LIFTING OFF WITH MAGNETISM:

ADVANCING AIR FORCE NURSING EXCELLENCE

by

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Abstract

The aims of this evidence based project were to transform a global organization's practice culture and advance nursing excellence by infusing Magnet characteristics into healthcare settings. A call to action by the Air Force Medical Service senior nursing officer signaled a new strategic focus and triggered a review of evidence specific to Magnet culture, nursing excellence, and patient outcomes. The American Nurses Credentialing Center (ANCC) Magnet credential is synonymous with nursing excellence and quality patient care. Magnet-designated facilities embody a culture that supports nurses. A robust body of literature links Magnet hospitals to increased patient and staff satisfaction, positive clinical outcomes for patients, and higher ratings on nurse-sensitive indicators than non-Magnet hospitals. An appreciative inquiry-infused organizational change strategy was selected for this project. At the heart of transformational change is an individual's reaction to change; thus, stakeholder engagement and consensus building factored into the selection of interventions. The merits of Magnetism and a proposed practice model for Air Force nurses were presented to stakeholder focus groups during interactive sessions. Targeted stakeholder groups were defined as direct care nurses (n = 11), service-line consultants (n = 11), and senior nurse executives (n = 21). Data were collected using a scholar-developed questionnaire that included scaled response and free-text fields. This project was deemed research exempt and non human research by an academic IRB. The intervention was designed to elicit consensus for change rather than to perform statistical analysis. Direct care and service-line consultant stakeholders supported Magnetism as the desired paradigm for nursing excellence. However, the proposed practice model did not garner consensus. Service-line consultants rejected the

model prototype, but endorsed the project for executive level consideration and continued study. Consistent with elements of Magnetism and appreciation, a collaborative effort involving Air Force nurses at all levels of the organization produced benchmarks for transformation. Most significant was the insertion of Magnet principles into the Air Force Total Nursing Force strategic plan.

Dedication

I dedicate this project to the men and women of the U.S. Air Force Medical Service. I joined this esteemed organization to serve my country. I remain because of the people I am privileged to care for and work alongside.

Acknowledgments

I wish to thank the Air Force Nurse Corps for my selection as the first Air Force Executive Fellow for Magnet Nursing. My fellowship experience gave me the confidence to pursue my dream of doctoral education. To Major General Kimberly Siniscalchi, thank you for your visionary leadership, sincerity, and continued mentorship. To Colonel Richard Eaves, you have been a trusted mentor and preceptor. Thank you for becoming a valued colleague and friend. To graduates of the Nurse Transition Program, this project was inspired by you – one of you, in particular. I am humbled by your trust in me and for the opportunity to pay it forward.

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CHAPTER 1. INTRODUCTION

Our nation has been at war for more than a decade, necessitating priority focus on supporting deployed troops and caring for thousands of ill and injured warriors. Declining combat care requirements suggest the time to address new initiatives has arrived. In a written report to Congressional leaders, the Air Force Assistant Surgeon General for Nursing Services testified:

> It is imperative our TNF [Total Nursing Force] possess the appropriate clinical and leadership skills for successful execution of our mission. The Magnet Fellowship provides the AFMS [Air Force Medical Service] with a rare opportunity to gain first hand, up-to-date insights into the Magnet Culture; an environment that promotes nursing excellence and strategies to improve patient outcomes. (*Defense Health Programs*, 2012)

This statement signaled a new strategic focus and triggered a review of evidence specific to Magnet culture, nursing excellence and patient outcomes.

Nature of the Capstone Project

This capstone project establishes evidentiary rationale for integrating the Magnet framework of nursing excellence into the Air Force Nursing Services. Magnet-designated facilities embody a culture that supports nurses. The cornerstone of a Magnet organization's nursing practice is a professional practice model (PPM). A practice model provides a visual representation of nursing practice and its connection to mission, vision, and values. A key element of this project is building consensus for a proposed model of Air Force professional nursing practice.

Description of the Problem, Environment, and Target Population

Air Force culture emphasizes Airmanship above specialty role identification (Secretary of the Air Force [SECAF], 2012). Although this satisfies Air Force role development, it leaves elements of the professional nurse identity open to interpretation. Ambiguous statements are found in nursing policy as well. For example, the Total Nursing Force Futures Plan states "the essence of what we do is patient care" (Total Nursing Force [TNF], 2012, p. 2). This statement leaves the reader to interpret how nurses practice in the Air Force setting. The American Nurses Credentialing Center (ANCC) Magnet credential is synonymous with nursing excellence and quality patient care. While the credential may not be practical for Air Force facilities at this time, adopting the Magnet framework can bring clarity to Air Force nursing practice.

The Air Force Medical Service (AFMS) encompasses 57,000 officer, enlisted and civilian personnel and has approximately 1.4 million enrolled beneficiaries, including 152,000 enrollees located outside the continental United States (Air Force Medical Service [AFMS], 2012). The AFMS infrastructure includes 75 medical treatment facilities (MTF), but just 13 are resourced for inpatient care services. Air Force hospitals serve as training environments for novice direct care providers (physicians, nurses, and unlicensed medical technicians) as well as currency platforms for medics preparing to deploy. Of the 13 hospitals, five host graduate medical education residencies and all have multiple discipline-specific training programs. The distribution of inexperienced direct care providers makes Air Force hospitals susceptible to inefficiencies in process, care, and quality (Donabedian, 2005).

Non-specialty inpatient units at Air Force hospitals have a diverse patient population, a patient care mission impacted by deployments or pre-deployment training, and a high proportion of direct care nursing staff serving in their first clinical assignment. Despite limited experience of most inpatient clinical nurses, care delivered in Air Force facilities is exceptional. All MTFs have a robust compliance program to ensure every facility meets or exceeds corporate, federal and Department of Defense regulations. Each hospital is fully accredited by the Joint Commission and all ambulatory care centers are fully accredited by the Accreditation Association for Ambulatory Health Care, Inc.

What Air Force nurses initially lack in experience is tempered with education and training. The minimum entry-level degree for nurse corps officers is a bachelor of science in nursing, whereas Magnet organizations average just 48% and the national average of baccalaureate prepared nurses is even lower (American Nurses Credentialing Center [ANCC], n.d.). Centralized programs provide incentives for nurses to obtain national certification in their specialty and pursue graduate nursing education. A comprehensive career counseling tool ensures nurses are aware of professional development opportunities and the expected timing for reaching various career milestones.

Clinical Question

Specific to this project, a clinical question was developed using the population, intervention, comparison, outcome, timeframe (PICOT) template (Fineout-Overholt & Stillwell, 2011).

P – Air Force nurses

I – Introduce elements of ANCC's Magnet Recognition Program

C – Maintain current Air Force guidance

O – Advance nursing excellence and promote professional practice culture

T – By the end of this Capstone project

What elements of Magnetism should be integrated into current Air Force guidance so that Air Force nurses can transform their practice culture and advance nursing excellence?

Purpose of the Capstone Project

The purpose of this project is to infuse Magnet qualities into Air Force healthcare settings. A professional practice model serves as the conceptual framework for professional practice and provides an illustrated answer to the question: how do nurses practice? It is the "schematic description of a system, theory, or phenomenon that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality care for those served by the organization" (ANCC, 2013, p. 41). Developing a PPM aligned with AFMS strategic priorities will clarify Air Force nursing practice and bridge the gap between Air Force and Magnet cultures.

