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An Essential Perspective of Surgery: a Family Nurse Practitioner Clinical Care Model

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Running head: AN ESSENTIAL PERSPECTIVE OF SURGERY

AN ESSENTIAL PERSPECTIVE OF SURGERY: A FAMILY NURSE
PRACTITIONER CLINICAL CARE MODEL

MICHELLE D. JOHNSON

Submitted in partial fulfillment of
the requirement for the degree of
Doctor of Nursing Practice

AUSBURG UNIVERSITY
MINNEAPOLIS, MINNESOTA

2018

**Augsburg University
Department of Nursing
Doctor of Nursing Practice Program
Scholarly Project Approval Form**

This is to certify that **Michelle Diann Johnson** has successfully presented her scholarly doctoral project entitled: **“An Essential Perspective of Surgery: A Family Nurse Practitioner Clinical Care Model”** and fulfilled the requirements of the Doctor of Nursing Practice degree.

Date of presentation: March 21, 2018

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Presentation

1:1 Clinical Care Model: Implementation of Family Nurse Practitioners in Surgery

October 3, 2016

Association of periOperative Registered Nurses (AORN)

Hiawathaland Chapter #2402 Meeting

Rochester, Minnesota

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Abstract

An Essential Perspective in Surgery: A Family Nurse Practitioner Clinical Care Model

Family Nurse Practitioners provide efficient, cost effective and safe care to patients in a variety of healthcare settings. Through the implementation of a clinical care practice model, the role of the Family Nurse Practitioner is a part of the multidisciplinary team caring for the outpatient surgical population. Patient satisfaction, system and patient benefits, including potential for increased revenue and effects on continuity of care across the spectrum of the surgical journey will be evaluated. This scholarly project examines the evidence in the form of literature review, conceptual and theoretical frameworks to evaluate the 1:1 clinical care model utilizing a Family Nurse Practitioners as part of the multidisciplinary team in the care of the outpatient surgical patient. The model was presented to a group of perioperative professionals belonging to the Association of periOperative Registered Nurses (AORN). Feedback in the form of a guided discussion and notecards provided networking opportunities, grey literature ideas, and further ideas for implementation locations. The eight Essentials of Doctoral Education for Advanced Practice Nursing were accomplished through completion of the project.

Key words: Family Nurse Practitioner, Surgery, Patient Experience, Continuity of Care

An Essential Perspective in Surgery: A Family Nurse Practitioner Clinical Care Model

Chapter One: Introduction

Family Nurse Practitioners (FNPs) are changing the way healthcare is delivered in a variety of healthcare settings. Increased patient, family and multidisciplinary healthcare team satisfaction, cost reduction and quality, safe patient care result from FNP provided services. The outpatient surgical environment can benefit from the implementation of a 1:1 FNP to Surgeon clinical care practice model because of the unique challenges and barriers that are present in the surgical environment.

To better understand the environment of surgery, it can be compared to that of a circus. Both have intricate moving parts, multidisciplinary teamwork and great potential for injury and death hanging in the balance. Just as tickets are paid for admission, patients pay money and expect results. With the changes in healthcare reimbursement, if the audience is not satisfied there is less reimbursement for the organization. Surgery and the circus are challenging, stimulating and exciting environments. They are both full of surprises, where participants learn to expect the unexpected and the environment is in constant evolution. The external colorful outfits of the circus reflect the internal colorful personalities present in the surgical setting. These diverse settings present many challenges. Implementing an FNP in the surgical setting is like a safety net under the acrobats or a director giving cues to the next act. The surgeon or ringmaster runs the show; however, the FNP enhances the experience and ensures smooth operation, increases audience member satisfaction, and optimizes the performance potential.

Problem Statement

Operating rooms (ORs) are one of the biggest financial engines and revenue creators of the healthcare locomotive (Marcario, 2010). Ineffective utilization of expensive OR time related to starting time delays is a major problem (Vermaat, Verver, Bisgaard, & Van, 2009). Obtaining a thorough and accurate history and physical of a patient preoperatively is essential to providing anesthetic and surgical care for the patient without delay (Varughese, Byczkowski, Wittkugel, Kotagal, & Kurth, 2006). Other possible delays include missing informed consent, site marking, documentation and lack of patient, family, and multidisciplinary team education. Lack of communication and distractions from paging and phone calls are some of the leading causes of error in the OR (Webster et al., 2008). These errors or delays in OR time result in costly consequences for the patient and healthcare institutions. Throughout the surgical experience, there are many opportunities for error and potential patient harm. Implementation of an FNP as part of the multidisciplinary team in the outpatient surgical setting provides a safe, cost-effective and efficient solution to improve the surgical patients experience.

Purpose of the Scholarly Project

The purpose of this project is to identify and implement a clinical care practice model for FNP delivered care in the outpatient surgical setting. Through a review of the Evidence-Based Practice, Mētis-Based Practice and nursing theoretical literature on the topic of FNP utilization in a variety of settings, this project will explore the benefits and outcomes of clinical care practice model implementation. FNP's in the outpatient setting can be utilized to expedite the surgical journey by orchestrating and collaborating with

the multidisciplinary team and collecting and interpreting pertinent patient data throughout the perioperative experience. In the outpatient surgical setting, there is increased patient satisfaction, system, and patient benefit and increased continuity of care with the utilization of FNPs (Kelly, Sweet, & Watson, 2001; Barnett, 2005; Horn, Badowski, & Klingele, 2014).

Clinical Question

Does the utilization of FNPs in the outpatient surgical setting, provide a system and patient benefit, alter patient satisfaction scores and impact continuity of care compared to the standard physician initiated surgical experience?

Objective

To explore a 1:1 clinical care practice model with FNP delivered services in the outpatient surgical setting and evaluate the benefits and level of patient satisfaction related to continuity of care.

Patient population and Healthcare setting for implementation of Project

Outpatient surgical patients at local hospitals in Minnesota.

The Essentials of Doctoral Education

In fulfillment of The Essentials of Doctoral Education for Advanced Nursing Practice (American Association of Colleges of Nursing, 2006), this project will explore the scientific underpinning for practice by developing a new practice approach in outpatient surgery based on the integration of recent research and data (I). Project implementation will improve access to quality and cost-effective healthcare while challenging and evaluating the current healthcare practices (II). This project will enhance the outpatient surgical practice and improve patient outcomes with decreased

complication and readmission rates (IV). Interpretation and disbursement of health information in the form of perioperative education are vital roles of the FNP in the outpatient surgical setting for patients, caregivers, and healthcare team. Interprofessional collaboration and multidisciplinary teamwork orchestrated by the FNP in this clinical care practice model will improve patient outcomes and continuity throughout the spectrum of surgical care (VI). Exploring new roles for FNPs through the implementation of a 1:1 clinical care practice model in the outpatient surgical setting results in the advancement of nursing practice (VIII).

