a whole other topic […] But um, yeah, I don't know. I don't know. I certainly would never want to be a nurse practitioner.

2020-004: It has been through this job in the last several years that I have come face to face with the difficulties of achieving optimal patient outcomes while attempting clinical excellence within a work environment that frequently erects barriers to the care being attempted. […]difficult to provide nursing care when so many other departments are also providing care for the patient […] nurse encounters role conflict with other healthcare providers on a regular basis. Within the healthcare setting [where] I work I collaborate with clinical pharmacists, nutritionists, physical and occupational therapists, speech therapists, palliative care nurses, case managers, chaplains and of course physicians.

2020-006: I love my patients, but I want to do so much more. The *healthcare system* is set up to fail immigrants, uninsured, low-education, low-income, non-English-speaking patients, to name a few. […] Translators are always an option,

but it's impossible (or providers just don't take the time) to have the emotional connection and build rapport with patients.

Emerging Theme: Moral Injury

2020-003: Um, and yeah, and so during my evaluation, I said, oh, you know, I had received one DAISY Award, directly. And then she said, Oh, well, here, let me give you these and she turns to my files and she pulls out [more than a half-dozen] Daisy awards. I think it was that she had been keeping for about the span of I think maybe eight months to a year, and I had never gotten [them]. She said, these are for you.

OBS #6: Nothing is worth this! I don't know what I'm gonna do with the rest of my life, but I'll never be a nurse again! And I don't even think I'll miss what nursing has become.

OBS #8: The day I walk away will be incredibly hard.

OBS #13: It's sad and demoralizing to watch my colleagues get sick and die Unnecessarily.

Emerging Theme: Institutional Betrayal

2020 001: (This facility has no critical care unit). No one has my back primarily in critical care and being one of the primary critical care nurses in the facility during my shift, I am completely underutilized for my skills and my practice as providers do not uphold the professionalism of nurses and we are seen as 'just nurses. Short inappropriate staffing; without appropriate education feels unsafe

working there. It peeves me that I'm jeopardizing my license several times a day and I have no control. […] If you're not nurse proactive, you're really not patient, proactive. If you take care of your staff, especially the nursing staff and the frontline staff actually the patient will be better cared for, so they obviously don't even really care about the patient.

2020-003: environment just wasn't conducive to really taking good quality, self-refreshing breaks, and lunches. And I said, hey, can you, do you mind watching my patients really quick while I go to lunch? And she said yes. […] I turned to go grab some items […] I turned back around, and she had left the station. I could see the passion and compassion in them in their work they were doing. …many of them were eventually, you know, they kind of just kept settling in my opinion, they kept settling for being tripled all the time.

2020-004: typical assignment in a progressive care unit in the US is 2 or 3 patients per nurse depending upon the anticipated patient care needs. […] The manager changed the staffing matrix. The manager increased the patient to nurse ratios (2–3 ICU patients per nurse instead of the national standard of 1-2 and 4 PCU patients per nurse instead of the national standard of 2-3 patients.

OBS # 4 Staffing ...like running during "season" without seasonal staffing. Holds in ER are over 24 hours due to r/o creating a bottle neck. Ambulances are diverting and on by-pass. Anxiety mounting. […] no overtime pay for extra hours worked, no raise, NO sick time. And they took our PTO [paid time off].

> OBS #9: Today we delegate, administrate, document, CYA, and barely have time to make patient eye contact let alone hold their hands.[…] regulations every time we turn around. Wearing trash bags for gowns. Wearing the same masks all day long.

OBS #10: I have seen a consistent deterioration in nursing and medicine that ironically parallels the advancement of medical science. Staff ratios were 5 to 1 back then and we actually delivered nursing care.

OBS #12: We are shamed if we don't come in on a day off then cancelled with no compensation for lost hours if the census is low.

OBS #15: As nurses we don't leave our patients and administration takes advantage of our nature.

> OBS #39: In one hospital the nurse executive wrote in the hospital nursing newsletter that the organization was proud that they had no issue of bullying in their hospital when in fact nurses reported multiple sources of both horizontal and lateral violence, another set of terms for bullying. Nurse team leaders used threatening language to staff.

Evidence of Trustworthiness

Credibility

Triangulation and member checking are two ways of showing credibility. I used both methods 1) by collecting data via a reflective journal and following that with a 30-60-minute interview to clarify any concerns I had about understanding the participant's

writings and 2) The collection of data via public fora verified areas that the individual participants shared in their reflective journals and interviews.

Transferability

Participant sampling took place via one- and two-way observation in six regions of the U.S. The one-way observation took place on public communication fora. The individual respondents came from the Northeastern, Southeastern and Midwest regions of the U.S. and the one-way observation participants came from the six regions of the U.S. The defining characteristics of the six U.S. regions (see Appendix C).

Dependability

I explained the data collection process in chapter 3 and later edited the methods so that I could show dependability of data within the sample and to build a clear pathway for others who might try to replicate the study. They could potentially use the same method in other participant pools as well.

Confirmability

I used both a one and two-way observation to collect data. I first used a reflective journal guided with 11 prompts to collect data that were specific to the research questions. My hope was that by supplying the prompts it would provide a more open narrative approach so that I could collect a richer sample of data. My intent was to disarm guarding behaviors that are a known issue in this type of research. Following with an interview allowed me to confirm the participants contributions and build on the interview by using probing questions to fill in the incomplete data. One of the five individual

participants contributed a reflective journal that covered a forty-year career. The others used the prompts as short answer essay questions, which made analysis more challenging. When probing for further information they resisted those probes. Mullen (2010) and Neville and Cole (2013) found that participant skipped questions that caused them to feel ashamed. One participant was transparent in their response when being interviewed. They told me that I was a nurse and should know what it was like to deal with the pressures of being a nurse and he would not answer my question.

Due to the pandemic caused by Sars CoV-2 I changed the data collection method by including a one-way observation in public communication fora. This strategy allowed me to reach the six regions of the country commonly used in nursing research. That allowed me to study a national sample and an added a way to build transferability, dependability, and confirmability.

Results

Moral distress and moral injury are terms that have surfaced in the recent medical and nursing literature as being preferred term because they do not imply the blame or shame as does burnout. Burnout out and resilience were terms that also had meaning to the study of chronic stress disorders. Burnout was said to have contributed to professional turnover rates and people changing their careers due to the suffering that they experienced in their work environments. Moral injury as described by Brewer is a result of an healthcare organization's exploitation of the nursing staff.

The acute care nurse participants did not show signs of burnout, instead they expressed frustration with being devalued and felt they were exploited by the system. One participant said that their expertise was ignored because they did not have prescriptive authority. Another commented on business office personnel's disrespect of staff meal breaks. One nurse also said that they advocated for therapeutic intervention that would set the patient in a higher state of well-being and life-satisfaction. The nurse said that they were placated but received no orders that would better support the client. The nurses spoke about lack of autonomy by saying that nursing had been co-opted into medicine.