Significance of the Capstone Project

In a letter to nurses at St. Thomas Hospital, Florence Nightingale wrote: "unless we are making progress in our nursing every year, every month, every week, take my word for it we are going back" (as cited in Nash, 1914). Nightingale's sentiment remains true today. Magnet facilities consistently report higher nurse satisfaction, better work environments, a more educated workforce, and lower rates of burnout (Berger, Conway, & Beaton, 2012; Kelly, McHugh, & Aiken, 2011; Lang, Patrician, & Steele, 2012; Miles & Vallish, 2010). Magnet facilities benefit patients as well; they have higher rates of

patient satisfaction and outperform national benchmarks for nurse-sensitive quality indicators (Berger et al., 2012; Kalisch & Lee, 2012; Kelly et al., 2011).

Unprecedented results in combat, humanitarian, and aeromedical evacuation missions while simultaneously maintaining regulatory accreditation at home station facilities are testament to the exceptional care delivered throughout the AFMS (AFMS, 2012). Maintaining the status quo will not degrade mission capability; however, transforming the Air Force practice culture by infusing elements of Magnetism will advance nursing excellence and prepare nurses to address emerging healthcare initiatives and mission requirements.

Definition of Relevant Terms

Air Force culture includes many terms and acronyms. Definitions and/or clarification of terms are located in Appendix B.

Assumptions

The primary assumption related to this project is that nurses want to advance their practice and will embrace a culture of Magnetism. A secondary assumption is that a culture of Magnetism is an enduring objective independent of any individual leader's philosophical priorities.

Limitations

Several limitations related to Air Force organizational structure have been identified. The first limitation is the concept of *Airman-First*. This concept refers to the

military role of Airman taking precedence over the occupational role. Second, Air Force mission requirements may impact the strategic priority of this project. The primary mission of a uniformed medical service is to support readiness and combat operations, thus a project that is intended for in-garrison healthcare may be viewed as a lessor priority. Third, the complexity of Air Force organizational, command, and functional culture will influence the implementation strategy, and may limit generalizability to civilian institutions. Finally, the number of focus groups participants was not sufficient for establishing consensus.

Capstone Project Objectives

The aim of this Capstone project is to integrate Magnet characteristics into Air Force healthcare settings. Several opportunities to advance nursing excellence have been identified:

1. Develop an Air Force consensus model for professional nursing practice. The TNF does not have a practice model. A Magnet organization's practice culture is informed by it's model.
2. Embrace a performance-based practice culture. Military culture is steeped in compliance. Good order and discipline requires that all airmen to know and comply with established standards (compliance). Magnet organizations are measured against peer-grouped outcomes (performance).
3. Integrate the Forces of Magnetism into TNF doctrine. Inserting Magnet concepts into Air Force organizational policies, guidance memorandums, and formal training program curricula is an important first step in the enculturation process.

CHAPTER 2. THEORETICAL FRAMEWORK AND LITERATURE REVIEW

This chapter lays out the transformational blueprint for achieving a culture of Magnetism within the AFMS. The Magnet Recognition Program® provides a theoretical framework for this project. The literature review guides this scholar's quest for an operational practice model that consolidates a fragmented professional construct and answers the question *how do Air Force nurses practice?*

Theoretical Framework

The chronology of Magnet Recognition Program development is well-documented in the literature (Drenkard, 2005; Kelly et al., 2011; Lundmark, 2008; McClure, 2005; Messmer & Turkel, 2011; Stolzenberger, 2003; Upenieks & Abelew, 2006). Briefly, studies of nursing excellence began in the early 1980s with 41 exemplary hospitals that were successfully recruiting and retaining nursing staff in the midst of a nursing shortage. In addition to a corporate culture that supported nursing and quality patient care, a set of characteristics emerged that would become the 14 Forces of Magnetism. These studies formed the basis of an evidence-based framework encompassing ideal practice environments to support nurses and promote nursing excellence. The first Magnet hospital was designated in 1994. As of October 2014, 398 U.S. hospitals and six international hospitals are recognized as Magnet-designated

organizations, accounting for less than 7% of 5,723 hospitals registered in the United States (ANCC, 2014; American Hospital Association [AHA], 2014).

The Magnet Recognition Program is grounded in standards outlined by foundational nursing documents that address practice standards (American Nurses Association [ANA], 2010a), ethics (ANA, 2015), and social policy (ANA, 2010b). In 2008, the Model for Magnet was introduced. The model maintained the enduring Forces of Magnetism, but organized them into four components: (a) transformational leadership; (b) structural empowerment; (c) exemplary professional practice; and (d) new knowledge, innovations, and improvements. Empirical outcomes are embedded into each component. Collectively, the components are influenced by and responsive to global issues in nursing and healthcare. The Magnet Model signified a shift in focus to the outcomes produced by organizational structures and processes. A revised set of application criteria were released in 2013, which streamlined the volume of evidence required while maintaining expectations for interprofessional collaboration and sustained performance outcomes (ANCC, 2013).

The structure-process-outcome paradigm was first introduced by Donabedian in the 1960s as a means of analyzing quality. The ANCC adopted this framework to guide hospitals toward nursing excellence and evaluate the quality of Magnet applicants. A PPM provides structure to support processes and promote positive outcomes (Donabedian, 2005). Magnet criteria require evidence of how nurses assimilate practice model characteristics and operationalize them to outperform national quality benchmarks (ANCC, 2013, p. 43). Thus, Magnet organizations have integrated practice model

elements into their procedural documents and use the model to frame clinical care and management decisions.

Summary of Relevant Research

Lundmark (2008) reviewed 59 articles in which nurse or patient outcomes referenced Magnet facilities or Forces of Magnetism. Studies consistently reported correlations between positive work environments and magnetism; however, the relationship between them was rarely explored. In fact, Lundmark's analysis revealed that much of the evidence about Magnet characteristics was gained from the Nursing Work Index instrument or derivatives, such as the Nursing Work Index-Revised, Practice Environment Scale, or Practice Environment Index (Lundmark, 2008). This was presented as a significant limitation of Magnet research.

While using similar instruments made study comparisons rather straightforward, this failed to advance nursing excellence or expand the reader's understanding of how Magnet characteristics promote better nurse and patient outcomes. Lundmark concluded that stronger theoretical frameworks and research methods were needed to advance nursing's effect on patient outcomes.

Professional Constructs and Magnet Culture

Nurse engagement. Pursuit of the Magnet credential demands organizational commitment and nurse engagement at every level. The significance of structural and process elements were explored in a qualitative pilot study using a convenience sample of 12 nurse leaders and 12 direct care nurses from two facilities with pending Magnet applications (Upenieks & Abelew, 2006). Questions were formulated from Magnet

characteristics and used to solicit participant responses, which were recorded during individual interviews. Interview data were categorized using structured content analysis and discussed within the context of Donabedian's quality framework (Upenieks & Abelew, 2006).

Researchers discovered that despite similarities in structure and processes, there were differences in nursing engagement and perceived organizational support between hospitals. At the hospital with lower nursing engagement, there was also a difference in perceived connection of organizational changes to Magnet culture amongst the groups of nurse leaders and direct care nurses, indicating that key messages were not well integrated throughout the facility. Researchers determined that executive leader support was the most influential factor in how well structures and processes were incorporated. Nursing engagement was more prevalent in the hospital where the Chief Nursing Officer (CNO) actively championed the value of embracing the Forces of Magnetism and instilled wide-spread passion for becoming a magnet of nursing excellence. Further, the CNO reportedly expressed a genuine appreciation for nurses and communicated the value of nurses to executive colleagues and to nurses themselves. In contrast, the hospital with lower nursing engagement reported less emphasis on championing the Forces of Magnetism because leaders reportedly believed a culture of excellence already existed.