Chapter Two: Literature Review

Family Nurse Practitioners (FNPs) are quickly filling the accessibility gaps in the healthcare delivery system, providing safe, efficient and quality care to patients. A review of the literature demonstrates overall satisfaction with FNP provided care in a variety of healthcare settings and diverse roles and a variety of practice models. While FNPs have become commonplace in the primary care clinical areas, there has been limited research into the utilization of FNPs in the surgical setting. Throughout the surgical experience from the initial consult clinic visit to receiving a diagnosis, decision of treatment, treatment implementation, and the recovery process, each step can be overseen by an FNP.

Patient satisfaction is a spreading factor in how hospitals and health care institutions are being reimbursed for services related to changes in reimbursement from The Centers for Medicare and Medicaid Services (CMS) (2015). Surgery is one of the highest institutional expenses and drives the economic engine for hospitals (Marcario, 2010). Patient satisfaction with their surgical experience is driving how hospitals are being paid for their services (CMS, 2015). As a result, the need to investigate ways to improve patient satisfaction is of dire importance to our hospital's survival and success as an institution. While there are numerous studies that examine the impact on the patient satisfaction of utilizing nurse practitioners (NPs) in the primary care setting, there are few studies have been conducted concerning the surgical patients experience. A review of the literature is categorized by the satisfaction of patients, family, and the multidisciplinary team, financial and cost consideration, patient and system benefits including continuity of

care, preoperative assessment and lastly, an example of a successful clinical care model and implementation.

Patient Satisfaction

After a review of the literature with key terms such as family nurse practitioner, patient satisfaction, and outpatient or ambulatory surgery, it was evident that there was a distinct lack of literature in this practice area. A refined search that included only the terms nurse practitioner and patient satisfaction produced an abundance of research related to NPs and patient satisfaction in a multitude of specialty areas such as primary care, emergency department, and clinics. The literature contained a majority of quantitative articles with a few key qualitative additions. Publication ranged in geographical location from Canada, the United States to the United Kingdom, New Zealand, and Ireland.

Research results did not vary by the geographical location or type of healthcare delivery system in those locations. In the publicly funded healthcare systems in the U.K. and Canada, patient satisfaction had an inverse relationship to waiting times. Resulting in overall greater satisfaction with NP provided care opposed to a longer wait time to see a physician (Sarro, Rampersaud, & Lewis, 2010; Thrasher & Purc-Stephenson, 2008; Williams & Jones, 2006). New Zealand and Ireland have a combination of both private and public funded healthcare systems and produced the same results in their research of increased satisfaction with NP delivered care in the areas of hematology and primary care (Gagan & Maybee, 2011; Kelly, Dowling, Burke, & Meskell, 2013). Across the world, the literature shows NPs providing quality, cost effective, satisfactory care.

Patient's perception of NP provided care is a prevalent topic in the literature.

The evolution of practice is evident when examining the literature on NPs. Literature from the 1990's focused on defining the role and scope of practice of the NP and articles with later publication dates focused increasingly on statistics of patient satisfaction and cost-effective care provided in a multitude of settings. Many studies on patient satisfaction also assessed for role perception and understanding (Gagan & Maybee, 2011).

The number of participants in each study varied widely with the least number of participants being 10 (Williams & Jones, 2006) in a qualitative interview and 2,053 participants in an electronic survey study conducted by Dill, Pankow, Erickson, and Shipman (2013). The majority of the literature stated 150-300 participants. These studies have adequate sample size according to multiple different calculation tools and have sufficient power to prevent type II errors (Houser, 2015).

Ethical consideration was discussed in half of the articles reviewed. Studies that did address ethical concerns mentioned approval gained from the local ethics committee, Institutional Review Board, research ethics board, or ethics review board. Maintaining ethical consideration and protecting research participants is necessary to produce quality research results (Houser, 2015).

An article from Baton Rouge, Louisiana from Lucie Agosta Ph.D., RNC, (2009) was found after searching for the source of a validated tool used in other studies to assess patient satisfaction with NP provided care. The tool, entitled "Psychometric Evaluation of the Nurse Practitioner Satisfaction Survey (NPSS)" provides excellent detail and statistics on the testing and compilation of a validated assessment tool. While complex, the article, in collaboration with a statistician, proves reliable and valid in measuring patient

satisfaction. The NPSS validated tool can be reproduced in an outpatient surgery setting to assess patient satisfaction with FNP provided care.

A qualitative article entitled, “Acceptance of Nurse Practitioners and Physician Assistants in Meeting the Perceived Needs of Rural Communities” interviewed 30 participants in an organized focus group lead by a trained investigator. The article provides a thorough analysis of themes from participant responses (Baldwin, Sisk, Watts, McCubbin, Brockschmidt, & Marion, 1998). All interviews were tape-recorded and transcribed, and saturation was achieved after four focus groups with a fifth focus group scheduled and completed. The author’s main findings included lack of previous experience with NPs and overall acceptance of the role.

Cole, Mackey, and Lindenberg, (1999) conducted an additional psychometric evaluation of an instrument measuring patient satisfaction with NP provided care. In contrast, to the article written by Agosta (2009), this article contains design flaws. A convenience sample of university and community primary care patients, who receive care at the University of Texas Health Services, were assessed. This population is not broad enough to generalize overall satisfaction with all NP provided care as the title suggests. The questionnaire was administered by a receptionist and not a trained individual which, could have resulted in bias or misinformation given to participants. Lastly, their analysis of the instrument is brief but sufficient. Overall, the article produced an instrument to assess patient satisfaction with NP provided care in a primary care setting however the tool would require additional research to ensure reliability and validity of the instrument.

An article by Dill, Pankow, Erikson, and Shipman, (2013) gathered information from an online survey in which panelists were recruited via email. This quantitative study

did contain a qualitative aspect in the form of an open-ended question at the end of the survey. The study had the largest number of participants being 5,533. The authors found that NPs are a solution to the physician shortage and lack of access to primary care. In some cases, the authors noted role confusion and difficulty distinguishing provider types (MD vs. NP), but patients voiced overall satisfaction with care received. Decreasing the amount of time patients had to wait to be seen was an additional benefit of the utilizing NPs in the primary care setting.

Unlike the previous articles that focused mainly on the adult population, Evangelista, Connor, Pintz, Saia, O'Connell, Fulton, and Hickey (2012) conducted a prospective descriptive, comparative study of 128 convenience-sampled patients at a children's hospital. This quantitative study also contained two qualitative questions that allowed participants the opportunity to explain their experience. There was no statistical significance found between patient satisfactions with physician-managed care versus pediatric NP in the cardiology clinic setting. Meaning, NPs in this role, provide a quality solution for increasing access to care and increasing satisfaction.

Gagan and Maybee (2011) conducted a descriptive correlational study on patient satisfaction with NP provided care in the primary care setting in New Zealand. This article utilized an adapted validated tool from Thrasher and Purc-Stephenson (2008) who created a 21-item 4-point Likert scale questionnaire to assess patient satisfaction in the emergency department in Canada. Both survey tools are statistically validated as an instrument to measure patient satisfaction. Thrasher and Purc-Stephenson (2008) and Gagan and Maybee (2011) found overall satisfaction with NP provided care in different care settings such as primary care and the emergency department.