Yet another stated that there were too many changes being made but no nursing representatives were on the decision-making team The result left the staff shuttling between floors trying to find equipment and supplies. In another hospital unit the nurse was caring for clients that were on opposite sides of the unit, and because of the structural shape of the unit the assignment was unsafe. The nurses each had their own way of expressing frustration because they had no time to connect with their patients due to the task orientation of their work setting.

The nurses were frustrated that they had no autonomy of practice. In one instance the nurse talked about being timed with a stopwatch and reprimanded because they talked with the client rather than doing the task and leaving the room. In another situation that same nurse was told that the unlicensed assistive person needed to leave their lunch and prepare a room for an admission by someone that did not know what nursing entailed.

The participants were distressed that they did not have enough time to adequately follow the progress of the client nor to determine how the client perceived their circumstances. Nurses cannot advocate for the clients unless they have the needed time to do the proper surveillance. Clients suffer as a result when they are discharged and must return to the hospital because they have not had the care they need to heal appropriately. The healthcare organization also loses revenue when clients must return because they did not receive enough support prior to discharge.

The nurses related their individual stories about spending inordinate amounts of time attending to the computer rather than doing direct care. The same nurse said they responded to the EHR prompts rather than being able to relate the patient's response to therapeutic intervention. The same nurse discussed how their interactions with the client were scripted as though they were at a theme park selling how great they were but ignoring the client's needs. The nurse said that it felt like it was more important to be liked than it was to provide proper care for the client.

One of the current problems is that hospitals are penalized when patients return to the healthcare organization within 30 days of discharge. Return in less than 30 days after discharge is an indication that the quality of care was less than satisfactory. This incentivized behavior is an example of Era 2 Medicine (Berwick, 2016).

The hospital is also penalized if a patient takes more time in the hospital to recover than is recommended by a set of CMS protocols. A hospital's reimbursement is

based on diagnostic related group protocols and penalized when a client does not fall within those confines.

Three Eras of medicine have been discussed by Freidson in *Profession of Medicine: A study in the sociology of applied knowledge* and L. Dossey in *Reinventing medicine: Beyond mind-body to a new era of healing* (Berwick, 2016; Dossey, 2005; Freidson, 1970).

Chapter 4 Summary

In this chapter I have presented the participants data sets and discussed the results and the resulting outcomes when needed surveillance must be neglected due to the task driven business model. I also discussed Era 2 medicine. In Chapter 5 I will bring the research to a close by interpreting the findings and describing how those findings extends the present literature in the context of the conceptual framework. I will make recommendations for further research and discuss the implications for positive social change and conclude the study in a way that the overall essence of the work is captured.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this chapter I will bring the discussion around expansion of the quadruple aim to a close by justifying the expansion by supplementing literature found in the proposal. Grounded theory invites the researcher to do a more extensive exploration of updated literature once they begin the discovery phase of analysis and bring it to a close. I used ground theory specifically to determine if there was enough evidence to back up an expansion based on burnout and traumatic stress and to explain the need to expand joy to professional career satisfaction. Joy is one part of the greater whole of professional career satisfaction.

The evidence supports a need for an expansion of the four tenets of the quadruple aim but the need for expansion was broader than I expected. I discovered three immerging theories that may change the trajectory of the present research. I also found supporting evidence that nursing must practice from the perspective of professional nursing and holistic nurse documents, which is different than medicine. The role of nursing and medicine serve healthcare needs in two separate ways.

When the value of professional nursing is not recognized the whole healthcare system suffers physically and fiscally. Nursing must have an intense sense of self in order to thrive and contribute in a way that best serves their mission and vision and the needs of the healthcare community. Nurses, the medical community nor the business of healthcare know what nursing is. The only way to overcome that lack of knowing is to use

professional nursing documents and nursing theory and philosophy to define nursing and include it in the quadruple aim. Nurses are the largest human resource in healthcare it is also the most expensive and to use a small portion of the talent that nursing brings to healthcare is wasteful of money and shortchanges both the nurse and the system. Holistic nursing serves a population that ranges from birth to death and from a local to a global perspective.

Purpose

The purpose of this research was to find patterns that would support the broadest and most inclusive framework for healthcare improvement from the perspective of the acute care nurse. What occurs at the local level moves outward to influence the gross domestic product as it relates to national healthcare system and budget. This positive shift would help nurses connect with their work, reduce turnover rates, improve safety, meet client needs and stabilize the financial standing of healthcare within society. What occurs at the local level reaches the federal system because the federal government manages approximately 44% of healthcare by the CMS. That percentage will increase as Baby Boomers mature and retire.

The quadruple aim served as the primary conceptual framework. This framework is a four-step plan that sets out to humanize and help improve the healthcare system (Perlo & Feeley, 2018; Sikka et al., 2015). The tenets of the quadruple aim written from a medical perspective would be more congruent with nursing if the quadruple aim better defined nursing by using nursing theory and the holism found in the AHNA five core-

values (ANA/AHNA, 2019; see Appendix D). Nursing cannot be defined in medical terms. The tenets of the quadruple aim are congruent with Walden University's mission and vision statement that students and staff be involved as agents of positive social change (Walden, 2017).

The IHI, which managed authoring the quadruple aim is one of a variety of professional organizations that has developed a healthcare improvement strategy. I have examined the perspective of acute care bedside nurses to learn how the workplace environment supports them in meeting client needs and how that environment supports nursing's professional career satisfaction. I have incorporated a medical, nursing, and psychological perspective by using guiding principles from each of these professions and business. Healthcare is a complex system, hence the complexity of this work. One must examine systemic patterns and the interconnectedness of the system in order to improve the system. The quadruple aim has the potential to further improve the healthcare system because of the way it was designed if it expands to include a more nurse friendly perspective.

My goal in using the quadruple aim as the conceptual model for this research was to expand and clarify the four tenets so that they would better reflect nursing's role in achieving the four tenets. These tenets are 1) improve patient satisfaction, 2) provide a model for population health improvement, 3) reduce systemic healthcare costs, and 4) to help professional care providers find meaning and purpose in their careers (see figure 2 & 3).

As the quadruple aim reads, it appears the value of nursing is limited by the misperception of what the nurses' role is in healthcare. Nurses can contribute to healthcare improvement in the four tenets of the quadruple aim from a local to national perspective if their skills and education are recognized and valued by the organizations for which they work and other professional organizations. The IOM (2010) recommended that all nurses practice at their highest level of education and skills. But from the view of the professional nurse, specifically the acute care bedside nurse is overwhelmed by the barriers to nursing practice in healthcare organizations. Nurses have the knowledge and skills to actively take part in health promotion and participate on boards of directors at all levels of healthcare and health promotion (Nurses on Boards Coalition, 2021).

Nature of the Study

I used A synthesized grounded theory to analyze the overall qualitative research question: How does the environment of care support the professional nurses' provision of high-quality person-centered care and bolster a meaningful and purposeful career? I first collected data from five acute care bedside nurses and later found it necessary to expand the study to include an observation of acute care nurses during the COVID-19 pandemic.

