The Evolution and Development of an Instrument to Measure Essential Professional Nursing Practices

Marlene Kramer, PhD, RN, FAAN
Barbara B. Brewer, PhD, RN, FAAN
Diana Halfer, MSN, RN, NEA-BC
Cynthia Nowicki Hnatiuk, EdD, RN, CAE, FAAN
Maura MacPhee, PhD, RN
Claudia Schmalenberg, MSN, RN

Nursing continues to evolve from a task-oriented occupation to a holistic professional practice. Increased professionalism requires accurate measurement of care processes and practice. Nursing studies often omit measurement of the relationship between structures in the work environment and processes of care or between processes of care and patient outcomes. Process measurement is integral to understanding and improving nursing practice. This article describes the development of an updated Essentials of Magnetism process measurement instrument, renamed Essential Professional Nursing Practices.

Forward-thinking nurse leaders have led the evolution of nursing from a task orientation to a holistic professional practice. This was accomplished by investing in the development of the profession through education, clarification of nursing practices, and research. As a result, RNs are perceived by colleagues, other disciplines, and the public as knowledgeable, skilled, trustworthy, valued members of the healthcare team. Wide differences exist in how individual RNs view their professional role. The following excerpts, abstracted from interviews with 795 Magnet hospital (MH) RNs and nurse managers during 3 studies in 2004-2007 and from interviews with 907 newly licensed RNs (NLRN), experienced RNs, and nurse managers in 2010, reflect the 3 major categories of responses to the questions: "What is nursing?" and "What does nursing mean to you?"
In the 1st excerpt, this experienced clinical nurse (CN) views nursing as a series of part tasks and expresses job satisfaction but not professional practice satisfaction. In the 2nd example, the NLRN expresses satisfaction with the professional holistic components of nursing practice, but describes a lack of competence and satisfaction with management of the “multiple patient/simultaneity complexity” of the professional nurse role. The 3rd experienced nurse describes satisfaction and outcomes from 3 components of the nurse role: practicing professionally, collaborating with a physician, and effective teamwork.

These interview excerpts introduce 2 issues/concepts significant in understanding the purpose of this research project, that is, the development of an up-to-date instrument to measure the Essential Professional Nursing Practices (EPNPs) CNs in hospitals. The 1st issue is the need to shift from the industrial to the professional model to enable us to meet the complex care needed by hospitalized patients. The 2nd issue is an understanding of the concepts and relationships between structures, processes, and outcomes and why accurate process measurement is so important to achieving desired patient, nurse, and organizational outcomes.

**From the Industrial to the Professional Model**

Ever increasing patient acuities, shortened length of stay (LOS), and increased technological and economic demands make it imperative that nursing shift from the part-task industrial model to the whole-task professional model. In the older part-task industrial system, the universe is perceived as stable, predictable, and regular with accountabilities delineated. The “whole” of care is broken down into “parts,” with the sum of the parts equal to the whole. Industrial systems are efficient and cost-effective because training is fast, resource conservative, and linear. Workers are trained only for the parts they will be doing. An example of the part-task model can be seen in the mid-1950s, when the primary author worked in an environment where only 5 RNs staffed a 1,000-bed general hospital, a tuberculosis hospital, a contagion hospital, and the polio clinic. In all hospitals, large open wards were staffed by licensed vocational/practical nurses who dispensed medications, provided treatments, and monitored IVs and by nursing assistants who helped patients with eating, bathing, toileting, and changing linens. The 5 RNs supervised the other staff, administered narcotics, and ensured that needed supplies and equipment were available. While this part-task industrial model continues in some hospitals today, with the gradual increase in the number of RNs assigned to a clinical unit, RN-patient ratio, and in the shift from team nursing to primary nursing delivery systems, there has been a gradual refocus in nursing practice from industrial model that emphasizes efficient task completion to provision and management of holistic care to a limited number of assigned patients.