A tool found to be reliable and valid in assessing patient satisfaction with NP provide care was Green and Davis (2005) who utilized the Caring Behaviors Inventory (CBI) and Jean Watson's theory of caring. In Ireland, Kelly, Dowling, Burke, and Meskell (2013) also utilized the Cronbach alpha testing to validate their assessment tool, a 23-item Likert questionnaire that also contained an open-ended qualitative item to allow for additional comment on the patient experience. Kelly, Dowling, Burke, and Meskell (2013) utilized a cross-sectional random sample of 142 patients in a hematology specialty center to conduct their study. Even though the sample collection methods varied from mail-in survey responses and secretary administered survey, the overall results from the two studies were the same. In Ireland and New Zealand, the authors concluded that NPs received high levels of satisfaction with hematology and primary care patients.

A quantitative descriptive study from Ontario, Canada assessed patient satisfaction in NP-led spine consultation ambulatory clinics. Sarro, Rampersaud, and Lewis (2010) surveyed 177 pre-selected patients utilizing the Consultation Satisfaction Questionnaire (CSQ) which utilizes a 5 point Likert scale. The researchers found NPs provide effective and efficient care in this specific setting. The researchers gained approval from an Ethics Board and assured the patients privacy to complete the survey as to avoid any possible bias.

A qualitative randomized control trial from Wales (Williams, & Jones, 2006) revealed the NPs ability to devote more time to consultation visits with patients. This enabled patients concerns to be fully explored and for the NP to offer strategies, other than prescribing, which provided a sense of empowerment to the patient that would not have been achieved through a shortened consultation time with a physician. This

qualitative study of 10 participants provides insight into how NPs provided care takes a different approach to that of the medical model of care.

A quantitative cross-sectional survey by Jones, Hepburn-Brown, Anderson-Johnson, and Lindo (2014), examines the patient satisfaction with NP delivered care in Jamaica. This study contained sufficient sample size of 120 participants over the age of 18. The authors discussed obtainment of ethical approval and informed consent. The study found high levels of patient satisfaction with NP performed services in two primary care settings Jamaica.

At Nationwide Children's Hospital in Columbus, OH a new clinical care model was implemented that adopted 1:1 surgeon to NP ratio. With this model, they found an increase in patient satisfaction, a reduction in phone calls related to questions about home care, and delivery of perioperative education leading to fewer patient perioperative issues (Horn, Badowski, & Klingele, 2014). This model shows the direct impact that NP provided care can have in the surgical setting.

Family Satisfaction

While many studies examined the patient's perception of their satisfaction, the family or caregivers are also a large part of the patient's support system and a crucial element of the surgical experience. Particularly in the realm of pediatrics, the family is increasingly important in the care and treatment of the patient. FNPs are found to ease anxiety and provide conclusive and thorough pre and post-operative education to pediatric patients and their families (Kelly, Sweet, & Watson, 2001). Counseling and education for patients and their families are major components of the perioperative care provided by an FNP (Guido, 2004). A review of the literature established decreased

parent and child anxiety with preoperative education related to pediatric outpatient surgery being provided by an NP (Frisch, Johnson, Timmons, & Weatherford, 2010). Knowledge is power and empowering patients, and their families are one way the FNP can aid them throughout the surgical process. Patients and caregivers are not the only learners in the healthcare community. While providing crucial patient and family education is a daily function of FNPs, other personnel and team members are continually learning from the FNP as well. The FNP provided care is impacting all those involved in the care of a patient in surgery (Horn, Badowski, & Klingele, 2014).

Team Satisfaction

Other members of the multidisciplinary team including residents, anesthesiologists, surgeons, CRNAs and nurses, caring for the patient and family experienced increased satisfaction with the addition of an NP to the surgical team. Residents and academic teaching institutions are facing increased challenges, with reduced working hours the pressure to maintain high patient volume and increase patient satisfaction. Holleman, Johnson, and Frim, (2010) found that, in response to work hour reduction, surgical departments have struggled to maintain surgical volumes, optimize education of residents, and provide safe, and efficient patient care. The solution that the academic pediatric neurosurgical services arrived at was the implementation of an NP. Holleman, Johnson, and Frim (2010) concluded that the number of potentially distracting and time-consuming pages and calls the resident received drastically decreased with the implementation of an NP in a pediatric neurosurgical service.

Anesthesia team members also expressed satisfaction with the implementation of NPs. Allowing anesthesiologists and other members of the anesthesia team to remain in

the OR and transferring the preoperative assessment to an NP was found to be efficient and beneficial (Kelly, Sweet, & Watson, 2001). The preoperative assessment, history and physical must be completed by personnel familiar with anesthesia requirements and be sensitive to the efficient use of costly OR time (Barnett, 2005). In a single-center, prospective, observational, longitudinal study with pre and posttest, Varughese, Byczkowski, Wittkugel, Kotagal, and Kurth, (2006) achieved increased levels of patient and staff satisfaction while providing timely, safe and effective care. In this study, they were able to transfer two anesthesiologists back to the operating room and out of the preoperative area. These positive outcomes were achieved with the implementation of an NP assisted preoperative evaluation.

In a survey questionnaire Holleman, Johnson, and Frim (2010) found that overall satisfaction of physicians, nurses and allied care providers increased with the addition of an NP, not specifically an FNP, to an academic pediatric neurosurgical service. Others research stated that having an NP in, specifically pediatric orthopedic surgery, elevated patient care from the standard resident or physician lead care that was originally implemented (Horn, Badowski, & Klingele, 2014). Completing tasks in collaboration with physicians, residents, and anesthesiologists have had proven benefit, but NP interaction with staff nurses has also led to increased satisfaction of team members. Nurses commonly teach other nurses and the FNP role is no exception to the collaboration among different health care providers (Hylka & Beschle, 1995). Hylka and Beschle (1995) also found an added benefit of utilizing NPs in the department of surgery included informal teaching that occurred in patient care areas between the NP and other

staff members. An FNP in the surgical setting is a resource to all team members that allows streamlining of the admission and presurgical process (Barnett, 2005).

Webster et al. (2008) examined the quality and safety problems in the ambulatory environment. The authors established that missed or delayed diagnosis, delay in proper treatment or preventative services, problems with medications or adverse drug events and communication and information flow processes were the key problem areas in ambulatory surgery. Their primary solution was to improve and strengthen the team approach when working with ambulatory patients. The authors concluded that an FNP is a key player in the implantation of the purposed tools and strategies including leading briefs, huddles, debriefs and using a closed-loop and structured communication techniques and Situation Background Assessment Recommendation (SBAR) communication tools. This article states that NPs are an asset to a patient's care team.