Prior to COVID-19, the environment of healthcare was in a constant flux which creates unrest and confusion. Participants from both the one- and two-way observations discussed the constant change being exhausting and frustrating. This is an example of ERA 2 medicine, according to the Berwick (2016). This approach better supported my goal of collecting data from a nationwide sample of acute care bedside nurses. The

participants were proficient in written and spoken English and had at least one year of experience on the unit where they worked during the collection of data. Expanding the study into other methods of collection data also gave me additional triangulation opportunities.

Research Questions

In this section I will respond to the overall qualitative research question and begin the discussion by discussing the four specific questions. The overall research question was how does the environment of care support the professional nurses' provision of high-quality person-centered care and bolster career satisfaction? The specific research questions were based on the experience of acute care nurses.

COVID-19 exacerbated the levels of stress that nurses were already experiencing prior to the pandemic. Nurses related in multiple contexts that they felt unsupported by management prior to COVID-19. However, during the pandemic leadership and management in many healthcare organizations distanced themselves from the staff and what they were facing. The observation participants were vocal about feeling exploited and unsupported. The two-way observation participants did not mention any attempts to offer psychological support for the staff who were suffering from elevated levels of trauma and fear. Medical, and nursing staff feared for their own and their family's safety and well-being, but that did not stop their dedication to those who were ill.

Two participants from the two-way observation said that staffing recommendation for their unit is two clients per nurse and this is supported by the professional

organization to which they belong. Nursing leadership does not support staff concerns, and in three cases participants noted that managers who did support their staff jeopardized that leaders job security.

At hospitals nationwide nurses were reprimanded, suspended, and lost their jobs for wearing masks early in the pandemic. I took part in multiple nursing leadership groups during the pandemic where nurses also discussed being told not to wear masks because it frightened the public. The nurses resorted to wearing garbage bags as isolation gowns. Single use designated PPE were collected, sterilized and redistributed to staff later. One nurse wrote an editorial to a newspaper about lack of safety, nurse patient ratios that were unsafe, and sanitation work arounds. The author posted the letter in an editorial and resigned their position.

Acute care bedside nurse participants from two-way observations described other nurses in their working environments as burned out but denied being burned out themselves. One nurse stated that they were burned out. Burnout and PTSD are two terms used in this research that are not appropriate as they are improperly understood and defined. Other terms that are commonly misused include joy to mean career satisfaction and compassion fatigue to mean a complex stress condition or burnout but these terms seem to have no fixed meaning.

Misuse of the term burnout is a common phenomenon in society as is PTSD. Burnout shames nurses and other healthcare providers and makes the nurse responsible for lack of self-care. Gentry (2012) among others stated that burnout is based on a toxic

work environment external to the provider of care. Literature is beginning to suggest terms that are more descriptive and are less accusatory. Terms that are being explored include moral distress, moral injury, and organizational abuse or exploitation (Brewer, 2021; Dean et al., 2019; Litz et al., 2009; Talbot & Dean, 2018).

The phenomena of co-optation was discussed in terms of co-optation into medicine, and though that term was identified by one participant it was a clear theme

throughout the discussion from both one- and two-way observation participants. co-optation appeared to be a healthcare organization phenomena disguised as medicine co-opting nursing. A colleague and I discussed the apparent conflict between medicine nursing as being driven by the organization with statements like the physician is the customer.

Professional Satisfaction: Joy as a Component

Joy is one part of the larger context of professional job satisfaction (see figure 3). To achieve professional satisfaction the components joy, peace, purpose, meaning and love, must be present (Gentry, 2012, Stamm, 2010). The task driven business model based on time management studies using a stopwatch requires nurses to abandon the moral and ethical values of nursing practice. Time management studies of professional nursing duties conducted by the business entities dehumanizes client care.

One of the reasons the quadruple aim was written is because healthcare had dehumanized clients. One of the two-way participants discussed this dehumanization in terms of the business model of healthcare. Dehumanization has been discussed in the last

10 years in public fora and was a topic of discussion when I was training as a spiritual care resource nurse in early 2006.

Nurses are treated as though they are task driven technicians, which further exacerbates the abandonment of nursing theory, philosophy, and ethical principles. When healthcare organizations force nurses to abandon their values, nurses feel betrayed by those for whom they work (Brewer, 2021). This creates moral distress, potentially moral injury, and if forced to continue the extreme consequence may be burnout. Burnout is an end product and I would suggest that if interventions began earlier burnout may be reduced or avoided.

Nurses are called upon to provide meaningful and less tangible or covert services to help clients achieve a sense of health and well-being with an ability to function as a whole person as well as overt services (See figures 5 & 6). One participant said that nurses are called to meet deeper and less tangible aspects of the human experience. Another nurse said, their primary drive was remembering that each client walked a different pathway and lived a different life prior to admission. The nurse went on to say it was their responsibility as the nurse to remember the client's vulnerability and support them in that state of being.

Nurses feel that their role is devalued because they cannot provide relationship-centered and supportive nursing care. They do not have time to spend with clients so they are unable to teach and support clients in a way that will help them feel valued as whole beings and stay out of the hospital once discharged. This business strategy not only under

mines the nursing staff but it also undermines the healthcare organization when the client must return to the hospital.

One nurse said their personal mantra was to teach with every touch, but without time to build relationship that teaching often comes across as controlling. The nurse said we know that does not work, because people do not like to be told what to do. Customer satisfaction as applied in the healthcare business model is to exceed the customers' expectations. Austin (2011) said that caregivers who want to spend time with patients create bottlenecks. Bottlenecks interfere with the task driven business model. This business model reduces the value of nurses and the client's humanity. It dehumanizes the client in addition to devaluating the role of professional nurse.

Environment of Care: Support of Quality Person-Centered Care

Systemic problems including toxic environments interfere with the provision of safe high-quality, relationship-centered care (Gentry, 2012). Some physicians circumvent the requirement to put their own orders into the electronic health record (EHR) and to obtain consultations. Nurses are then asked to pick up those tasks to free up the physician. This is a sample of co-optation of the nurse by the medical and business models. Business representative often stating that nurses should take care of physicians because they are the customer (Andersson and Liff, 2018).

The nurses experience considerable role conflict as coordinators of care and doing direct care. Clinical pharmacists, physical therapy, occupational therapists, family and visitors, dietitians, diagnostic technicians and others must also see patients and

collaborate with the nurse and client. This makes it difficult for the nurse to provide necessary direct care and the patient lacks the needed time to rest so that they can recover.

Electronic Health Record. The EHR has created more separation from patients and reduced necessary communication between physician and the nursing team. The EHR is often referred to as the electronic medical record and the programs have not been developed to document clients outcomes as they relate to nursing care (Southard et al., 2021). The participants discussed substantial amounts of duplicative charting and others discussed being overburdened with chart audits. One nurse said that an area of free texting could be used to document client responses to nursing care. The problem with this is that nursing care is not visible because there are no nurse centric area in which to chart. Nurses spend from 9% to 23% more of their time in documenting on the EHR now than prior to the implementation of EHR (Baumann et al., 2018). Physicians spend from16% to 28% more of their time with documentation than they did prior to implementation of the EHR. Prior to the switch to the EHR the time spent documenting had increased to the extent that nurses believed documentation was interfering with direct care. Healthcare organizations require additional charting beyond that, which documents care. Nurses and physicians have been shown to spend up to 50% of their time addressing compliance and administrative issues much of which is duplicative (Shanafelt et al., 2018). If charting is done at bedside patients complain about the clinician having no eye contact with them.