In contrast to the part-task industrial model, holistic professional care/practice is based on the practitioner being educated and skilled in performance of the “whole task”\(^5,6\) as defined by that profession. In nursing, this is direct care of patients including continual assessment, performance of multiple skills, modifications of practice based on patient needs/responses, and continual scientific developments and innovations, as well as the complex management of care for multiple patients. Most recently in nursing is recognition of the plethora of complex adaptive systems and system interactions that CNs must take into account in the planning, provision, and management of patient care.\(^7,10\)

With respect to the last cited factor, not only does each patient constitute a group of interactive microsystems (nervous, digestive, muscular-skeletal, etc), but also the group of assigned patients constitutes an additional mesosystem. Moreover, in the planning, delivery, and management of care, CNs must consider other complex systems that may affect the planning and management of care for each patient—family, other healthcare professionals, unit, hospital, and economic.\(^7,9,11\) It is not unusual for CNs to have to make decisions based not only on multiple patient needs but also on available resources. Short-term immediacy issues often override longer-term resources that may affect outcomes such as LOS and hospital readmission. Hospital-based patient CNs are the only healthcare professionals responsible and accountable for surveillance and provision of care to a group of patients simultaneously; other healthcare professionals provide care sequentially.\(^4,8,9,12,13\)

In a series of studies that included 82 observations and interviews with 907 NLRNs, CNs, nurse managers, and educators in 34 Magnet-designated hospitals, Kramer and colleagues\(^4,14-16\) conducted a series of studies in which respondents frequently commented that patients today are so ill and require such complex, adaptive care that only professional CNs have the requisite knowledge and skill to provide such care. In addition to being educated and skilled in holistic practice, CNs increasingly provide evidence of meeting Flexner’s other criteria and characteristics of a profession—use and continuous development of scientific knowledge through research/evidence-based practice (EBP), professional (context of practice) and clinical (content of practice) autonomy, ethical and legal responsibility for practice, and a service to society orientation.
Donabedian’s\textsuperscript{18,19} structure-process-outcomes (S-P-O) model advocates studying the impact of structures on process and process on outcomes. Examples of structures are physical layouts, written policies/regulations, nurse-to-patient ratios, shared governance council models, nurse residency programs, and traits/characteristics of employees such as the percentage of BSN-prepared RNs. Structures are measured/documenting by reported presence or written evidence such as policies, procedures, and salary structure. In nursing, processes are the constellation of clinical reasoning, management and teaching, and care interventions that CNs engage in to achieve desired outcomes.\textsuperscript{20} A 2004 IOM report\textsuperscript{21} identified nursing processes as strategies such as examination of and improving assessment, preparing for care, and timeliness of care interventions the professional nurse makes to avert unsafe or undesirable outcomes. Accurate measurement of processes requires verification or observation of enactment of the steps and components of the practice. Often observing or reviewing documentation to ascertain whether the steps/components of the practice were enacted and followed in the proper sequence to ensure optimal outcomes measures a process. Processes cannot be measured by self-report or access to policies and procedures such as outlined in the MH standards.\textsuperscript{22} Documents that outline desirable practices do not mean that these practices are operable. With regard to the 3rd step in the S-P-O model,\textsuperscript{17-19} there are 3 types of outcomes of interest in acute care hospitals: patient, RN/other employees, and organizational/economic. Patient outcomes include clinical indicators such as patient falls and mortality rates; personnel outcomes are measures such as nurse turnover or job satisfaction; patient LOS and readmission rates are examples of organizational outcomes. In the linear S-P-O model, the impact of structures on practices can be studied, or a research question can be posed from a post hoc perspective, that is, what is the relationship between patient mortality (outcome) and professional nursing practices? Most nursing studies focus on the structure-outcome relationships, ignoring the process dimension. Deficits in S-O studies were demonstrated in a national interdisciplinary study\textsuperscript{23} led by a physician. In this study of the impact of intensive care unit structures on the outcome, acuity-adjusted patient mortality, investigators found that 2 processes—physician nurse collaboration and autonomous clinical decision making—had the most significant impact on the outcome, patient mortality. A nursing example of S-O deficit and lack of process measurement may be seen in studies comparing the relationships between the presence of Magnet-designation criteria such as a shared governance structure on the outcome, patient mortality.\textsuperscript{24} In studies of this type, it is often concluded that the reason why no differences in outcomes are identified is because there are no differences between Magnet-designated hospitals and non-MHs.\textsuperscript{24}