Not only can the utilization of NPs enhance team collaboration, efficiency, and satisfaction but, an additional benefit is cost reduction. According to Frisch, Johnson, Timmons, and Weatherford (2010), the utilization of NPs in the completion of preoperative assessment the hospital saves money by not paying an anesthesiologist to complete the same task. Overall, the entire health care team benefits from the addition of an FNP to the surgical practice (Hylka & Beschle, 1995).

Cost Reduction/Financial Consideration

Marcario (2010) in the Journal of Clinical Anesthesia examines the cost and charge of one minute of operating room time. The price tag was as high as \$133.00 per minute. Cost reduction and financial benefits that resulted from the implementation of an FNP manifests in increased patient volumes, decreased waiting times, reduced length of

stay and decreased readmission rates and complications (Marcario, 2010).

In a comparative, two group, quasiexperimental design, researchers found that collaboration of physicians and NPs reduced the length of stay and improved hospital profits with no effect on readmission rates or morbidity and mortality (Cowan et al., 2006). According to Barnett (2005) in a review of the literature at the Hospital of the University of Pennsylvania, there was an increase in patient satisfaction and 40% increase in patient volume with decreased OR delays when the preoperative assessment was completed by an NP as opposed to an anesthesiologist. Does, Vermaat, Verver, Bisgaard, and Van (2009) state that space is limited and costly in the operating room and that optimizing the utilization of these spaces is fundamental to efficient and effective hospital management. FNPs are a factor that is utilized to increase efficiency and optimize operating room time management (Does et al., 2009). The Medical Center of Central Massachusetts found significant financial gains related to correct preoperative test being ordered, efficiency and reduced delays in the operating room time and a reduction of procedure cancellations with the implementation of an NP assisted preoperative evaluation (Barnett, 2005). Barnett (2005) found five other examples of institutionally established value and benefit with the implementation of NPs performing the preoperative evaluation at the Hospital of the University of Pennsylvania, Stanford University Medical Center, Brigham & Women's Hospital, Evanston Hospital, and Alfred I. DuPont Hospital for Children.

Care provided by NPs in a variety of settings result in a financial benefit to the patient and institution. Through a review of the literature, Guido (2004) found that the goal of NPs in an ambulatory surgical unit was to reduce operating room delays and

assure patient and documentation preparedness. Reduced patient and insurance cost was an established outcome of the implementation of a 1:1 NP to surgeon ratio in pediatric orthopedic surgery (Horn, Badowski, & Klingele, 2014). Hylka and Beschle (1995) also found that NPs met the ever-changing requirements of the healthcare system and provided a sustaining cost-effective strategy to combat the increased demands on the system to provide cost savings and improved patient care in the department of surgery. Lome, Stalnaker, Carlson, Kline, and Sise (2010) found that NPs caring for trauma patients lead to a decrease in length of stay in the intensive care unit and overall reduction of the hospital visit with fewer complications and reduced readmission rates. Lome et al. (2010) also noted an increase satisfaction for patients, staff nurses, and physicians.

A structured literature review, conducted by Naylor and Kurtzman (2010), produced information and resources on the high-value contribution of NPs, their economic impact, limitations, state laws, payment, and tensions. The article reviewed the role of NPs in primary care and how the role is providing solutions to the inaccessibility of quality health care.

Clinical Care Model

NPs focus on providing direct clinical services to patients. Guido (2004) explains the evolving role of the NP. Originally, the role was created in response to increased demand related to physician shortages in primary care with underserved populations. With a shortage of medical residents and decreased working hours, there is increased need for NPs in settings such as surgery. The role of a NP in surgery includes; case management, communication facilitation, collaboration with physicians and nurses, leading and actively implementing timely processes, multidisciplinary rounds, and

surveillance of cost-effective measures (Cowan et al., 2006). The NP gathers, recognizes and interprets pertinent patient data related to results of labs and diagnostic tests, medication prescription and perioperative education to patients and their families in partnership with the physician (Barnett, 2005). Other duties of the NP in ambulatory or outpatient surgery include the collection of thorough health histories and complete in-depth physical examinations, as well as diagnosis and treatment of chronic and acute illness and monitor disease progression (Guido, 2004). The author makes an important distinction that; ambulatory surgery NPs are not acute care NPs but are primary care NPs, practicing in an outpatient hospital environment. FNPs are uniquely suited for the outpatient surgical environment because of a solid foundation and training in primary care and ability to intervene in any stage of the lifespan, infant to older adult.

A 1:1 surgeon to NP practice model was implemented at Nationwide Children's Hospital in Columbus, OH where this clinical care model helped to increase patient volume, reduce wait time, improve patient satisfaction, increased clinic revenue and improve continuity of care in pediatric orthopedic clinics (Horn, Badowski, & Klingele, 2014). Through the implementation of this model, it has increased patient access to care and generated increased revenue because of the increase in the number of patients seen and the number of procedures performed. The 1:1 model increased patient and caregiver satisfaction while adding monetary and quality value to the department. With the collaboration of a NP and surgeon, the healthcare team was able to increase continuity of care and reduce complication and readmission rates. The clinical care model sets an example for the rest of the healthcare industry of optimizing patient care in an evolving healthcare system with increasing demands. Further research and replication of this study

in different outpatient surgical settings leave room for continued enhancement and role development for FNPs.

Throughout the literature, different tools have been utilized to assess patient satisfaction in a variety of care settings and geographical locations. The data gained from these various studies allow for replication and adaptation to test patient satisfaction with NP provided care in the surgical setting. All tools mentioned above could be adapted for use in measuring patient satisfaction with FNP provided care in the outpatient surgical setting.

FNPs provide cost effective, quality healthcare to the patients in a multitude of specialty practice areas ranging from primary care to the emergency department, community health, pediatric cardiology, hematology, and ambulatory spine clinics. In a review of the literature Barnett (2005) found six examples of institutions that had implemented an NP into the preoperative assessment. With the addition of NPs, the authors established improved satisfaction, reduced waiting times, efficiency of care and overall cost savings for the institutions (Barnett, 2005). Outpatient surgery is no exception to the opportunity for NPs to provide quality, cost-efficient, exemplary care. The lack of current research in this practice area leaves room for further research and development on the subject of patient satisfaction with NP provided care in the surgical setting. Lack of research on incorporating an FNP into the surgical patients experience and patient satisfaction with FNP provided care in the outpatient surgical setting offers an opportunity for future studies. The literature review was able to identify the gaps in the literature and to define satisfaction and system and patient advantages with FNP delivered care and determined that the use of FNPs is a potentially effective method to

increase patient satisfaction and continuity of care in the outpatient surgical setting.