Relationship Centered Care. Client loads allow for task driven care, but not for relationship-centered care that allows nurses to support their clients. Nursing is an art and a science, and it cannot be reduced to tasks without reducing client and nursing satisfaction and increasing the cost of healthcare (Lewis et al., 2014; Shanahan et al., 2018). According to nurse participants, clients and their families become distrustful and angry when nurses are unaware of physician visits or what the physician said to the patient. Patients expect their nurses to be aware of what is happening with them and to be able to explain what a physician has told the client. The nurse cannot do that "when the doctor come through like a ghost and evaporates," according to one of the participants.

Physicians no longer stay on the unit long enough to write orders instead they may write an opening note and enter orders off site. This strategy was used when the EHR was designed to help physicians have more control over their time. The consequence for nursing interactions was not considered when the programming took place. The people who designed the EHR were not nurses and did not know the importance of physician and nurse rounding together. Nurses only became involved when it was time to train super users for the bedside nurse to refer to when first learning to use the new systems. Since then nursing informatics has become a nursing specialty.

Environment of Care and Professional Career Satisfaction

Nurses feel they have been co-opted or subsumed by medicine and describe situations that also indicated that they have also been co-opted by the businesses for which they work. That theme is obvious throughout my discussion with the nurse

participants. The main part of the discussion revolved around nurses not having enough time to directly care for their clients because they were too busy charting, administrating and administering medications, but had insufficient time to spend with patients to provide relationship centered care. Nurses are lost in the shuffle of doing tasks rather than caring for patients. Nursing is a relationship centered profession. Rapport building is necessary to build trust (Erickson et al., 2017). Nurse participants believed their passion for caring was being taken advantage of by hospital administration.

One of the participants said that in some cases nurses have forgotten that their role is to be attentive to the client's bio-psycho-social needs. Nurses are co-equal care partners in the tending of clients. The role of physician is different than that of a nurse practicing the art and science of nursing.

Interpretation of the Results

When analyzing the data, I found that much of what the acute care bedside nurses offered in their journals and their discussion in the two-way observation with me did not lead to a meaningful data set by itself. However, once I compared the themes listed in chapter 4 to a prior discussion with a colleague and recently published literature that we had discussed, I was able to identify three emerging themes that informed the research questions.

I found three sets of themes in Chapter 4. The positive themes are listed as professional nursing identity, professional philosophy of nursing practice. The themes that the nurses discussed with regard to the healthcare organizations for which they

worked included systemic barriers to practice, co-optation of nursing, nursing role devaluation due to lack of respect and support, and the negative aspects of caring. The emerging themes included moral distress, moral injury, and institutional betrayal or exploitation.

Discussion with a colleague expanded my perspective taking. Birkmyer used the term moral injury rather than the term burnout saying that burnout was not an accurate term and that by using it the physician or nurse was being systemically shamed (F. Birkmyer personal Communication, February 1, 2019). Gentry (2012) suggested the same thing by saying burnout is precipitated by a toxic environments. Birkmyer also addressed the chiasm between physicians and nurses as a systemic issue precipitated by the business model. Berwick, 2016 addressed this issue in his discussion on the three eras of medicine. Healthcare organizations often remind nurses that the physician is the customer and that nurses are there to serve the needs of the physician.

Moral Distress and Moral Injury

Moral injury has been studied primarily in the military theater. Moral distress a condition that according to the nursing literature has been studied for four decades. Brewer (2021) wrote a conceptual analysis of the term institutional betrayal that provided more meaning to what the participants of this study shared. Moral distress, moral injury, and institutional betrayal emerged as themes, which are based on ethics that are significant to one's personal belief system and professional ethical practices. Moral harm is more likely to be exacerbated by and to be more visible to the public in high-risk

situations such as that witnessed during the pandemic in 2020 and 2021. The pandemic only highlighted an already toxic environment of care, it however did not cause the toxicity that the public is witnessing.

Moral distress and moral injury are conceptual models that need to be more clearly defined. Moral distress has been studied in nursing for four decades. Moral injury on the other hand is a new concept in nursing in the context of this research, though it is not the only profession to which moral distress and injury is pertinent. Moral injury is a term that has been studied in the military theater.

Both moral distress and injury are connected to the environment of care. Holistic nurses practices in one of two ways. One may practice as though they are the environment of care or they practice in the environment of care. In either instance, the nurse is still responsible for either patterning or creating a healing environment (Quinn, 1992). The nurses in this study each had their own way of saying that they believed they were falling short of a moral practice based on institutional devaluation and barriers to professional nursing practice. The nurses believed their individual integrity was being challenged, which may cause psychological and spiritual pain otherwise understood as moral injury (Grimell & Nilsson, 2020).

Lateral and Horizontal Violence and Bullying

Four of the participants observed bullying in their environment. Nursing professional have experienced bully over history. Other terms used for bulling are lateral and horizonal violence. Bullying behaviors may be subtle or covert and at other times the

act of bullying may be overt. Bullying is a rampant problem in nursing. It is the primary precipitating factor of depression, and depression is a precipitating factor to suicide (Gentry, 2012; Davidson et al., 2018; 2020).

Between 2017 and 2018 the rates of suicide for women was 17.1 per 100,000, and 31.1 per 100,000 for male nurses. Nurses were rated higher than physicians and female nurses had markedly higher rates of suicide. Male nurses were marginally higher. Female nurse rates of suicide were more than double the general public (Davis et al., 2021). Lack of respect, co-optation into medicine, or by the system creates a toxic environment that also creates an unsafe environment of care. Brewer (2021) suggested that if left untreated that moral distress and injury may result in burnout as an end result.

Quadruple Aim Expansion

An expansion of the quadruple aim that enhances the understanding of professional nursing may have the power to achieve a more comprehensive and collaborative improvement of the four tenets of the quadruple aim. The nursing standards, ethics, and social covenants are the basis of nursing practice. Managerial and executive levels of administration may benefit from having a clearer understanding of how nurses function in the caring process. The economic value of an organization is more likely to be realized when nursing professionals are better supported by executives who understand and value nursing practice standards (Kutney-Lee et al., 2015; Lewis et al., 2014; McElligott, 2010, Shanahan et al., 2018).

Healthcare Organization, which are Magnet credentialed recognize the value of the nursing profession and organizations maintain a stable work environment as a result (McHugh & Ma, 2014). McElligott (2010) and Shanahan et al. (2018) also provide evidence in their writings that acknowledged the value of nursing professionals to healthcare organization that show they value nursing by investing in the nursing staff's wellbeing.