A second finding was that organization-wide Magnetism did not take hold until manifested at the executive level as a top-down commitment to change. This finding was supported by the fact that direct care nurses could not consistently describe initiatives put in place to support the Magnet journey, whereas the engaged facility demonstrated awareness of Magnet initiatives at every level.

A third finding was that engaged nurses displayed a willingness to share information and participate in process improvement activities, which demonstrated a magnetized culture. Meanwhile, nurses reporting lower levels of engagement perceived formal processes, like nurse councils, as additional tasks and approached them as something to manage rather than a forum in which to advance quality care (Upenieks & Abelew, 2006). As such, they failed to connect councils to Magnet culture and perpetuated a fragmented professional construct.

Nurse-sensitive quality measure. Magnet hospitals provide optimal work environments for nurses so that they can deliver high quality care to patients and minimize risk of error with or without injury. An emerging measure of quality care in the acute setting is an indicator referred to in the literature as missed nursing care, unfinished care, or rationed care (Kalisch & Lee, 2012). Collectively, these concepts are labeled errors of omission.

In a study that addressed Lundmark's concern for limited relational studies, researchers explored the relationship between practice settings (structure), missed nursing care, and reasons for omitted care (process). An adaptation of Donabedian's framework, the Missed Nursing Care Model, formed the conceptual framework. The amount and type of missed care as well as reasons identified by nursing staff were measured on nursing units at Magnet and non-Magnet facilities using the MISSCARE Survey. The survey instrument was developed by researchers and tested in a three-hospital validation (n = 459 nursing staff) and a second ten-hospital validation (n = 4,288 nursing staff).

The study utilized a cross-sectional descriptive design and was conducted in 124 nursing units at 11 hospitals. Units were evenly divided between Magnet and non-

Magnet status and reflected a wide-range of diagnoses. Researchers achieved a response rate of 57.3% with a total sample size of 4,412 nursing staff. Overall, nursing staff at Magnet facilities reported significantly less missed care than their non-Magnet facility peers. Ten of 24 specific nursing care elements were omitted significantly more often at non-Magnet facilities and no elements were omitted more frequently at Magnet facilities. Significant variability was noted in turning, feeding, meal set-up, full documentation, patient teaching, mouth care, IV/central line site care, call-light response, medication effectiveness assessment, and skin/wound care. The top reasons for reported missed nursing care were communication and labor resources; neither of which was cited more frequently by Magnet nursing staff (Kalisch & Lee, 2012). Two limitations were identified in this study. First was the inability to generalize findings from this study's 11 hospital sample to all hospitals. The second limitation was that missed nursing care was retrieved from staff perceptions rather than direct observation.

Results of this study are promising. Missed nursing care reflects a new dimension of quality measurement and additional studies have the potential to contribute to current evidentiary work by identifying how nursing process impacts patient outcomes. This study clearly highlights the value of Magnet culture.

Enculturation

ANCC's vision statement for Magnet organizations informs stakeholders what to strive for as they seek a cultural transformation: "Magnet organizations will serve as the fount of knowledge and expertise for the delivery of nursing care globally" (ANCC, 2013, p. iii). Transformation, or enculturation, is enhanced through integration of a well-designed professional practice model (Berger et al., 2012; Smith & Kehl, 2009).

In their quest to transform nursing culture at a 800-plus bed academic medical center, Jost and Rich (2010) examined elements of professional practice. They began by reviewing four characteristics of nursing that distinguish it as a profession. The nursing profession has a distinct knowledge base, autonomy of decision making, a peer-reviewed practice, and professional standards of practice (Jost & Rich, 2010, p. 32). One of their challenges was to ensure the essence of nursing practice was not lost in the cultural transformation. Their strategy placed the nurse-patient relationship at the pinnacle of their practice model and unified the nursing identity while also reinforcing the valuable work of nursing.

Military Perspective

Researchers studied the impact of nursing structures and processes on patient outcomes in military hospitals (Kee, Foley, Dudley, Jenkins, Minick, & Harvey, 2005). Patients and nurses on adult medical-surgical and intensive care units at two U.S. Army hospitals were recruited for this study. Nonprobability samples of patients (n = 138) and nurses (n = 103) provided data to address outcomes and nursing processes. Structure was defined by unit type and clarified as critical care or medical-surgical nursing inpatient unit. Multiple data sources and survey instruments were used for data collection, including the Nursing Work Index-Revised (NWI-R). As noted by Lundmark, this instrument, which measures autonomy, control over practice, and nurse-physician relationships, has been widely used to establish differences between Magnet and non-Magnet hospitals.

Overall, there were minimal differences between unit types when comparing acuity, adverse events (falls, pressure ulcers, and urinary tract infections), and satisfaction

with pain management. Although intensive care patients were slightly more satisfied, there were no substantive relationships established between variables. Kee and colleagues (2005) attributed relative similarities in reported findings among unit types and nursing processes to unique characteristics of the military healthcare system that were not isolated in this study. For example, patients and staff shared many attributes including military experience, pay and benefits, values, and lifestyle. The nature of military training requirements suggest that differences are more likely to appear in rank (seniority) than in unit type, because most military nurses participate in advanced life support and trauma training. Finally, eligible beneficiaries receive no-cost or low-cost hospitalization as part of their military benefits, which may have accounted for similarities in patient responses for this study.

Military Practice Environments. Work environments provide the interface between direct care nurses and patients. As the frontline of patient care, characteristics of these environments leverage tremendous influence over perceptions of staff, their performance, quality of care, and patient outcomes (Kelly et al., 2011; Lang et al., 2012; Lundmark, 2008; Patrician, Shang, & Lake, 2010). Military and civilian registered nurses assigned to stateside U.S. Army hospitals were queried for impressions of their practice environment, quality of nursing care and factors influencing their perspectives. Practice environments were rated more favorably than unfavorably, with higher ratings reported among military respondents; however, job dissatisfaction was rated 27% overall, high emotional exhaustion was indicated by 30% of respondents, and 34% of the sample reported their intent to leave their position within twelve months. Researchers utilized the Practice Environment Scale of the Nursing Work Index and the Maslach Burnout

Inventory, both of which were well documented in the literature and yielded reliability and validity with previous participants (Patrician et al., 2010). The strongest indicator of negative work outcomes was a work environment rated unfavorably. Interestingly, neither skill mix nor education correlated with perceptions of positive or negative work environment in the military setting.

Combat Practice Environments. In a related study, researchers examined nursing practice environments and burnout of U.S. Army registered nurses and licensed professional nurses at two deployed combat support hospitals in Iraq. Burnout was then compared to a similar sample of nursing personnel at a stateside U.S. Army hospital. Like Patrician and colleagues (2010), researchers utilized the Practice Environment Scale and the Maslach Burnout Inventory-Health Services Survey (Lang et al., 2012).