Process measurement tools are more difficult and time consuming to construct than are structure or outcome tools, and they also become quickly outdated because the healthcare environment is constantly changing, and patient acuity and care complexity are increasing. To implement strategic improvements leading to quality patient outcomes, measurement of the steps and components of professional nursing practices should be done at the clinical unit level.\textsuperscript{24-28} Patients on different clinical units have unique needs and characteristics requiring different professional practices. The original 1984 Nursing Work Index was designed to measure nurse practices. Instruments now widely in use, such as the NWI\textsuperscript{29} and the Practice Environment Scale of the NWI,\textsuperscript{30} measure the structures of the work environment rather than professional nurse practices that impact patient and nurse outcomes. The validity—via confirmatory factor analysis—of the NWI was found to be questionable in a 2006 study.\textsuperscript{31} To remedy these deficiencies in measurement of nursing practices, in 2001 Kramer and Schmalenberg,\textsuperscript{32,33} developed the Essentials of Magnetism (EOM) process measurement tool. The EOM was updated to the EOM II\textsuperscript{34,35} in 2008. EOM scores from 10,514 CNs practicing in 8 MHs and 16 non-MHs led to development of the National Magnet Hospital Profile (NMHP)\textsuperscript{35} that hospitals can use for gap analysis and for making strategic improvements. A study, other research or a hospital self-study, is provided a summary of their hospital data and unit-level data if more than 40% of the RNs on the unit completed the survey.\textsuperscript{36} In addition, the EOM and EOM II have excellent external validity and generalizability.\textsuperscript{37} The latter has been demonstrated by its use in more than two-thirds of the MHs, in hundreds of other hospitals in the United States,\textsuperscript{34,15,33,35} as well as its translation and use in 17 foreign countries.\textsuperscript{38,39} The purpose of the study reported here was to develop a comprehensive list of current professional nursing practices, entitled the Dimensions of Magnetism II (DOM II) and then, through analysis of DOM II data, to identify the most essential professional nursing practices.

**Development of DOM II Survey and Identification of EPNP**

**Methods**

Descriptive/qualitative methods were used to identify the current, most frequently performed, effective nursing practices for construction of the DOM II instrument.
Informal, individual, or small group interviews were conducted with 187 volunteer attendees at 2 national conventions. Nurse job descriptions from 24 MH and 8 non-MH hospitals were reviewed and analyzed. Written-in suggestions regarding additional professional practices that should be added to the EOM II from hundreds of EOM II respondents over a 4-year period were reviewed and analyzed. Finally, responses from 89 nurses who agreed to engage in a volunteer e-mail dialogue with the primary author were analyzed and frequency tabulated. Dialogue related to the following questions, “What do you see as the most important components of your practice?“ “What nursing practices are very important to your achievement of the goals of your practice?“ “What do you do repetitively that is most valued by you and your patients?“ From analysis of this data, the 51-item DOM II survey containing the most frequently cited nursing practices was constructed.

Quantitative methods were used to achieve the 2nd goal of this study—identification of essential nursing practices. The DOM II was administered online to nurses in 12 hospitals and to the Academy of Medical-Surgical Nurses (AMSN) membership. The invitation to complete the DOM II survey specifically requested participation of experienced CNs (≥1 year of hospital clinical nursing practice), CNs who were the “informal” unit leaders, and advanced practice nurses (APNs). The DOM II requests that respondents first identify the relative importance of each item on a 4-point Likert scale from very important = 4 to achievement of desired patient outcomes. Then they were asked to review all of their selected “very important” practices and from these to indicate the “top 10” (of the “very important”) items selected by the respondents over a 4-year period were reviewed and analyzed.

**Data Analysis**

To identify a current list of EPNPs, 3 analyses were conducted on the DOM II survey data. The 1st was a frequency analysis of “very important” survey items (Table 2). To determine significant differences between AMSN and the 12-hospital subsamples on “very important” survey items, $\chi^2$ (SPSS 20) with $z$ test statistics was used. In the 2nd analysis, the percentage of “top 10” (of the “very important”) items selected by the AMSN and hospital subsamples was compared and analyzed. In the 3rd analysis, a principal component factor analysis (PCA) with varimax rotation was done on DOM II items from the total sample and from the AMSN and hospital subsamples. Individual hospital sample sizes were insufficient for PCA analysis.