Nursing Leadership

It is not enough to ask nurses what matters to them in their work environment. Nurses need to be included in leadership roles, and in infrastructure where they work with patients and other staff. Nurses need to be included in developing parts of the systems in which they interact such as architectural changes, EHR, financial stability, and development of patient care strategies (*The Future of Nursing: Leading Change, Advancing Health* (IOM, 2010). Nurses have the knowledge and skills to actively take part in health promotion and participate on boards of directors in multiple areas of healthcare and health promotion to achieve health and well-being (Nurses on Boards Coalition, 2021).

Nurses not only have graduate level health and nursing education, but they also have nursing degrees that focus on, information technology, business, and leadership. Other professional nurses have graduate level education with a clinical focus. Nurses also have graduate level education in public and community health, so their focus is on health promotion in leadership roles as well as in staff roles. When the nurses practice based on

holism they focus on health and well-being in any population from birth to death. As an example of how professional nursing can contribute to population health, Allard (2019) along with a team of nursing professionals designed a population health system inspired by the triple aim. Hospital admissions were reduced. Erickson et al. (2017) found that 39 such programs were developed by nursing professionals. Nursing influences the improvement of health promotion and health and well-being.

Limitations Imposed by Data Collection

Historically, people express doubts about the confidentiality of online surveys. One nurse questioned me several times to make sure there was no way that they could be identified. Assuring the participant that the data were collected from a national sample helped the person relax. I assured the participant that no area or location would be identified and that I asked people not to identify the hospital nor the location of the hospital where they worked. I have been careful to not use any form of identification as to gender, age, race, culture, nor have I used initials even though the participants gave me initials to identify them. I used one exception where it was necessary to indicate inclusion of minority statis participation. I vetted software applications that were used for data collection or transcription and for participants privacy once they qualified on Research and Me.

Reflective Journaling in addition to posting sensitive information to an email account might cause participants concern about confidentiality. I attempted to ease that concern by using a secured email account. Reflective journaling can sometimes feel

threatening for the same reasons, it is no longer confidential once written. Journaling is also used for stress reduction and to overcome the wounding which occurs in life circumstances. One participant mentioned their use of reflective journaling but used the prompts as short answer essay questions as did three others of the two-way observation participants.

Responding to the prompts as though they were essay questions made it difficult to code their contributions because the data sets were not complete. The participants bypassed free flowing thought process when they used and essay format. As a result, what they provided was guarded. The participants also chose which of the prompts they would respond to and which they would not. When I conducted the interview one participant refused to be transparent by telling me that they would not elaborate because I was a nurse and that I knew how it was.

In the interviews participants often used projection and deflection to avoid my follow up interview questions. One nurse claimed to be burned out the other four said others on their unit were burned out but denied that they might be experiencing what they described as burnout. Add deflection and projection strategies to the choice of treating the journaling and interview process as short answer essay questions and then picking which questions to answer hindered my ability to analyze the data set. Braun & Clarke, (2006) discussed these kinds of efforts and how they sabotage a researchers ability to analyze data. However, in quantitative research this phenomena also occurs and it does not

discount the data set. A researcher must deal with these kinds of challenges and seek meaning out of the data that participants choose to share.

Summary of Results

That data set contributes to the overall research question by showing that expansion of the quadruple aim may provide a reasonable addition with which to improve healthcare. Nurses are passionate well-educated providers of nursing care who need to be recognized in the context of professional nursing rather than in the context of medicine with whom they collaborate. The autonomy of a nurses' practice is an asset to the healthcare organization for which they work and when recognized for their individual contributions it helps them to obtain career satisfaction. In turn, career satisfaction reduces turnover rates and it provides more expedient support for patients and improves patient satisfaction scores (Lewis, 2014; Shanahan et al., 2018).

The task driven business model used in the healthcare business model requires nurses to abandon their moral and ethical values of nursing practice. Time management studies of professional nursing duties conducted by the business entities dehumanizes client care. Dehumanization of healthcare is one of the reasons the quadruple aim was developed. The philosophy of doing more with less is counterproductive based on the evidence in this research and the other researchers like Aiken and a variety of her colleague.

The value of nursing has gone unrecognized as instrumental to the health and wellbeing of people. An unclear understanding of what nurses are capable of and that

nursing is a separate profession from the curative biomedical model of healthcare has devalued professional nursing. Nursing must be defined in the context of both conventional and holistic professional nursing's documents otherwise the profession appears to be a part of the biomedical model. This is one of the concepts that has led some nurses to believe that they have no practice autonomy and that their responsible is to medical follow orders.

Positive Social Change

Warren et al. (2011) found that the cost of presenteeism in one hospital system in Tennessee was $12,605 per person and nationally the cost burden of presenteeism was $33 trillion. They also noted that 50% of the nurses in the same research contributed to presenteeism rates based on anxiety and depression. The psychological symptoms that participants reported included lack of energy and various forms of pain.

Turnover rates also contribute to a large financial cost to healthcare organizations (Jones, & Gates, 2007; Killian, 2008; Kovner et al., 2014; O'Brien-Pallas et al., 2006). Financial executives consider these losses a cost of doing business, but when you consider that toxic environments of care lead to depression and suicide it also costs lives (Davidson et al., 2018; Gentry, 2012). Nurses that are this stressed and devalued cannot care for patients adequately.

The quadruple aim uses four tenants to facilitate positive healthcare changes that are in line with Walden University's positive social change criteria (Berwick et al., 2008; Bodenheimer & Sinsky, 2014; & Perlo & Feeley, 2018; Yob et al., 2016). It includes

nursing but defines nursing in terms of medicine. Expanding and clarifying the model has the potential to further improve the efficacy of healthcare and therefore improve national healthcare spending.

Healthier environments of care value nurses and support an autonomous nursing practice (Aiken et al., 2008; Lake & Friese, 2006; Weston, 2010). Mark et al. (2009) stated there is no additional cost to recognizing and supporting professional nurses autonomy and control over their practice. Increased nursing satisfaction reduces turnover rates and improves the safety of care so that patients can heal and become whole (Kramer & Schmalenberg, 2004.

Clarifying nursing may lead to more effective collaboration between the carative nursing model as defined by Watson (2012 & 2018) and the curative medical model. Understanding what nurse are capable of bringing to the caring environment may contribute to building a more inclusive practice model that will support the four tenets of the quadruple aim.

Multiple agencies including the Joint Commission, a healthcare certifying body, has mandated the need for a change in the healthcare environment that contributes to improved communication. In turn this increases healthcare safety (Joint Commission, Sentinel Event Alert, 2012; 2016; 2017, & 2018).

Turnover, absenteeism, and presenteeism are not a cost of doing business though some healthcare executives believe they are. These phenomena are indicative of an unsafe environment of care that may be more effectively constrained by recognizing the

value of nursing professionals. When nurses' are empowered to practice at their highest level of education it signals to the nurses that they are valued. Recognizing the full value of professional nurses has the potential to improve client care and improve healthcare outcomes (Jones, & Gates, 2007; Killian, 2008; Kovner et al., 2014; O'Brien-Pallas et al., 2006). When employees believe they are valued they are less likely to contribute to turnover rates. Turnover increases safety concerns because it is destabilizing.