A nonexperimental cross-sectional design was selected for this study of three convenience sample cohorts: (a) Combat Support Hospital Central East (n = 65); (b) Combat Support Hospital Northwest (n = 40); and (c) Stateside U.S. Army Hospital (n = 152). Researchers determined that nursing personnel in all groups were emotionally exhausted, with the smallest cohort (Combat Support Hospital Northwest) reporting lower, but statistically significant, exhaustion scores. Scores in the other burnout domains, depersonalization and reduced personal accomplishment, did not achieve statistically significant differences between units. Among the Combat Support Hospital cohorts, Northwest respondents rated all practice environment variables higher than their colleagues at Central East. Results were statistically significant for adequacy of staffing resources; leadership, management, and support for nursing; and participation in hospital governance. Collaboration with physicians was not significantly different with mean

scores of 2.65 and 2.70 out of 4. Interestingly, Kee and colleagues (2005) identified inverse nurse-physician relationship scores in their study as well, which may indicate that interprofessional practice behaviors warrant further study in military practice settings.

Although all cohorts were emotionally exhausted, causal factors varied among cohorts. Among the stateside cohort, additional responsibilities related to military nursing, night shift, caring for combat casualties, and working more than 80 hours in a two week period were primary factors in exhaustion. However, deployed cohorts identified perceived lack of support by management, foundations for quality care, suboptimal collegial relationships with physicians, and an extended work schedule as primary factors in exhaustion. Deployed cohorts also reported higher scores for depersonalization, which may indicate cynicism towards patients or a coping strategy employed to manage their response to recurring trauma and life-altering injuries.

The primary limitation of this study was lack of comparison data from pre or post deployment surveys, which could have provided additional context for analyzing results. The prevalence of burnout among nursing personnel in this study is concerning, but equally disturbing are the differences in factors contributing to burnout. While Lang and colleagues acknowledge additional study is needed, findings reinforce the importance of professional practice environments in all military settings. Given the benefits attributed to a culture of Magnetism, this study corroborates development of an Air Force PPM.

Reconciling military nurse roles. A significant difference between military nurses and nurses working in a civilian setting is that military nurses must perform as both professional nurse and commissioned officer. Griffiths and Jasper (2008) explored

the blend of personal, professional, and organizational beliefs of nurses and the triad's effect on their nursing role in a wartime environment.

This qualitative study employed in-depth interviews to elicit responses from a sample of 24 nurses serving in the United Kingdom's Navy, Army, and Royal Air Force. Researchers conducted interviews in three phases using purposive sampling to establish context, selective sampling for comparative analysis, and theoretical sampling to form a focus group of military nurses. Data were analyzed with open, axial, and selective coding. Open coding identified patterns and themes from interview notes. Axial coding was a continual process in which themes and patterns were sorted into categories and then re-sorted and re-ranked as additional data were analyzed. Selective coding resulted in three groupings: "it's just different levels" (p. 94), "that double hat" (p. 95), and "it's who we are!" (p. 96). These three groups formed a core category of "caring for war: transition to warrior" (p. 97). Data saturation was achieved after interviewing 16 military nurses and validated by a focus group of 8 military nurses (Griffiths & Jasper, 2008).

Researchers identified several salient response patterns in their study. First, contrasting roles may cause military nurses to compartmentalize their identities, a phenomenon referred to as mental fences (Griffiths & Jasper, 2008, p. 96). Another pattern noted was that military nurses in their sample adopted a generalist skillset to ease transitions between traditional and warrior nursing roles. Finally, researchers surmised that adequate preparation for all military nursing roles should be part of military induction. While adopting a generalist role identity might promote smoother role transitions needed to accomplish mission objectives in a high operations tempo

environment, this strategy may not allow nurses to appreciate the value of structures and processes that produce successful outcomes.

Elements of a Professional Practice Model

Hoffart and Woods defined a PPM as a "system (structure, process, and values) that supports registered nurse control over the delivery of nursing care and the environment in which care is delivered" (Hoffart & Woods, 1996, p. 354). Within a cohesive practice model are five subsystems that detail an organization's values, relationships, care delivery system, management approach, and mechanism of compensation and rewards. Hoffart and Woods compared these elements to a five-stranded rope, with the stabilizing strand representing core values of professional practice. Like a rope of intertwined strands, professional practice is strengthened by forming a cohesive framework of individual elements.

Professional Values

The first element of a practice model is professional values. The American Association of Colleges of Nursing describes the values of altruism, autonomy, human dignity, integrity, and social justice as fundamental to the discipline of nursing (American Association of Colleges of Nursing [AACN], 2008). These values have been reinforced in nursing's foundational documents.

From the moment individuals enter the Air Force they are taught the concept of *Airman-First* (SECAF, 2012). Air Force core values are the essence of Airmanship; integrity first, service before self, and excellence in all we do can be found in every aspect of an Airman's military service. Delivering excellent care with integrity reflects

core values, but does not explain the *how* of nursing practice. Rather than lessening the import of Airmanship, a PPM would illustrate how Air Force culture informs nursing practice.

Professional Relationships

The quality of professional relationships reflects values defined in the practice model. Relations with other healthcare partners are influenced by communication, collaboration, and respect (Hoffart & Woods, 1996). In light of recent emphasis on lowering healthcare costs, Jost and Rich (2010) cautioned readers to protect the relationship between nurse and patient. Without nurse-patient rapport, nursing could be diminished to a series of tasks and treatments.

Characteristics of Air Force culture minimize many of the relational challenges faced in civilian hospital organizations. *Airman-First* gives precedence to military rank over professional discipline, which helps equalize power and influence among members of the healthcare team. There are policies and mandatory training that address social issues like bullying and discrimination, as well as sanctioned agencies that monitor compliance and provide assistance to anyone concerned about a potential violation (SECAF, 2012). While this doesn't eliminate unprofessional behaviors entirely, it ensures available recourse and promotes accountability of Air Force members.

Patient Care Delivery System

A care delivery system is utilized to assign patient care and coordinate care amongst healthcare staff. There are many care delivery systems, but some of the most common are functional, team, primary, and patient-centered care (Hoffart & Woods, 1996).

Air Force acute care settings utilize nurse (officer) – medical technician (enlisted) teams. Musanti, O'Keefe, and Silverstein (2012) described a similar care delivery method called Partners in Caring involving registered nurse – nursing aide pairs. After specialized team training, pairs worked to the full scope of their individual practice and improved care for a team of patients. This framework has a theoretical and evidence base that may strengthen the link between care delivery and outcomes. Partners in Caring is particularly intriguing to this author because of potential applicability to current Air Force nursing care delivery.

Management Approach

The fourth element of a PPM addresses governance and decision making at every level. Organizations empower nurses and demonstrate their value and support of nursing by promoting decentralized decision making and participatory management practices (Hoffart & Woods, 1996). ANCC advocates for a shared governance approach. Magnet applications require evidence of CNO involvement and executive level authorities regarding nursing issues (ANCC, 2013).

The Air Force is a highly bureaucratic system with a well-defined chain of command. Fortunately, nurses are included in governance at every organizational level. There is an executive-level nurse position at every MTF, and all nursing units are managed by nurse corps officers or civilian nurse equivalents.

Compensation and Rewards

The final PPM element addresses salary, recognition, professional development and advancement of nurses within the organization. Clinical ladders, which promote professional nursing development, often focus on direct care nurses. In response,

Omoike, Stratton, Brooks, Ohlson, and Storfjell (2011) created a program to advance leadership skills in nurse managers. They recognized a void in skill development that was compounded by the escalating rate of change in healthcare. Hoffart and Woods (1996) categorized rewards according to three features: (a) funding related to temporary or short-term activity; (b) structural policies aimed at recognizing professional achievements; and (c) internally motivated projects or roles.