**Results**

**Description of Hospitals, Units, and CN Sample**

Nine of the 12 hospitals in the hospital subsample were MHs; 7 were members of healthcare systems. No attempt was made to obtain a representative sample of clinical units as it has been demonstrated that patient characteristics (resiliency, vulnerability, complexity, etc) are of more importance with respect to professional nursing practices than are clinical unit labels. Clinical units represented in the hospital subsample included all major types of medical-surgical units found in most hospitals as well as pediatrics, obstetrics, operating room, float pool, and psychiatry. Although all types of clinical units were represented in the 2 subsamples, there was a significant difference ($\chi^2 = 712.008$, $P < .0001$) in clinical practice units, with 84% of the CNs in the AMSN sample compared with 32.6% of the 12-hospital sample, practicing on medical-surgical, medical, surgical, or operating room units. This difference was not unexpected because the AMSN professional organization focuses on the medical-surgical specialty. The number of hospitals in the AMSN sample is unknown, but based on AMSN advisors, the latter is estimated to be well more than 200.

Total sample size was 2,137 to 1,204 in the 12-hospital subsample and 933 in the AMSN subsample. The hospital subsample ranged from 60 to 251, with a median of 172 CNs per hospital. Significantly more ($\chi^2 = 64.575$, $P < .0001$) CNs were prepared at the BSN level (61%) and fewer at the associate degree (ADN) level (20%) in the 12-hospital subsample than in the AMSN subsample (BSN: 46%; ADN: 28%). More AMSN CNs (17%) had returned to school for their MSN than had CNs in the hospital subsample (13%), but the difference was not significant. Groupings used to obtain years of CN experience were as

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Item</th>
</tr>
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<tbody>
<tr>
<td>10</td>
<td>Advocate for the patient</td>
</tr>
<tr>
<td>18</td>
<td>Assignment supports safe and effective patient care</td>
</tr>
<tr>
<td>12</td>
<td>Respect is demonstrated among nurses, physicians, and other team members</td>
</tr>
<tr>
<td>9</td>
<td>“Concern for the patient” is a core organizational cultural value</td>
</tr>
<tr>
<td>32</td>
<td>Positive and enthusiastic nurses and team members</td>
</tr>
<tr>
<td>37</td>
<td>RNs are empowered to make independent and interdependent decisions</td>
</tr>
<tr>
<td>49</td>
<td>Promote caring, compassionate, supportive, and therapeutic environment for patients</td>
</tr>
<tr>
<td>51</td>
<td>Working with other nurses who are clinically competent</td>
</tr>
<tr>
<td>23</td>
<td>Physicians ask my opinion and respect what I have to say</td>
</tr>
<tr>
<td>38</td>
<td>Effective communication among members of the healthcare team</td>
</tr>
</tbody>
</table>
follows: less than 3, 3 to 5, 6 to 10, 11 to 20, 21 to 30, and more than 30 years. Hospital subsample was significantly ($\chi^2 = 64.617, P < .0001$) more experienced than AMSN subsample in all but 1 group. The group with 11 to 20 years of experience was virtually the same for both subsamples (AMSN n = 233, 50.5%; hospital n = 228, 49.5%).

**Internal Consistency**

Cronbach’s $\alpha$ was used to evaluate internal consistency of the DOM II. Cronbach’s $\alpha$ for the 51-item survey was .98. Thirteen items had interitem correlations equal to or exceeding $r = 0.81$, indicating a considerable amount of item redundancy or possibly that differences between items such as collaborative and collegial interprofessional relationships are too subtle to be meaningful to CNs (Table 3).

**“Very Important” Professional Nursing Practices**

Table 2 presents numbers/percentages of respondents for the 11 items selected as “very important” (1st column on the 4-column DOM II survey) by at least 70% of the total sample. The 11th item, “Practice is based on research/EBP,” was selected by 73% of the AMSN group and by 69% of the hospital subgroup, but the average was 70.9%. Utilizing $\chi^2$ analysis with $z$ test, significant differences, ranging from 4% to 6%, between percentage of respondents in AMSN and hospital subgroups selecting the item as “very important” were found on 4 of the items: the EBP item ($\chi^2 = 35.313, P = .0001$); “concern for patient is a core value” ($\chi^2 = 46.882, P = .0001$); “Compassionate, caring, patient environment” ($\chi^2 = 45.252, P = .0001$); and “clinically competent peers” ($\chi^2 = 38.374, P = .0001$). For all of these items, the mean percentage of the AMSN sample was higher than that of hospital subsample.