Recommendations

Nurse Coaching

Implement the use of professional nurse coaching within healthcare organizations. Nurses began to incorporate nurse coaching at undergraduate and graduate levels of practice to empower clients. Nurse coaching is important to the work of those in leadership roles because it helps them build stronger teams. Nurse coaching is also within the practice authority of nurses when used in the client population. Several nurse coach training opportunities are available as is board certification of nurses. Nurses took the first professional nurse coaching board examination in 2013 (Southard et al., 2021). This places nurses in a leadership role as an instrumental part of improving healthcare.

The Future of Nursing: Leading Change, Advancing Health (IOM, 2010) urged nurses to take a leading role in healthcare change. One way of taking a leading role is by incorporating professional nurse coaching because it has the power to move healthcare forward. Professional nurse coaching is specific to nursing and is an area of nursing that can serve the public and help reduce the cost of healthcare. Nurse coaching skills can

help develop careers, promote and support lifestyle changes, and improve health and wellbeing skills, among others.

Holistic Nursing

Incorporate holistic nursing at all levels of nursing practice within a healthcare organization. Holistic nursing is a way of "being" in the world rather than a practice of modalities. This perspective of Holistic Nursing allows the nurse to practice in any setting. Holistic nursing takes place wherever growth, development, and healing occur" (AHNA/ANA, 2019 p. 42).

Holistic nurses partner with clients to help them achieve what is most important in the journey to wellness. Nurses are instruments of healing and a part of the healing environment. Holistic Nurses are not directive in their approach they support clients so that they may discover new things about themselves (AHNA/ANA 2019; Peplau, 1957).

Holistic nurse when working with individuals use therapeutic relationships, which employ counseling, coaching, and social support to help others build positive habits to achieving each person's best health and well-being with unconditional positive regard (compassionate caring). This focus is part of creating a healing environment, which extends to creating and developing caring cultures and communities that support and respect each individual.

Research Development

Conceptual analysis of moral distress, moral injury, and increase research of institutional exploitation of professional nurses may help develop other growth potential

for nurses, medicine, and business entities. It may also move the healthcare industry toward a model more aligned by ERA 3 concepts in healthcare. Once the concepts are defined and developed tools will need to be designed for use in further research. By following these steps the work may better contribute to an understanding of the prevalence of moral distress and moral injury as it relates to healthcare.

Conflation and Misuse of Terminology

Conflation of terminology distorts the meanings of phenomena. Burnout was used inappropriately by the participants as was the term PTSD. Burnout shames anyone who is said to be burned out because it makes them responsible for the toxic environment which causes the condition. The propensity to burnout is related to toxic environments of care. It may behoove healthcare organizations to recognize their part in creating burnout and work toward resolution before burnout occurs.

Secondary traumatic stress is included in the ProQOL as one of the two components of compassion fatigue. Compassion fatigue is neither burnout, secondary traumatic stress, nor vicarious trauma. These are three different terms and through there are finite differences they must each be clearly defined as they cannot be used interchangeably without causing confusion. Witnessing someone else's trauma is a secondary issue. Secondary and primary stress is possible but limiting interventions to the condition as one or the other may not be as productive in resolving the complex stress and treating the individual rather than the process. Compassion fatigue is a combination of the two term. (Gentry, 2012; Stamm, 2010).

PTSD occurs over time and is a primary condition. People use PTSD instead of acute distress disorder or syndrome (ASD). Nurses often experience acute stress disorder and complex traumatic stress. PTSD is a primary mental health issue (Figley, 1995; Gentry, 2012) that takes time to become stuck in the neurons. ASD is an acute condition that can be treated and resolved more readily than PTSD can be resolved.

Transition to ERA 3 Healthcare

Era 1 was idealistic and focused on self-regulation because the physician was said to have education that others did not have. Physicians were given authority to regulate the quality of their own practice. The idea that the physician knows best was born of protectionism in this era.

Healthcare is in the midst of Era 2. Conflict between Era 1 and 2 is creating a constant struggle and discord between "professional trust and prerogative" (Berwick, 2016, p.1329). The Affordable Care Act, EHR requirements and usage, the change in payment structures, mergers of healthcare organizations and healthcare plans create a division in beliefs, which challenges professional's morale. Berwick (2016) and others have made several recommends that have the ability to move healthcare into Era 3 where transparency and self-control of greed is reigned in. Berwick also calls for professional organizations and academic healthcare centers to model moral values and reduce institutional greed, therefore creating higher moral standards across the board in healthcare.

Modify the Quadruple Aim

Medicine and Nursing and two separate but collaborative healthcare professions. Each profession must be defined based on their separate purposes that they serve in healthcare. Nursing cannot be defined in terms of medicine because it serves a different purposes than does medicine. Professional nursing must be defined and clarified by using both conventional and holistic nursing documents.

Amend the quadruple aim so that professional nursing is defined by using both conventional and holistic nursing documents. Career satisfaction may be a better way of including joy in this healthcare improvement model. Burnout appears to be a result of moral distress and moral injury. These conditions must first be resolved in order to achieve career satisfaction of which joy is a part. Including nursing professionals as part of the leadership team may increase the depth and breadth of healthcare improvement (IOM, 2010; Nurses on Boards Coalition, 2021).

These modification to the quadruple aim may send a strong signal to nursing professional that their career choice is valued by other healthcare professionals. It may also improve collaboration between medical and nursing professionals The Joint Commission has discussed higher levels of collaboration as a way to improve safety (Gourley, 2008, Joint Commission, 2008 & 2016; 2011 & 2016; 2012; 2015; 2017).

Conclusion

The aim of conducting this research was to help improve healthcare by better defining the quadruple aim to make it a more professionally inclusive document. The

document as it is written has a medical focus. Even though the authors did include nursing in the model it appears that they defined nursing in the context of medicine, which discounts or devalues professional nursing.

Once nursing is defined according to professional nursing criteria, which includes theory and philosophy, then the quadruple aim can be used to improve the environment of care in a way that values professional nursing. Professional collaborative communication improves safety (Joint Commission, 2008 & 2016; 2011 & 2016; 2012; 2015; 2017). The quadruple aim cuts across healthcare's infrastructure and responds to the systemic complexities of healthcare.

The value of nursing is multi-factorial. Nurses contribute to the financial wellbeing of the organization, but only if they practice at the top of their education and training (IOM, 2011). As it stands the government healthcare system does not reimburse for nursing service. The CMS implemented the DRG model in1983 by stripping the original model of nursing charge criteria (Buerhaus et al., 2010; Welton et al., 2006). This eliminated reimbursement for nursing services. These actions turned nursing into a cost center rather than a revenue center. Eliminating the nursing charge signaled that nursing service lacked value.