Chapter Three: Conceptual and Theoretical Framework

Nursing theory deepens understanding and appreciation of nursing practice. Presence, intentionality, and energy permeate all aspects of the nursing profession. The Theory of Human Caring and Transpersonal Caring Science (TCS) embody these concepts as envisioned by Jean Watson. Jean Watson, a grand nursing theorist on the topic of human and transpersonal caring science, and consciousness began her nursing career in the surgical suites of a Virginia hospital. In a video interview, Watson describes her childhood and evolution of her nursing career (Fawcett, Wallace, & Coberg, 1988). Watson stated that a career start in the technical environment of surgery is an interesting contrast to the elevated conceptual framework of nursing that she now embodies. However, Rexroth and Davidhizar (2003) state the Jean Watson's Theory of Human Caring is universal and applies to any patient in every unique care setting, including surgery. In areas of nursing practice where the emphasis on the technical aspect is dominant, the Theory of Human Caring and TCS has the potential to have a greater impact on the patient-provider relationship. Highly technical areas of nursing practice, such as the operating room, often neglect the relational, consciousness and intentionality of patient care. Through the implementation of Jean Watson's theories, the operating room, and perioperative environment are unique spaces, and the surgical suite can be transformed into a sacred space of healing and caring. The Family Nurse Practitioner (FNP) armed with the knowledge and application of Watson's theories of Human Caring and TCS can elevate the perioperative nursing practice and enhance the care provided to the surgical patient.

Jean Watson addresses the theory that encompasses the elusive and controversial idea of caring. She explores nursing as a science and art with caring integrated into health and healing. Watson states that caring is central to the practice of nursing (Watson & Smith, 2002). Nursing embodies caring yet caring is enhanced when consciousness is increased (Cowling, Smith, & Watson, 2008). The Theory of TCS speaks to the higher level of energy in the healing relationship of both the FNP and patient. Jean Watson acknowledges energy presence and describes nursing as a higher frequency than that of non-caring energy. With the use of Jean Watson's TCS and Human Caring theories, caring is present in the surgical environment and FNP's who consciously choose to care, bring a higher frequency wavelength to the operating room. Jean Watson's Theory of Human Caring Science relates the core principles of authentic presence and being to create a caring-healing environment. Awareness, intention, consciousness and caring elevate the practice of nursing to allow for a broadened ability to create healing and understand the universe (Watson, 2008). A true caring relationship is one in which the FNP possesses the energetic patterns of consciousness, intentionality, and authentic presence. The two theories will be evaluated through the application of a caring-healing environment, intentionality, conscious awareness and the art of presence and how these concepts are intertwined in the work of an FNP in surgery.

Caring-Healing Environment

Perioperative FNP's have the honor of accompanying the patient, providing meaningful interaction and altering energies during the stressful life event of surgery (Thompson, 2005). Bioenergetic hazards are created not only in the presence of sick patients but any person that presents with negative energies (Gerber, 2000). The highly

technical environment of the operating room may appear to lack a caring atmosphere because it is thought of as a place for treating and curing. Analysis through the lens of Jean Watson's Theory demonstrates the idea of preserving dignity and honoring the humanity of the patient is exceedingly applicable to the OR environment (Burchiel, 1995). Cowling, Smith & Watson (2008) discuss hand washing as a means of centering oneself and creating manifest intention. Throughout the whole healthcare environment, but especially in the operating room, hand hygiene is fundamental. Each person who enters the environment of the OR is required to "scrub" or perform hand-hygiene. This simple ritual can be used by the FNP as a self-care exercise to create balance and positive energy. Richard Gerber (2000) describes the bioenergetic hazards of working with sick people and the healing and energetic cleansing properties of water through hand washing.

Intentionality and Increased Conscious Awareness

Historically, the concept of intentionality resides in the domain of philosophy and social sciences. More recently the term has been adapted into nursing theory such as Watson's idea of the caring consciousness. Through research into intentionality and nursing theory, Watson's exemplary exercise points the way to identifying one's intentions (Watson, 2002). The eight intentions include 1) begin each day with a spiritual practice, 2) honor nursing as a spirit filled practice, 3) use intentional awareness to cultivate discernment, 4) offer authentic presence and find spirit filled persons, 5) grow more deeply in your humanity, 6) commit to cultivating intention, 7) at the end of the day, offer gratitude for all, and 8) creating your own intention. Incorporating these seven intentions enhance and guide FNP practice throughout the surgical process. These steps

allow the FNP to gain an in-depth and transpersonal understanding of the concept of intentionality when working with patients undergoing surgery.

Intentionality is a complicated, abstract concept closely related to consciousness. Jean Watson describes transpersonal caring-healing praxis as one that connects the concepts of intentionality and consciousness. She uses the terms consciousness and intentionality interchangeably and co-dependently. The complexity of intentionality is evident by Watson's use of quantum physics and her idea of our created reality on the part of intentionality (Zahourek, 2004). Through transpersonal caring and love, FNPs and patients create a spiritual connection that transcends beyond the ordinary in the spiritual dimension (Watson, 2002).

FNPs bring perspective into a time of great stress in a patient's life. Through intentionality, FNPs transcend barriers that doctors or other health providers may not have recognized. The power of intentionality is demonstrated by the FNPs work with patients before surgery. When completing a pre-operative assessment and obtaining a history and physical the FNP can make a conscious decision to be fully present with the patient. Watson (2002) demonstrates the idea of presence by stating, "It is in this space, which is created through manifesting one's caring intentions, that one witnesses safe space, sacred space, authenticity, commitment, and reverence, cherishing values of love, beauty, peace, and goodness through a purposeful encounter" (p. 15). It is in this sacred space that patient's spirit energy can change from one of high entropy to that of a higher wave frequency, closer to love and compassion.

An example of the energetic shift and elevated practice is found in a middle-aged woman who arrives at the hospital for a robotic pyeloplasty to remove an obstruction at

the ureteropelvic junction. The patient had previously undergone a traumatic robotic hysterectomy that had not gone as planned. In the preoperative waiting area where the FNP met with the patient, she was withdrawn, tearful, nervous, and didn't want to have surgery. The FNP recognized her resistance and affect were a result of a bigger picture. The FNP was able to form a connection with this patient and explain in terminology that the patient could understand, exactly what was going to happen and why the surgical team chose to perform the procedure robotically. The FNP discussed how the ureters were like two wet pieces of spaghetti that her surgeon is going to sew end to end to remove the obstruction. Also, the FNP explained that with robotic assistance, the surgeon has better visualization and control as opposed to performing the procedure on an open abdomen. The FNP and patient also discussed the benefits of having four small incisions instead of a large abdominal incision, and that recovery and pain would be shorter and more manageable. After the pre-operative conversation, the tears had stopped, and the patient conveyed to the FNP that through this explanation the patient now understood the procedure. Had the prior explanation been similar, the anxiety would have been lessened. The patient then thanked the FNP for her explanation. The patient entered the OR with a completely different affect and energetic presence than what the FNP had witnessed in the preoperative waiting area. By honoring the whole of the patient, the FNP can observe the product of intentionality and conscious awareness of energetic presence as demonstrated by this interaction.

The Art of Presence

For FNPs, the practice of presence enhances and transforms patient care. To achieve greater fulfillment from the FNP's work with patients, Watson (2008) encourages

nurses to attend self-caring practices that assist in the evolution of consciousness.