**“Top 10” Essential Nursing Practices**

To identify the “top 10” essential nursing practices, respondents were asked to review all of their “very important” items and then to write into the appropriate box the item number of those that were their “top 10.” The AMSN subsample selected 11 items as “very important”; 2 of the items were tied in percentage for “top 10.” With the exception of EBPs (1 of the 2 tied items), the hospital subgroup selected the same 10 “very important” items as their “top 10.”

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**Table 2. Frequency of “Very Important” Professional Practice Items Identified by Total CN Group**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Professional Practice</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Advocate for the patient, ie, work on behalf of the patient to resolve ethical and</td>
<td>1,837 (86.9)</td>
</tr>
<tr>
<td></td>
<td>clinical concerns when patients cannot do so for themselves</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Have sufficient staff to support safe and effective patient care</td>
<td>1,739 (81.5)</td>
</tr>
<tr>
<td>9</td>
<td>Practice in a culture in which ‘concern for the patient’ is a core value</td>
<td>1,737 (81.5)</td>
</tr>
<tr>
<td>51</td>
<td>Work with other nurses who are clinically competent</td>
<td>1,705 (81.3)</td>
</tr>
<tr>
<td>12</td>
<td>Respect among nurses, physicians, and other members of the patient care team is</td>
<td>1,723 (80.9)</td>
</tr>
<tr>
<td></td>
<td>demonstrated in their actions</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Make autonomous decisions in both independent (within nursing sphere of practice) and</td>
<td>1,557 (74.1)</td>
</tr>
<tr>
<td></td>
<td>interdependent (nursing overlaps with other disciplines) spheres of practice</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Work with other RNs/team members who are positive and enthusiastic about their practice</td>
<td>1,545 (73.5)</td>
</tr>
<tr>
<td>23</td>
<td>Work with physicians who ask my opinion about patients’ conditions, needs, and</td>
<td>1,590 (75.0)</td>
</tr>
<tr>
<td></td>
<td>treatments and respect what I have to say</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Promote a caring, compassionate, supportive, and therapeutic environment for patients</td>
<td>1,694 (80.9)</td>
</tr>
<tr>
<td>53</td>
<td>Use clinical reasoning to plan care</td>
<td>1,602 (76.3)</td>
</tr>
<tr>
<td>24</td>
<td>Professional practices based on research and EBP</td>
<td>1,486 (70.9)</td>
</tr>
</tbody>
</table>

Italicized items are those in which there is a significant difference between the AMSN and hospital subsamples, but both samples are greater than the 70% criterion. Bolded item is the 1 item in which there is a significant difference between the 2 subsamples, but total sample still falls within the criterion.

**Table 3. Degree of Interitem Correlation on the DOM II Survey**

<table>
<thead>
<tr>
<th>DOM II Items</th>
<th>Correlation</th>
<th>Possible Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>23, 41, 48</td>
<td>0.85-0.86</td>
<td>All items ask about nurses’ relationships with physicians.</td>
</tr>
<tr>
<td>9, 49</td>
<td>0.83</td>
<td>Both items ask about the presence/visibility of cultural values.</td>
</tr>
<tr>
<td>32, 51,52</td>
<td>0.83-0.84</td>
<td>All items are related to competency/relationships with coworkers.</td>
</tr>
<tr>
<td>37, 47</td>
<td>0.82</td>
<td>Both items are related to autonomy.</td>
</tr>
<tr>
<td>30, 39, 57</td>
<td>0.82-0.83</td>
<td>All items describe structures rather than processes or professional practices.</td>
</tr>
</tbody>
</table>
Dominant Domain Factors Leading to Identification of EPNP