Additional financial shortfall in healthcare organizations is created by turnover, presenteeism, absenteeism. Financial executives see these as a part of doing business and overlook the cost to an organization (Jones, 2008; Kerfoot, 2015; Martin et al., 2014). Additionally, when nurses do not practice to the top of their education it creates less

revenue and increases the propensity of reducing safety in the environment of care. These issues are controllable by valuing what nurses bring to an organization, using their education, and training to enhance a facilities well-being and presence in the community.

The nursing work force is the largest in a hospital and as such they were 30% of the operating budget and 44% of direct care costs (Thompson et al., 1979). The largest and most costly human resource in a hospital is the nursing workforce. Baumann et al. (2018) point out that healthcare staff are important resources and stated that the resource should be used wisely to optimize healthcare quality. To do otherwise is a detriment to the national health goals. Financial stability starts at the personal level and radiates out through communities, states, and finally through the national healthcare spending budget.

Nurses are highly educated and motivated to support individuals and society. A nurse's client is whomever needs care, whether it is an individual or a cross-section of society. Nurses for the most part come to healthcare out of their passion to care for others. The acute care nurses who took part in this research are no different.

Nursing education has had a well-defined, and balanced standard based on nursing theory and philosophy. During the last several decades educational programs have begun to focus more on the biomedical model, which causes nurses to lose sight of their own scope of practice (Barrett, 2017; Marien & Pharris, 2018; Smith, 2019; Watson, 2018). This may cause nurses to believe that nursing theory is of no value to their education. This distraction from nursing creates an environment where nurses feel devalued, and in turn they may devalue themselves. Some nurses have become followers

rather than healthcare leaders, by believing that their role in health care is to follow rather than using their own initiative. Nursing is an art and a science. Nurses are well suited to partner with others to improve the four tenets of the quadruple aim when nursing is redefined according to nursing and not in the terms of medicine.

Nurses have been disempowered and devalued by the commercialization of healthcare, which turned the moral act of caring into leadership excellence, people management, exceeding expectations, and brand loyalty (Austin, 2011; Romano et al. 2013). Perpetuation of the business model based on *The McDonaldization of Society* contributed to the commercialization of healthcare (Ritzer in 1983). This changed the focus of healthcare from the original mission of a moral public service to being a profit-driven commercial business interest (Sikka, 2015; Perlo & Feeley, 2018).

Healthcare management has reinforced this model by pushing nurses to exceed the patients' expectations as if they work in a theme park or at a restaurant ("Disney Institute Announces," 2011). Exceeding the client's expectations may not be in the client best interests. The commercialization focus fuels the need to turn a profit, and as the government tightens the requirements for repayment options, chief financial officers require care providers to do more with less (Austin, 2011; Romano et al., 2013).

The commercialization or care has not taken into consideration that carative nursing is based on developing relationships and is person-centered rather than on task performance (Watson, 2012; 2018). Nursing care is based in theory, and it is theory that makes the clients feel that the nurse is connected to their profession. When nurses are

task oriented they may be less likely to rely on person centered care, which is the basis of nursing theory. Clients may feel like there is something missing in the care that they receive even though the care is perceived as competent when nurses care is not grounded in theory (Barrett, 2017).

At the height of commercialization, business consultants began to recommend that nursing interactions be scripted. This is also when nursing badges, and doorways were coded to record the amount of time a nurse spends in a room. The scripting and time management studies continue to regulate time spent with a client. This dehumanizes the caring that is required of nursing. Based on what research participants contributed, phones are a source of interrupted client care. Phones, which hang on nurses' uniforms interrupt the need for focused interactions with clients.

Watson (2018) discussed the what happens with nurses are immersed into the medical model.

Forcing nurses into the medical model destabilizes their perceptions about nursing practice. Separating nurses from their professional philosophy and the foundation of those underpinnings of professional nursing leads to career dissatisfaction and potentially to turnover. Nurses are unable to meet professional expectations when they are pulled away from their theoretical and philosophical roots (Watson, 2018). Watson's on-going message in each iteration of her theory is that et care changes the nurse and client in lasting ways and influences nurses' healing partnerships with those for whom they care.

When nurses achieve career satisfaction by reconnecting with their calling, then client and nurse satisfaction scores improve, which also reduces turnover rates (Shanahan et al., 2018). Reduced turnover and presenteeism leads to a safer, higher quality of care, which supports health improvement for Americans and increases the rate of return on investment for healthcare organizations.

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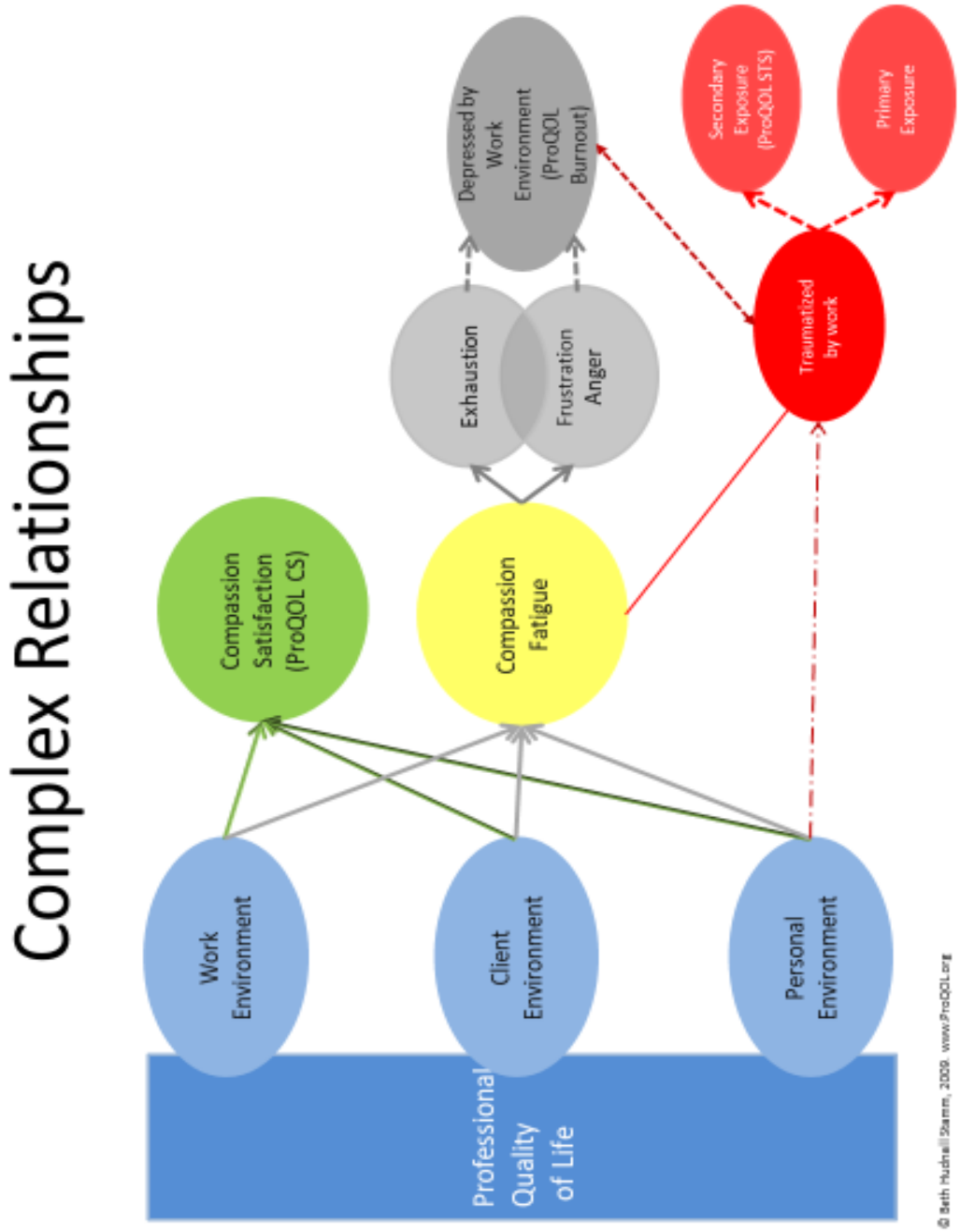
Chapter 10 of the *Publication Manual of the American Psychological Association, seventh edition,* includes numerous examples of reference list entries. For more information on references in APA Style, consult the APA website or the Walden Doctoral Capstone Form and Style page on APA References.