Practicing the art of presence increases consciousness awareness. Increasing conscious awareness and practicing presence can be accomplished through self-reflective exercises such as meditation and yoga. Within the transpersonal caring relationship, the FNP is affected as well as the patient. There is a reciprocal relationship in which the caring occasion influences both. Depending on the consciousness of the FNP and patient, new energy fields can be created out of these transpersonal caring relationships (Fawcett, Wallace, & Coberg, 1988). Jean Watson's (2008) Theory of Human Caring states that care for self and others is interdependent, not mutually exclusive. "The goal of nursing is to help persons gain a higher degree of harmony that fosters self-knowledge, self-reverence, self-caring, self-control, and self-healing processes while allowing increased diversity" (Watson, 2012, p. 61). To achieve this higher degree of harmony, FNPs must first take care and know themselves. According to Jean Watson (2012), "the more one is able to experience one's self in right-relation with source, the more harmony there will be, and a higher degree of health/wholeness will exist" (pg. 69). FNPs need to acknowledge and care for themselves if they want to be fully present and care for others.

One of the core principles of Jean Watson's Theory of Human Caring is the authentic presence (Watson, 2012). Being present is the art of understanding and meeting with the patient. Time is a critical factor in the OR; however, the key to practicing presence is to avoid preoccupation with other thoughts or ideas and just be. Similarly to the art of meditation, the art of being present with a surgical patient requires conscious thought and practice. Through intention, perioperative FNPs gain proficiency in the art of being present. Presence creates a healing atmosphere. Part of being present is sensing the

energy frequency given off by a person and meeting the patient at the same frequency (Gerber, 2000). Being present is the highest level of honoring presence. A caring presence manifests itself in eye contact, body language, and tone of voice. Through these transformative experiences, the FNP's interactions with the larger whole of the patient and how energies and self effect the environment. According to Watson (2002), "One's intentionality becomes activated through one's conscious focus toward aspects of reality that incorporate, but transcend the physical as the object of attention" (p. 13). Attention to intention influences the art of being present and creating caring and healing relationships. Through the lens of Jean Watson's Theory, the idea of preserving dignity and honoring the humanity of the patient is exceedingly applicable to the OR environment (Burchiel, 1995). Perioperative FNPs have the honor of accompanying the patient and providing meaningful interaction during the stressful life event of surgery through intentionally practicing presence and being in the moment with patients (Thompson, 2005).

Cowling, Smith, & Watson (2008), discuss wholeness, caring, and consciousness as unique aspects of nursing. According to Lome et al. (2010), because of the perspective brought to the healthcare team, FNPs are uniquely suited to have a positive impact on patient outcomes and staff satisfaction. "The nurse practitioner's holistic approach, emphasis on communication, attention to detail, flexibility and availability has a substantial impact on patient outcomes as well as staff satisfaction" (p.80). FNPs provide a unique, holistic perspective, different than that of the traditional medical model. Jean Watson's theories bring nursing's healing perspective to the surgical patient experience by viewing the patient as a whole summation of mind, body, and spirit which complements the technical and curing orientation of the western medical model. In a

video interview Jean Watson speaks to the differences of healing versus curing and that FNPs, through increased conscious awareness and intentionality, utilize nature and the universe energies to work with the life force of a person in contrast to the manipulation and control of the medical model (Fawcett, Wallace, Coberg, 1988). A transforming presence by the FNP can transform the surgical patient's experience. Jean Watson (2012) states that nurses "can choose to pursue more of the private, intimate world of human caring and healing and inner subjective human experience rather than concentrate on the public world of non-human technocure techniques and outer behavior" (p. 24). The decision to undergo a surgical procedure is a deeply intimate invasion into one's being. Focus on the whole person and patient experience rather than diagnosis and correction of ailment is a unique perspective brought by an FNP to the surgical scenario. Through the unique perspective of the FNP, the surgical patients experience is enhanced by the utilization of Jean Watson's theories by manifesting intentionality, increasing conscious awareness and practicing the art of presence.

Chapter Four: Methodology and Evaluation

The 1:1 clinical care model was presented at a professional organization meeting involving discussion between the key stakeholders. Chapter four, Methodology and Evaluation, evaluates the subjects, clinical setting, tools, interventions, and data collection with analysis and results of implementation.

Subjects

Project participants or clients, defined by Moran, Burson, and Conrad (2014) as anyone with interest in the project outcome includes those identified in as key stakeholders in the Power Map (see Appendix A). Perioperative nurses are one integral population established in the implementation of the 1:1 clinical care model. The model was presented to members of the Association of Operating Room Nurses (AORN) Hiawathaland Chapter #2402. The chapter member participants included eight perioperative nurses employed in southeastern Minnesota, specializing in areas ranging from outpatient surgery, orthopedics, administration, supply chain, and retired urology and general surgery registered nurses. This population, as key stakeholders, provides critical feedback on the implementation of the 1:1 clinical care model in outpatient surgery.

Clinical Setting

The presentation took place at a conference center in a large Minnesota city. Application of the 1:1 clinical care model can be applied in both the outpatient and inpatient surgery practice settings as examined during the presentation and discussion with key stakeholders. The presentation focused on the implications that the 1:1 clinical care model would have with FNPs in the rural or community setting. During the

discussion, it was brought to light that there are a variety of Family Nurse Practitioners practicing with a similar model within local hospitals throughout southeastern Minnesota. While, not officially utilizing a 1:1 clinical practice model, these nurses are actively working in the role of coordinating care for outpatient surgery in the areas of orthopedics, neurology, and otorhinolaryngology (ENT).

Tools

A PowerPoint presentation (see Appendix B) was created and presented to the group. The goals and objectives were effectively communicated for a 1:1 clinical care model of utilizing FNPs throughout the course of the outpatient surgical experience in the community hospital. At the beginning of the presentation the presenter's public narrative (see Appendix C) was shared to explain the inspiration for the project, and how the clinical care model applies to the FNP practice in preoperative and postoperative outpatient surgery. The narrative identified the challenge of creating a better care delivery model for patients undergoing outpatient surgery. A summary of the problem and explanation of project necessity is briefly discussed in an elevator speech (see Appendix D) in the second slide of the presentation. Other tools utilized, included blank notecards that were distributed before the presentation for participants to provide feedback in a medium other than a group discussion. A group discussion was held at the conclusion of the presentation. The discussion was lead by the presenter with prompting key discussion questions and open dialogue about the role of FNPs in outpatient surgery.