The Air Force has an enviable portfolio of compensation and rewards, including progressive levels of professional development designed to cultivate Airmanship and leadership (SECAF, 2001). The Nurse Corps career counseling tool is very helpful in identifying both short and long-term career goals and vectoring members towards future roles and training opportunities. Incentive special pay is available to nurses who are nationally certified and meet criteria (SECAF, 2009; Force Management Branch, n.d.). Nurse advancement is determined by the Air Force promotion system (SECAF, 2012), but opportunity is capped by Title X, Section 523 of United States Code (Defense Officer Personnel Management Act, 1980). Senior leaders are actively engaged in creating greater promotion opportunity for Air Force Nurse Corps officers (TNF, 2012).

Considerations for Air Force Professional Nursing Practice

Patient-centered care (PCC) has been reported in the literature as a philosophy of care for decades (Hobbs, 2009). However, it wasn't until the release of companion reports from the Institute of Medicine (Institute of Medicine [IOM], 1999; IOM, 2001) that PCC was linked to healthcare quality and outcomes. Described as "respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (IOM, 2001, p. 6), PCC was identified as one of six

core elements of quality care. These IOM reports renewed interest in PCC and generated a substantial increase in the volume of literature related to the concept.

Despite acceptance of the IOM findings and recommendations, the complexity of patient centeredness and the multitude of applications make PCC an elusive concept. A recurring theme within PCC literature is the lack of consensus regarding a definition (Carver & Jessie, 2011; Grob, 2013; Hobbs, 2009; Lones, 2011; Lusk & Fater, 2013; Pelzang, 2010; Small & Small, 2011). Hobbs (2009) recounted the evolution of PCC in acute care settings from an element of room design, emotional support, and meal selection to its role in admission, discharge and assessment processes. Others made it a foundation of primary care and patient-centered medical homes (Carver & Jessie, 2011; Lewis & Holcomb, 2012).

Engagement

Patients engage the healthcare system in response to real or perceived vulnerabilities in their well-being. Conditions revealed in in a dimensional analysis of PCC include response to illness, needs that exceeded capacity to self-manage, suffering, and disease condition (Hobbs, 2009, p. 55). Employing therapeutic engagement is an effective method of alleviating vulnerabilities of the patient and demonstrates understanding of PCC.

Patients and care providers also engage one another as bi-directional partners in care. They share power and responsibility for informed decisions about intervention strategies (Carver & Jessie, 2011), and rely upon a relationship of trust and clear communication to plan care. Nurses in acute care settings engage patients through a series of interactions. They rely upon collegial relationships and utilize documentation

and established hand-off processes to ensure continuity and consistency (Hobbs, 2009; Lones, 2011). In contrast, patient engagement in primary care settings is described as episodic and characterized by breaks in both time and patient condition (Hobbs, 2009; Lewis & Holcomb, 2012).

Nursing Presence

A number of similarities exist in the concepts of nursing presence and caring. For example, each occurs within the context of the nurse-patient relationship, and are terms that describe the art of nursing (Finfgeld-Connett, 2008; Kostovich, 2012; Osterman, Schwartz-Barcott, & Asselin, 2010). In a qualitative comparison and synthesis, Finfgeld-Connett (2008, p. 116) determined that are a "notable lack of differences" between nursing presence and caring. Further, both concepts are more evident in healthy work environments.

Presence in daily care. The concept of nursing presence has been explained as presence, partial presence, full presence, and transcendent presence. Presence occurs when two individuals share a space without any interaction. Partial presence indicates shared space with a focus on a particular task rather than the other individual, as when a nurse is documenting care or checking machine settings. Full presence occurs when there is intentional interaction between individuals within a shared space. Transcendent presence, is "more abstract and elusive" because it occurs when a spiritual connection takes place (Osterman et al., 2010, p. 198).

Extending their previously reported concept analysis of nursing, Osterman and colleagues applied their conceptual definitions of nursing presence to an actual care setting and refined characteristics for each of their conceptualized ways of "being there"

(2010, p. 198). A qualitative descriptive approach was selected to explore the use of presence on an oncology unit. A convenience sample of five oncology nurses and ten patients admitted to an oncology unit in a 275-bed community hospital in New England participated in this study. Data were collected by a single data collector. Data were gathered from direct observations, individual and group interviews with nurses, and individual interviews with patients. There were two notable findings in this study. First, nurses interacted with their patients in different ways reflecting their individuality, as well as their awareness of how patients were responding to them. Second, there was evidence of a deliberate process of being present that fluctuated according to the nursing task. For example, nurses demonstrated presence in their initial assessment of room safety and equipment, but were fully present when educating patients and responding to their questions.

Presence of nursing scale. In contrast to the explorative approach employed by Osterman and colleagues (2010), Kostovich (2012) conducted a psychometric assessment of new instrument intended to measure patient perceptions of nursing presence. Kostovich asserted that nursing presence was unique from presence described by other disciplines in that nursing care was built upon a "holistic multidimensional paradigm" (2012, p. 169). This assumption framed a study to test the researcher's conceptualization of nursing presence and assess reliability and validity of a 25-item Presence of Nursing Scale (PONS). A non-probability convenience sample of 330 patients admitted to one of four acute medical-surgical nursing units at a Midwestern community hospital was recruited for this study. The first part of the analysis was reserved for assessing the psychometric properties of PONS. Procedures for content validity, construct validity,

internal consistency reliability, and test-retest reliability were all described and supported by the literature. In particular, test-retest reliability was addressed because the procedures used for this study varied from recommended methods. There was a sound justification; however, the number of patients who completed the retest (n = 8) was cited as a limitation.

Once PONS was established as a valid and reliable instrument, demographic and survey data were analyzed and reported. A secondary analysis determined no significant differences in perception by participant groups: gender, previous admissions, length of stay at time of survey, ethnicity, and education level. This analysis improved the probability that the instrument could achieve accurate results in other populations (Schmidt & Brown, 2012). Given the increasing import placed on patient satisfaction, nursing leaders may be able to use this tool to target specific interventions that improve nursing presence and indirectly impact patient satisfaction while improving PCC (Kostovich, 2012).

Provision of Care

Another hallmark of PCC is continuity. From the patient's perspective, quality care is integrated and multidisciplinary. Members of the healthcare team (including the patient) communicate the plan of care and strive for seamless handoffs between services and care settings (Pelzang, 2010). Educating patients about their condition, signs and symptoms of deterioration, treatments, and follow-up are an expectation in all settings. Within patient centered medical homes, access to health professionals via telephone, secure messaging, virtual, or face-to-face appointments demonstrates appropriate demand

management and care from the right professional at the right time (Carver & Jessie, 2011; Lewis & Holcomb, 2012; Pelzang, 2010).

Change Fusion

Contemporary change theory requires active participation and shares a commonality with nursing in that individuals' reactions to change are the focus. (White, 2012). Fusing organizational change theory with appreciative inquiry is appropriate for introducing a culture of Magnetism because it references individual or team functions throughout the transformation process. Further, change fusion retains desired elements of Air Force nursing practice and ensures that transformation is framed in positivity.