Appendix A: Professional Quality of Life: Complex Relationships Model



Appendix B: Reflective Journal Prompts

1. What matters to you in practicing your profession in your work environment?
2. Identify any unique impediments to your working in the local context.
3. What is your sense of being valued by the organization for which you work?
4. What is your perception of how professional nurses can provide high-quality person-centered care in the environment where you work?
5. Describe your personal mission and vision and how it fits into the mission and vision of the hospital where you work.
6. How does the environment of care support your mission and vision of providing a meaning and purposeful career?
7. What motivated you to become a nurse and how has your motivation changed over time?
8. What are your thoughts about the use and need of selfcare?
9. Describe your sense of being valued by the organization for which you work.
10. Discuss any perceived practice barriers to doing meaningful work on your unit.
11. Discuss what supports your ability to do meaningful work on your unit.

Appendix C: Demographics

Choose	<24 25-30 31-39		40-49 50-59	60- 69 >70
male	Female	Ethnicity:		Years practice_____ Years on present unit _____
Employment		Indicate how many total hours per week here ____ and identify how the hours are split in the columns		
Practice site_____ Practice unit_____ Role(s) _____ **Key: practice site and Role identification** For profit; Not for profit; Private; Rural; Urban; Critical Access **Unit**: cardiac; neuro, etc. **Role:** team leader & bedside; Bedside only **Patient load ratio**: 1 nurse/ to patient **provide a pseudonym:**		Days 12 hrs full-time		12 Part-time
		Nights 12 hrs full-time		12 part-time
		Days 8 hrs full-time		8 Part-time
		Nights 8 hours full-time		8 Part-time
		Other: Identify Over time as required or voluntary and any hrs that you may work at a second job		
		Regional Distribution: circle one REGION **(do not** designate a state) **Northeast** – ME, NH, MA, CT, NJ, NY, PA, DE, MD, VT **Southeast** – NC, SC, FL, GA, TN, VA, WV **Midwest** – OH, MI, IN, IL, WI, MN **Southwest** – AR, LA, OK, TX, NM **Central** – SD, IA, MO, NE, KY, CO, UT, WY **Western** – AK, AZ, CA, ID, OR, WA		

Exclusionary Criteria (please do not participate if you have any experience in the following	
Magnet or Pathway	
BirchTree or Plane Tree Model	
Holistic Nursing education	
Holistic Nurse or Nurse Coach	

Formal education	
Diploma /ADN (date completed) _____	RN to BSN Completion _____
BSN in Nursing (date completed) _____	RN to MSN Completion) _____
Other or additional educational (i.e. first career/degree; specialty)	

Appendix D: Holistic Nursing and Standards of Practice

Excerpted from Holistic Nursing: Scope and Standards of Practice 2nd Edition (2013)

Core Values
Core Value 1. Holistic Philosophy, Theories, and Ethics
Core Value 2. Holistic Caring Process
Core Value 3. Holistic Communication, Therapeutic Healing Environment, and Cultural Diversity
Core Value 4. Holistic Education and Research
Core Value 5. Holistic Nurse Self-Reflection and Self-Care

Holistic Nursing Standards of Practice
Standard 1. Assessment
Standard 2. Diagnosis
Standard 3. Outcomes Identification
Standard 4. Planning
Standard 5. Implementation
- Standard 5A. Coordination of Care
- Standard 5B. Health Teaching and Health Promotion
- Standard 5C. Consultation
- Standard 5D. Prescriptive Authority and Treatment

Standard 6. Evaluation

Standards of Professional Performance
Standard 7. Ethics
Standard 8. Education
Standard 9. Evidence-Based Practice and Research
Standard 10. Quality of Practice
Standard 11. Communication
Standard 12. Leadership
Standard 13. Collaboration
Standard 14. Professional Practice Evaluation
Standard 15. Resource Utilization
Standard 16. Environmental Health

Appendix E: Publishers Letters of Permission

Dear Ann,

Thank you for your inquiry seeking permission to include figure 1 (Four Steps for Leaders) from the IHI White Paper, *IHI Framework for Improving Joy in Work*, in your doctoral dissertation. We are delighted that you find this content useful in your work.

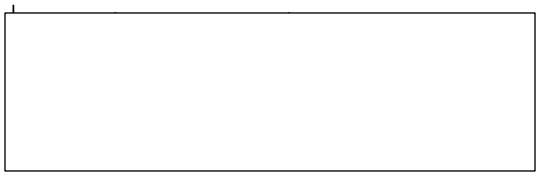
IHI is pleased to grant you permission to use the specified IHI content for the purpose stated in this email. Please acknowledge IHI as the source of the original content by including a source citation with the material, as follows:

Source: Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. *IHI Framework for Improving Joy in Work*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2017. http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

Also, please take a moment to let us know about anything we could have done to better serve you by clicking HERE. We greatly appreciate your feedback.

Best,

Appendix F: Nursing Economics Rutherford Figures



Hello Ms. Fuller,

Please accept my sincerest apologies; your other requests must have been marked as spam, just as this one is. I am glad to have found this third request. Rest assured this does not normally happen for the journal.

Permission is granted to use Figure 1. Imperative Components of the Nurse-Patient Relationship and Figure 2. The Balance of Nursing's Intangible and Tangible Assets provided the following credit line is published:

Reprinted from Rutherford, M.M. (2014). The value of trust to nursing. *Nursing Economic$, 32*(6), 284. Used with permission of the publisher, Jannetti Publications, Inc., East Holly Avenue, Box 56, Pitman, NJ 08071-0056; Phone: 856-256-2300; Fax: 856-589-7463; Email: nejrnl@ajj.com; Website: www.nursingeconomics.net. For a sample copy of the journal, please contact the publisher.

Best of luck with your dissertation.

Kind Regards,