The last analysis was a PCA with varimax rotation of data from the total sample of 2,137 CNs. Seven factors with eigenvalues greater than 1 explained 66.93% of the cumulative variance. To be included, an item had to have a rotated factor loading of 0.50 or more, and no higher than 0.30 on any other factor.41 Table, Supplemental Digital Content 1, presents PCA results, http://links.lww.com/JONA/A340. Factor 1, containing 27 of the 51 items, explained 35.55% of the variance. Comparison of the items loading on factor 1 with results from the “very important” and “top 10” analyses indicated that the major loadings on factor 1 were of items inherent in 3 professional nursing practices: RN-MD interprofessional relationships, patient advocacy, and autonomous clinical decision making. The conceptual foci of these 3 practices are listed as subfactors of factor 1 in Table, Supplemental Digital Content 1, http://links.lww.com/JONA/A340. Study of the items loading on each of these subfactors led investigators to conclude that they loaded on 1 factor because these nursing practices are interrelated. For example, most activities that nurses engage in to “advocate for a patient” involve some degree of autonomous decision making and, frequently, interprofessional collaboration. Interdependent autonomous decision making involves and is based on collaborative/colllegial RN-MD relationships. In the future construction of the EPNP instrument, these 3 nursing practices will be viewed as 3 separate processes. With the 1 exception noted earlier, the same professional nursing practices emerged from the “very important,” the “top 10,” and the PCA analyses. Items related to organizational structures, such as the “salaried rather than paid on an hourly basis,” were eliminated.

Essential Professional Nursing Practices

With the elimination of organizational structures and separation of factor 1 into 3 subfactors, the 2,137 CNs who completed the DOM II identified 8 essential processes/EPNPs: RN-MD/interdisciplinary relationships, patient advocacy, clinical autonomy, sufficient number of competent CNs, control over nursing practice, practice based on evidence/research, positive cultural values, and use of complex adaptive systems theory in clinical reasoning. Subsequently, digitally recorded individual and small group interviews were conducted with 139 CNs and 8 MDs in 5 of the participating MHs. Fourteen participant observations—unit interdisciplinary patient care rounds, grand rounds, and council meetings— were also conducted. The purpose of these interviews and observations was to ascertain the dimensions, steps, and components for each of the 8 EPNPs identified by the CNs in the survey. It is from identification of these 8 EPNP items and the analysis of interview recordings and observation notes that the items for the new EPNP process measurement instrument will be constructed.

Conclusions

Results of data analyses indicate a high degree of redundancy in the 51-item DOM II survey (see Table, Supplemental Digital Content 2, http://links.lww.com/JONA/A341). This is evidenced by the internal consistency Cronbach’s α of .98, the high degree of interitem correlation, and the unusually high loading of 0.90 to 0.93 for 18 of the factor 1 items. If DOM II survey items are used to identify the importance of professional nursing practices in other settings or studies, it is suggested that the number of items be condensed and redundancy eliminated. The DOM II measures only the degree of importance; it does not measure whether the components of practice/process are operational.

It is also recommended that the 4 structural items (desirable qualities of the CN, salaried rather than hourly workers, self-scheduling—no floating, and flexible scheduling), loading on the last factor in the factor analysis but not cited as “very important” or on the “top 10” list, be eliminated. Both CNs and APNs participated in the construction of the DOM II, but practices important to APNs are not necessarily the same as those important to CNs.

As noted in the Results, the size of the AMSN response group was comparable to the number of responses from the 12-hospital subsample. The 8 EPNP identified by the AMSN and hospital subgroups were very similar. However, the number of hospitals represented in the AMSN subsample was undoubtedly larger than 12. Thus, the results of this study demonstrate that the items hold strength in external validity and are generalizable to CNs in hundreds of hospitals across the country, not just to nurses in MHs.

Process measurement instruments such as the EOM and the soon-to-be-constructed EPNP are useful and needed not only for research studies, but also to engage in gap analysis and strategic improvements needed to improve professional nursing practices as well as patient and practitioner outcomes. The Institute of Medicine’s Future of Nursing report11 recommends that nurses lead change. Nurse executives and managers must create and expand opportunities for CNs to engage in leadership activities that produce the desired changes in nursing practices. Leading from the bedside is dependent on evidence at both the unit/clinic and hospital levels. Scores from the EOM II process instrument are effective, not only in defining where the unit/hospital stands as compared with the NMHP,33 but also in detailing specific steps or components of the practice that...
need to be improved or changed. Organizations that may not have the resources needed to pursue Magnet designation can make improvements and seek excellence by using process measurement tools to identify and target specific gaps and successfully change CN practice environments.32

References