Studies of more than 100 companies revealed that a phased process of sequential tasks is critical for successful transformation. Presenting facts that change the way one thinks are necessary, but data that change one's feelings have greater impact by instilling urgency and action in stakeholders (Kotter, 2007). Regarding policy, Kingdon conceded that not all issues elevate to problems: "For a condition to be a problem, people must become convinced that something should be done to change it" (Lewis, 2010). Kotter (2007) reported that more than 50% of organizations fail to generate urgency and action needed to implement change suggesting that setting the stage is one of the most critical steps in successful transformation.

The essence of appreciative inquiry (AI) is seeking to understand the social system within which transformation will take place (Richer, Ritchie, & Marchionni, 2010). Collaborative partnerships are a hallmark of the appreciative change paradigm, and reciprocal influences are evident in the interactions of individuals or groups of

individuals throughout an organization (Richer et al., 2010; Trajkovski, Schmied, Vickers, & Jackson, 2013). AI's positivity and individual engagement are ideal for Air Force nurses; soliciting their ideas and participation will ignite direct care nurses and empower them to drive change.

AI considers change in four non-linear phases, known as the 4-D process (Trajkovski et al., 2013). Discovery is a phase of appreciation. In this phase a group identifies influential motivators of the individuals and the organization. In the Dream phase, members envision results. Social norms and values emerge in this phase and future possibilities are introduced. The Design phase is also labeled co-construction. The group selects their ideal end point and describes how the selected course of action will impact the organization. The final phase is Destiny. In this phase, work of the previous phases is implemented and evaluated by asking "how to empower, learn, and improve" (Richer et al., 2010, p. 167).

CHAPTER 3. CAPSTONE PROJECT DESIGN

Project Design and Description

A collaborative, participatory design was developed for this evidence-based quality improvement project. The design promoted both consensus and appreciation, which were threaded into the project from its inception. A scholarly merit review of the capstone project was completed by the Department of Nursing DNP Progression Committee and approved as exempt and non human subject research by the Capella University Institutional Review Board.

Developing a Practice Model for Air Force Nurses

Air Force nurses do not currently utilize a PPM. This gap in practice was identified using the ANCC Assessment for Magnet Excellence tool (ANCC Magnet Recognition Program, n.d.). Standards for Air Force nursing practice are located in an assortment of documents, and there is no central repository that links them to one another or to AFMS doctrine. In contrast, a PPM is an essential tool used by Magnet organizations to communicate organizational values and expectations with patients, interprofessional partners, and one another (ANCC, 2013).

The proposed Air Force PPM (Figure 1) was inspired by a former TNF catch phrase: our true north is hi-touch, hi-care. Each element of the prototype describes a component of Air Force nursing. The outer blue ring symbolizes teamwork and synergy

created by the tenants of Airman, leader, legacy, and innovator. The blue circle in the center of the graphic represents patient centeredness. When nurses provide hi-touch, hi-care, the mission objectives are met and patients receive quality nursing care that is patient-centered, effective, efficient, timely, equitable, and safe (IOM, 2001).

Figure 1

Proposed Air Force Model for Professional Nursing Practice

Supporting Tenants

Four supporting tenants of hi-touch, hi-care philosophy were developed from this author's application of lived experience as a career Air Force Nurse Corps officer to guiding principles, strategic priorities, and Air Force Instructions. The four tenants addressed Airmanship, leadership, legacy, and innovation.

Airman. The *Airman-First* concept permeates Air Force doctrine. Although not specific to nursing practice, this tenant provides organizational alignment and helps define nursing identity within the context of military nursing. Elements of Airmanship

include physical fitness, medical readiness, deployment operations, developmental education, and the Uniform Code of Military Justice.

Leader. Leadership is a significant influence for both officer and nursing roles. Activities linked to leadership include the Air Force mentoring program, preceptorship, team leading, educational degree progression, professional certification, participation in unit committees and functions, and career development tools.

Legacy. Military traditions are an important part of Air Force culture. Historical figures and military operations are featured in many enlisted and officer training programs. This is also where foundational nursing documents and regulatory guidance are located. Air Force nursing core competencies, duty or role descriptions, and professional awards and recognition programs are additional components of the legacy of Air Force nursing.

Innovator. The final tenant of the proposed model blends Air Force and nursing priorities. The Air Force Chief of Staff coined the phrase *Every Airman an Innovator* to encourage new and better ways of performing the mission. A culture of inquiry signifies the import of research and evidence-based practice within nursing. Other activities that demonstrate innovation include simulation, military-civilian partnerships, social media, informatics, and performance management systems.

Rationale for Design Framework

An AI-infused organizational change theory was selected for project development and implementation. A unique quality of AI methodology is retaining elements of processes that work well and using the common ground as a starting point for

improvement (Richer et al., 2010; Trajkovski et al., 2013). This approach fosters a culture open to learning, innovation, and empowerment.

Capstone Project Intervention

Focus groups are frequently used during the discovery and dream phases of AI (Trajovski et al., 2013). Stakeholder-specific focus groups received an overview of the Magnet Model and the Magnet Recognition Program. Stakeholders were defined as direct care nurses in entry-level assignments, service-line consultants with operational-level focus, and executive nurse leaders serving in pinnacle positions.

Direct Care Nurse Focus Group

The first stakeholder group consisted of nurses engaged in direct patient care in an entry-level assignment. The perspectives of these stakeholders demonstrated a shared governance approach to PPM development. In order to achieve consensus, a PPM must support nursing practice at every level of the organization. Nurses in this focus group were invited to participate because they were enrolled in an Air Force-sponsored specialty care fellowship hosted at a Magnet-designated hospital. In addition to the Magnet overview presentation, participants were given copies of the host facility's PPM and asked about their awareness of the model and perceptions of how the model was used to inform nursing practice at the hospital. The proposed Air Force model (Figure 1) was then introduced so that nurses could provide feedback about the prototype and the value of integrating Magnet principles into Air Force nursing practice.

Service-line Consultant Focus Group

The second group was made up of subject matter experts assigned to an Air Force Staff Agency. These stakeholders facilitate policy implementation at the MTF level. Prior to this activity, service line consultants had limited knowledge of the Magnet Recognition Program. To increase Magnet understanding, participants attended an interactive tour at a Magnet-designated hospital before the Magnet overview presentation. These stakeholders provided insight into key concepts and images that symbolized Air Force nursing and nursing excellence within the Air Force environment.

Board of Directors

The final group of stakeholders consisted of executive nurse leaders assigned to pinnacle nursing positions throughout the Air Force. Their primary purpose for inclusion in this project was to champion the design and destiny of practice transformation. Support from these strategic-level executives was a critical measure of project success. Unlike the two focus groups, the primary activity involving executive nurse leaders was a two-day strategic planning summit. This scholar was invited to participate in strategic planning as the Air Force subject matter expert for the Magnet Recognition Program.

Assessment Tools

A scholar-developed questionnaire was used to evaluate consensus with elements of the proposed practice model. Positively framed statements supported the premise of appreciative inquiry. Space for free text comments was included to enrich respondents' feedback and inform discovery ("Difference Between," n.d.; Rattray & Jones, 2007; Trajovski, 2013).

The advantages of questionnaires include their simplicity and the relatively low price to produce and distribute. However, the free text element makes a questionnaire best for small respondent samples (Rattray & Jones, 2007). The stakeholder consensus questionnaire is located at Appendix C.