Intervention and Data Collection

The group discussion resulted in information sharing, networking, and collaboration among the perioperative professionals. The presenter actively listened to

participants and gained insightful information from the key stakeholders. Discussion included implication for practice and enforcement of the necessity of the holistic nursing model in compliment to the medical model when caring for outpatient surgical patients. A suggestion for gray literature was presented on a notecard including a book entitled *The Scalpel and the Silver Bear: The First Navajo Women Surgeon Combines Western Medicine and Traditional Healing* by Lori Alvord and Elizabeth Cohen Van Pelt (2000). Discussion on potential barriers to implementation included over-extending the FNP and the practical implication for FNP availability in the community setting. Ideas for improving the surgical patient's experience through coordination of care and the FNP as the "spoke that holds the wheel together" were ideas brought forth through the discussion.

A question was posed regarding academic teaching hospitals, and when are there too many people in the operating room, potentially compromising the sterility of the environment. The perioperative nurses identified strength in the 1:1 clinic care model application in smaller community hospitals but not necessarily in the large academic institutions. Names and examples of FNPs working in similar surgical settings were shared for future networking opportunities. The participants were thanked for their time and assured that their input provides value to the project implementation.

Analysis

Professional organizations such as AORN offer a platform for professional development and practice growth of the FNP in all outpatient surgery settings. Implementation through the presentation of the 1:1 clinical care model to the AORN group was an effective method of information dissemination, gathering, and networking.

Results

As a result of the presentation, information was distributed to enhance and pursue further implementation of the 1:1 clinical care model in the outpatient community setting. Insight into networking among FNPs in community clinics and gray literature opportunities were shared in addition to ideas for further development of the 1:1 clinical care model that will be discussed further in chapter five.

Chapter Five: Significance and Implication

This scholarly project examines the evidence in the form of literature review, conceptual and theoretical frameworks to evaluate the 1:1 clinical care model utilizing a Family Nurse Practitioners as part of the multidisciplinary team in the care of the outpatient surgical patient. It examined not only the increased patient and family satisfaction outcomes but also the research indicating decreased adverse events, readmissions, and increased operating room efficiency. Other members of the healthcare team including the surgeon, anesthesia, nursing, allied health staff and the institution benefit from the incorporation of an FNP because of increased efficiency, enhanced staff education and decreased cost. Overall the FNP in outpatient surgery provides effective, efficient, and patient-centered care that produces positive outcomes for the individuals, the surgical community, and the healthcare system.

The 1:1 clinical FNP care model was presented to a group of perioperative professionals belonging to the Association of periOperative Registered Nurses (AORN). Feedback in the form of a guided discussion and notecards provided networking opportunities, grey literature ideas, and further ideas for implementation locations. Constructive input and barriers to implementation were discussed. Overall support and enthusiasm were shared for the future of the 1:1 clinical care model.

The American Association of Colleges of Nursing (2004) in the position statement on the practice doctorate in nursing states, “transforming healthcare delivery recognizes the critical need for clinicians to design, evaluate, and continuously improve the context within which care is delivered. Nurses prepared at the doctoral level with a blend of clinical, organizational, economic and leadership skills are most likely to be able

to critique nursing and other clinical scientific findings and design programs of care delivery that are locally acceptable, economically feasible, and which significantly impact health care outcomes” (p.3). This chapter describes the significance and implication of a 1:1 clinical care model for the Family Nurse Practitioner (FNP), patient care, disease management, and clinical education in the outpatient surgical setting. Each of the eight Essentials of Doctoral Education for Advanced Practice Nursing (AACN, 2006) (see Appendix E) will be described and applied to the clinical care model. Future integration of the 1:1 clinical care model into clinical practice will be discussed.

Essential I: Scientific Underpinning for Practice

The first Essential of Doctoral Education for Advanced Practice Nursing includes scientific underpinning for practice which views nursing science as a pattern that brings unity to knowledge with a focus on the human response to illness. This is a unique perspective brought by the FNP to the care of a patient in surgery. The FNP in surgery brings a perspective grounded in positivism, ethics, and analytics, along with historical, biophysical, psychosocial, and organizational knowledge (Zaccagnini & White, 2011). Jean Watson’s theories of transpersonal caring science and human caring served as the theoretical framework for this scholarly project. The FNP brings caring into the highly technical environment of surgery through energetic patterns of consciousness, intentionality and the practice of authentic presence. The application of this unique theory-based practice through the 1:1 clinical care model is what differentiates advanced nursing practice from that of other medical modalities and is necessary for the holistic care of the surgical patient.

The utilization of the 1:1 care model falls in step with the Institute of Medicine (IOM) aims for healthcare improvement and core competencies for healthcare professionals by providing safe, effective, and efficient care. This means, avoiding injuries to a surgical patient undergoing a procedure that is intended to benefit the patient. For example, an FNP ensuring proper site marking and informed consent is obtained before the start of a procedure. This model is an application of quality improvement and an example of an FNP working within an interdisciplinary team. The role of the FNP in an outpatient surgery setting includes the incorporation of evidence-based practice and utilizing informatics in providing effective care (IOM, 2001; IOM 2003). Chapter Two reviewed the literature on the use of FNPs in surgery. This science-driven research found that incorporating an FNP as part of the surgical team reduces waste; waste of costly operating room time, waste of undue patient and family anxiety, and waste of resources or supplies such as unnecessary laboratory testing and pre-procedure testing duplication (i.e. electrocardiogram, complete blood counts, kidney and liver function testing). The FNP in the care of the outpatient surgical patient provides safe, effective, and efficient care through the scholarship of integration of science through evidence-based practice, nursing theory, and metis knowledge that culminates in advanced nursing practice.

Essential II: Organizational and System Leadership for Quality Improvement and System Thinking

The second Essential of Doctoral Education for Advanced Practice Nursing is organizational and system leadership for quality improvement and system thinking. This includes the same safe and effective care described by the IOM six aims for healthcare improvement but also fulfills the delivery of timely and equitable care (IOM, 2001). The

FNP involved in the care of an outpatient surgical patient can reduce wait time and harmful delays for both the surgical team and the patient. The unique perspective brought by an FNP includes equitable and holistic perspectives. Caring for the mind, body, and spirit of a patient without wavering in quality depending on the patient's characteristics including gender, ethnicity, geographical location or socioeconomic status.

Through practicing at the full extent of the FNP's scope of practice and as a full partner with the surgeon and other healthcare professionals, the 1:1 clinical care model redesigns how care is provided to the outpatient surgical patient (IOM, 2010). This model highlights the FNP as an organizational and systems leader emphasizing ongoing practice improvement with positive health outcomes and increased patient safety (Barnett, 2005). The FNP works interdependently within the system while maintaining integrity, flexibility, balance, and financial responsibility to the patient and health-care system.

The systems approach brought by the 1:1 clinical care model decreases fragmentation of care for the outpatient surgical patient. This perspective views the surgical experience as more than just the individual surgeon, the procedure itself, or operating room dynamics. The FNP understands the intricacies and dynamics that alter the perceptions of a patient's experience and is a leader in creating positive outcomes. The FNP creates stability through understanding the interrelationship among components of the system including importance of a thorough history, physical and preoperative assessment, intraoperative multidisciplinary education, and postoperative recovery course expectations of the patient and family members (Cowan et al., 2006).