Other Evaluative Strategies

An essential piece of measurement planning is consideration of strategy and stakeholders. Harrison, Rouse, and DeVillers (2012, p. 243) suggest that "performance management needs to reflect particular organizational settings". Further, they argue that accountability and measurement are necessarily linked. Therefore, a comparison of stakeholder group comments is an important factor in measuring consensus and ensuring the model resonates with nurses at every level of the organization and in all practice settings.

Reliability and Validity

Specific to this project, validity was the accuracy with which the proposed model described and illustrated attributes of Air Force nursing. Reliability was the consistency with which the model described and illustrated Air Force nursing when applied to different specialties, practice settings, and stakeholder groups.

CHAPTER 4. ANALYSIS OF IMPACT

Findings

This chapter summarizes data collected during focus group presentations. The intervention strategy described in Chapter Three was designed to elicit consensus for change rather than to perform statistical analysis. A total of 22 active duty nursing services personnel in direct care or service-line consultant focus groups participated in the project. Focus groups took place in May and June 2014 and lasted approximately 75 minutes each. Although focus group feedback highlighted differences in perspective and perceived value of the proposed PPM, participants were united in their support for a culture of Magnetism.

Demographics

Direct care nurses (n = 11) were baccalaureate-prepared registered nurses with between three and six years of military service and nursing experience. All direct care nurse participants were fully qualified medical-surgical nurses transitioning to the critical care setting in a structured military-civilian fellowship located at a Magnet-designated level-one trauma center. Service-line consultants (n = 11) included both active duty nurses and enlisted nursing personnel. Education in this group spanned associate to doctoral level preparation. Years of military service varied from 13 to 29 years. All service-line consultants held administrative positions with no direct care activity.

Focus Group Data

The first questions posed to focus group participants solicited impressions of Air Force nursing within the context of the PPM prototype. Data are presented in Table 1.

Table 1

Average Ratings of Air Force Nursing Services

Focus Group	Current State	Desired State
Direct Care Nurses	2.7	4.5
Service-line Consultants	3.4	3.8

Question 1. To what extent does this model describe your current impression of Air Force Nursing Services? Direct care nurse responses ranged from 1 to 4 with an average rating of 2.7. Service-line consultant responses ranged from 3 to 4 with an average rating of 3.4. Said one participant from the direct care group: "I feel like leadership, officership, and excellence was not promoted well at my previous assignment". Regarding the model verbiage, a service-line consultant wrote: "hi-touch hi-care fails to recognize the science of nursing and makes it seem more maternal than scientific".

Question 2. To what extent does this model describe your desired impression of Air Force nursing services? Direct care nurse responses ranged from 3 to 5 with an average rating of 4.5. Service-line consultant responses also ranged from 3 to 5 with an average rating of 3.8. Among the direct care nurses, a sense of unclear expectations and role identity emerged. Said one participant:

> I love the mission and we're all about it [readiness] and I love serving, but I feel that this piece [practice model] is missing that helps tie it all together. I also feel we are VERY inefficient in how we apply our innovation and resources. How many man hours are wasted every day to

satisfy the COMPLIANCE piece versus the PATIENT CENTERED CARE? I'm very passionate about this and hope to change our culture for the better in the future.

Model Components. Focus group participants were asked to rate how well various elements of the proposed PPM captured Air Force nursing practice. Data are presented in Table 2. Additional comments and facilitated discussion produced a wide range of opinions and revealed a lack of consensus between groups and among participants.

Table 2

Average ratings for elements of the proposed professional practice model

Focus Group	hiTOUCH hiCARE	Team Work	Synergy	Airman	Leader	Innovator	Legacy
Direct Care Nurses	3.5	4	3.9	4.2	4.2	3.8	4
Service-line Consultants	3.4	4.4	3.2	4	3.8	3.6	3.6

Advancing Practice. The final question posed to focus groups was: to what extent do you perceive an Air Force practice model provides a framework for advancing nursing practice? The focus groups provided a similar range of responses to this question, with average ratings of 4.3 for direct care nurses and 4.4 for service-line consultants.

Analysis of Project Impact

The Magnet credential is a performance-based award reserved for healthcare organizations achieving sustained outcomes above national benchmarks in the domains of practice, leadership, improvements, and empowerment. An extensive collection of evidence linking cultural characteristics in Magnet organizations to better patient

outcomes has been published (Kalisch & Lee, 2012; Kelly et al., 2011; McClure, 2005). However, literature from Air Force healthcare settings is sparse. Developing an Air Force PPM has the potential to transform nursing practice culture across the AFMS.

Discovery and Dream

Data collected during facilitated focus group interactions ensures stakeholder inputs will be a key element in advancing nursing excellence. Stakeholder feedback clarified points of consensus while highlighting areas ripe for further study. Direct care and service-line consultant stakeholders supported Magnetism as the desired paradigm for nursing excellence. However, the proposed PPM did not garner united support. While service-line consultants endorsed the overall project for executive level consideration and continued study, they rejected the prototype.

Design

Feedback from the third stakeholder group, executive nurse leaders (n = 21), was collected at a strategic planning offsite. During the two-day workshop, a number of strategic initiatives specific to advancing nursing excellence were proposed and accepted for the TNF strategic plan.

The TNF strategic plan now identifies the Magnet Recognition Program as the framework for Air Force nursing excellence. This significant achievement marks the beginning of a deliberate practice culture transformation. ANCC's Magnet Recognition Program promotes nursing leadership, exemplary practice, empowered structures, innovation, and measurable outcomes. With full support of the Air Force Nursing Board of Directors, Magnet-specific content is being inserted into all formal Air Force nursing courses and symposiums.

CHAPTER 5. IMPLICATIONS AND CONCLUSIONS

Implications for Practice

Excellence is a universal healthcare value, but advancing it as a culture can be a daunting task in many organizations. In order for transformational change to occur, structural components must be fortified to support reimagined processes. In a study of nurse engagement, researchers concluded that executive leaders were the most influential factor for incorporating new structures and processes (Upenieks & Abelew, 2006). Similarly, this project has demonstrated that strategic level support and endorsement are essential to transformational efforts. Infusing Air Force nursing policies with the nursing excellence framework ascribed by the ANCC has the potential to enrich a practice culture that exists to care for this nation's active duty and retired military service members and their families.

Transformational leaders create an environment that fuels energy, creative thinking, and innovation (Botting, 2011; Doody & Doody, 2012). These characteristics and more will be necessary to realize the destiny envisioned by Air Force nursing stakeholders. At the heart of transformational change is an individual's reaction to change. While vision and influence are traits associated with executive leaders, the actual practice change stems from an engaged workforce that has been empowered to act and drive informed practice improvements.

The Secretary of Defense recently ordered a comprehensive review of the military health system (MHS; *MHS Review*, 2014). This fortuitous event provided strategic-level endorsement for advancing excellence. A DoD-chartered panel, including six renowned experts from the civilian healthcare sector, analyzed MHS data and processes related to access, quality, and safety. Panel members then compared MHS data to that of three external healthcare systems, which provided data strictly for comparative analysis.

Findings presented in the final review confirmed that the provision of care in the MHS is safe, timely, and achieves outcomes comparable to civilian care settings. The panel also discovered broad performance variability across the MHS. Variability was noted between MTFs and within specific performance measures. Accordingly, six recommendations were submitted to the Secretary of Defense:

I. Take immediate action to improve underperformance
II. Establish clear enterprise performance goals with standardized metrics and hold the system accountable for improvement
III. Make good decisions by relying on accurate data
IV. Show information to everyone – patients, providers, and policy makers
V. Drive the necessary change with MHS governance
VI. Leverage common standards and processes to facilitate improvement (MHS Review, 2014, p. 7-8).

Adopting a culture of Magnetism positions Air Force nurses to address the MHS review recommendations and influence AFMS transformation. In particular, the Magnet framework offers evidence-based standards and processes for improvement. As this destiny is realized, nurses at every level of the organization will be able to articulate their contributions to quality care across the spectrum of health.

Summary of Outcomes as Related to Evidence-Based Practice

The aim of this Capstone project was to infuse Magnet characteristics into Air Force healthcare settings in order to transform a global organization's practice culture and advance nursing excellence. The primary aim of this project was accomplished. The recently approved TNF strategic plan validated that senior nursing leaders associate Magnetism with nursing excellence.

The first objective developed for this project was to develop an Air Force consensus model for professional nursing practice. This ambitious goal was not realized within the compressed timeframe of a scholarly project. Instead, stakeholders opted to incorporate this task as an initiative within the TNF strategic plan. Model development will continue as a collaborative research study informed by the findings presented in this capstone project.

A second objective developed for this project related to a performance-based practice culture. One example of how Magnetism is gaining momentum within Air Force nursing is a demonstration project to define the role and validate the impact of clinical nurse specialists (CNS) in Air Force practice settings. This project addresses the transition of advanced practice nurses into clinical settings. Participants are working within an established CNS conceptual framework to create a standardized dashboard of performance measures that emphasize the outcomes they influence rather than the work that they do. In addition to supporting TNF strategic objectives, the CNS demonstration project is defining how nurses practice within the federal system of care.

The third objective developed for this project involved the integration of Magnetism into TNF doctrine. Significant progress toward achieving this milestone was

noted. As a core element of the TNF strategic plan, a number of initiatives have been approved. They include formal course curriculum updates to socialize components of the Magnet Model, analysis of advanced degrees earned by nurses, and defined transitional milestones for advanced practice nurses and other specialty roles in the TNF. These initiatives are important steps in the enculturation process.

Conclusions

This capstone project established evidentiary rationale for embracing the Magnet framework of nursing excellence and integrating elements of Magnetism into Air Force nursing doctrine. Infusing Air Force nursing policies with elements of Magnetism enriches the emerging performance-based culture envisioned by AFMS senior leaders. The need for a clearly defined practice framework was supported by comments and feedback during the discovery and design themed stakeholder focus groups. Nurses provided candid feedback about the proposed PPM, and indicated a need for an occupational identity separate from that of their military role. Without exception, nurses reported a desire for patient-centeredness in their practice and proposed PCC as a unifying element of Air Force nursing practice.

The Magnet credential is recognized as the gold standard for nursing excellence. Consistent with elements of Magnetism and AI, a collaborative effort involving Air Force nurses at all levels of the organization produced benchmarks for transformation. The most significant indicator of project impact was the incorporation of Magnet principles into the TNF strategic plan. A platform now exists for developing a culture of Magnetism and advancing nursing excellence throughout the AFMS.

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APPENDIX A. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University's Academic Honesty Policy (**3.01.01**) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

> Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)
>
> Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (**3.03.06**) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

> Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (**3.01.01**) and Research Misconduct Policy (**3.03.06**), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.

Learner name and date	*//signed, dlz, 10feb15//* Deedra L. Zabokrtsky February 10, 2015
Mentor name and school	LYDIA FORSYTHE, PhD, MA, MSN, CNOR, RN School of Nursing and Health Sciences

APPENDIX B. RELEVANT TERMS AND ACRONYMS

AFMS	Air Force Medical Service.
Airman	An airman can be an aviator or an enlisted rank in the U.S. Air Force. When a capital Airman is used, it signifies a member of the U.S. Air Force of any rank or specialty.
Consensus	Consensus is a method of collaborative problem solving, or in the case of this project, it is a collaborative way forward. Similarly, evidence-based practice (EBP) is a problem solving approach to clinical practice. It includes the critical appraisal of relevant research, one's clinical experience, and preferences and values of the stakeholder (Melnyk & Fineout-Overholt, 2011).
DoD	Department of Defense.
Medical Treatment Facility (MTF)	An MTF is an Air Force medical center, hospital, ambulatory care, or dental clinic where patient care is delivered. An MTF can include both inpatient and outpatient care services.
Outcome	Quantitative and qualitative evidence related to the impact of structure and process on the patient, nursing workforce, organization and consumer. These outcomes are dynamic; measurable; and may be reported at an individual unit, department, population, organizational level. These are the changes (desirable or undesirable) in individuals and populations that can be attributed to healthcare (ANCC, 2013, p. 4, 72).
Process	Magnet describes processes as actions involving the delivery of nursing and healthcare services to patients, including practices that are safe and ethical, autonomous, evidence-based, and focused on quality improvement. These are the activities constituting healthcare including diagnosis, treatment, rehabilitation, prevention, and patient education – usually carried out by professional personnel, but also including other contributions to care, particularly by patients and their families (ANCC, 2013, p. 4, 73).

Structure	Magnet describes structures as characteristics of the organization and the healthcare system. They include leadership, availability of resources, and professional practice models. These are the conditions under which care is provided, including material resources, human resources, and organizational characteristics such as the organization of the medical and nursing staffs, the presence of teaching and research functions, kinds of supervision and performance review, and methods of paying for care. (ANCC, 2013, p. 4, 75).
Total Nursing Force (TNF)	The TNF includes nurses, aerospace medical technicians, surgical services technicians, and government service civilian nursing personnel serving in the active, reserve, or guard components of the Department of the Air Force.

APPENDIX C. STAKEHOLDER QUESTIONNAIRE

Stakeholder Consensus Questionnaire: Air Force Professional Practice Model

A Professional Practice Model is the overarching conceptual framework for nurses, nursing care, and interprofessional patient care. It is a schematic description of a system, theory, or phenomenon that depicts how nurses practice, collaborate, communicate, and develop professionally to provide the highest quality care for those served by the organization. The professional practice model illustrates the alignment and integration of nursing practice with the mission, vision, values, and philosophy that nursing has adopted (ANCC, 2013, pp. 21-22).

To what extent does this model describe your:	1 = Not at All 3 = Somewhat 5 = Very Close (please circle your response)
Current impression of AF Nursing Services?	1 2 3 4 5
Desired impression of AF Nursing Services?	1 2 3 4 5
Additional impressions of AF Nursing Services:	
To what extent do the following elements capture Air Force nursing practice:	1 = Not at All 3 = Somewhat 5 = Very Close (please circle your response)
▪ hi-TOUCH, hi-CARE	1 2 3 4 5
▪ Teamwork	1 2 3 4 5
▪ Synergy	1 2 3 4 5
▪ Airman	1 2 3 4 5
▪ Leader	1 2 3 4 5
▪ Innovator	1 2 3 4 5
▪ Legacy	1 2 3 4 5
Additional elements of AF nursing practice:	
Does this model address relevant professional, regulatory, and Service-related guidance?	1 2 3 4 5
What additional aspect or aspects of AF nursing practice would you incorporate into a practice model?	

To what extent do you perceive an Air Force practice model provides a framework for:	1 = Not at All 3 = Somewhat 5 = Very Close (please circle your response)
Advancing nursing practice	1 2 3 4 5
Developing the next generation of nursing leaders	1 2 3 4 5
Promoting health for all we serve	1 2 3 4 5