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

The third Essential of Doctoral Education for Advanced Practice Nursing discusses evidence-based practice in clinical scholarship and analytical methods. Through scholarship of research, evidence gathering, and data synthesis discussed in Chapter Two, the utilization of FNPs throughout an outpatient surgical patients experience provides increased patient, family, and multidisciplinary team satisfaction, financial benefit, and increased continuity of care. One of the best examples of this model implemented in practice is at Nationwide Children's Hospital in Columbus, OH. The 1:1 clinical care model implementation resulted in effective and efficient quality improvement that increased patient satisfaction, resulted in a reduction in phone calls related to questions about home care, and delivered perioperative education leading to fewer patient perioperative issues (Horn, Badowski, & Klingele, 2014). Replication of this model and application of data produced would result in positive patient and system benefits.

When contacted regarding the authorship of the above mentioned article and application of care model, Pamela Horn, MS, CNP, ONP-C, of the Department of Orthopedics at Nationwide Children's Hospital, Columbus, OH stated that when her institution trialed this model, it was found to be so successful that they ended the trial early, implemented and are now expanding the practice because of the overwhelming success of this 1:1 model. The research and application of evidence-based practice and individual FNP's scholarship is evident in the 1:1 clinical care model. Continued research, analysis, and publication of findings in the area of FNPs in surgery are necessary to increase clinical scholarship and advance the practice.

**Essential IV: Information System/Technology and Patient Care Technology for the
Improvement and Transformation of Health Care**

While the focus for an FNP is patient care, information technology is an integral part of daily practice. The FNP in surgery supports the workflow of health information technology through daily navigation and contribution of the electronic health record. Online communication between providers and patients is becoming commonplace, and the FNP brings proficiency and ability to navigate clinical decision support tools, Internet resources and online patient education materials. Competence and literacy with technology including, computers, information, and informatics allow the FNP to work as part of the interdisciplinary team providing patient-centered care.

The perioperative setting is a technology-rich environment that requires information literacy and critical evaluation of data through daily process outcomes management to prevent adverse events. The application of translational science or putting research into practice to transform healthcare to increase quality outcomes through the application of evidence-based research and leading change through the meaningful use of technology is a contribution of the FNP to surgery. The FNP can spearhead initiatives such as quality improvement through the use of technology like the SurgiCount Safety-Sponge™ system and barcode verification to allow for safe and efficient patient care. The FNP acts as a liaison or interpreter in this technologically rich environment to be an advocate for implementation of evidence-based research and quality improvements throughout the patient's surgical experience.

Essential V: Health Care Policy for Advocacy in Health Care

Nurses hold a positive standing in the public opinion for a good reason. Named as the number one honest and ethical profession by the 2016 Gallop Poll, FNPs bring an understanding of the patient's perspective and therefore are influential in the realm of politics and policymaking at the local, state and national level. Part of patient advocacy is policy advocacy. Just as the FNP has an obligation to the patient, there is an obligation for political activism. This action results in increased access to care, institutional and system improvements, healthcare reform, expand funding, and removing financial barriers to practice. The FNP has a role in influencing healthcare reform, promoting global health and advancing the profession. The 1:1 clinical care model is an example of institutional and system improvement enacted by an FNP.

The FNP may engage in the process of legislation by cultivating relationships through contacting their representative or senators, lobbying by sending a letter to a member of Congress, and coalition building with others within the profession by involvement in professional organizations such as the Association of PeriOperative Nurses (AORN), American Nursing Association (ANA) and American Academy of Nurse Practitioners (AANP). The implementation through the presentation of the 1:1 clinical care model to a group of AORN members is an example of cultivating relationships and network building.

The perioperative FNP may monitor the federal register for purposed rules and regulations that will become law to be up to date on legislation coming down the pipeline and encourage the continued advancement of the profession. The FNP provides cost-effective, efficient, patient-centered care and is an advocate for access to quality, safe,

and financially responsible healthcare, equality in reimbursement and a voice in the formation of Medicare federal regulations. The FNP may contribute to their states Nurse Practice Acts that include the extent of supervision by physician colleagues and prescriptive authority regulation.

The FNP throughout outpatient surgery provides patient-centered care, respectful of and responsive to individual patient needs, preferences, and values. The patient values guide all clinical decisions of the interdisciplinary surgical team. The FNP brings a trusted voice of ethics and competency to the policy-making table and has a responsibility to the equitable allocation of resources. As discussed earlier, the operating room is one of the biggest financial engines of the healthcare institution, and responsible use of resources ensures system fiscal accountability (Marcario, 2010). The FNP in the 1:1 clinical care model ensures proper use of costly surgical resources including time, supplies and knowledge.

The responsibility of the FNP to health policy advocacy ensures efficiency and sustainability of the profession. The FNP in surgery can influence policy to ensure implementation of policy based on cost, quality, and access to care. This fifth Essential of Doctoral Education for Advanced Practice Nursing includes the FNPs role in health care policy and advocacy and fulfills the IOM (2001) aims for healthcare improvement including, providing effective, efficient, patient-centered care by utilizing informatics, employing evidence-based practices, working in interdisciplinary teams and applying quality improvement (IOM, 2001; IOM 2003).

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

The sixth Essential of Doctoral Education for Advanced Practice Nursing includes interprofessional collaboration for improving patient and population health outcomes (AACN, 2006). In the book *The Doctor of Nursing Practice Essentials: a new model for advanced practice nursing* (2nd ed.) the authors perfectly describe the purpose of the 1:1 clinical care model when they state, “Providers, policy leaders, and health systems will need to shift their mindset from traditional models of linear, disease-focused care to new delivery approaches. In a redesigned model, each discipline brings specialized skills and abilities, practices at the highest level of the individual provider’s scope, assumes new roles, and participates in a collaborative manner with other professionals to provide high-quality, safe, cost-effective, patient-focused care” (Zaccagnini & White, p. 219, 2011). The 1:1 clinical care model is utilizing the FNP and the top of their scope of practice, maximizing their unique holistic perspective, creating a new role, collaborating as part of an interdisciplinary team thus resulting in increased positive outcomes for the patient and system (IOM, 2010).

The FNP in outpatient surgery is a part of the multidisciplinary teams, including the patient and family, focused on improving health outcomes, maximize resources, coordination of care and preventing errors. The operating room requires specialized skill and abilities. Attainment of the Registered Nurse First Assistant (RNFA) would be a way for the FNP to refine skills and increase marketability in the surgical arena. The FNP in surgery encourages the open exchange of information between surgeons, residents, technologists, anesthesia, and nursing staff. The FNP understands the value of knowledge

sharing, shared decision-making, and mutual respect. If present in the surgical environment, this atmosphere of respect creates a space of healing and wellness for a patient. The FNP in the outpatient surgical setting is a team leader equipped with scientific knowledge, skills, abilities, an understanding of the system and organizational improvements, outcome evaluation, and healthcare policy. The FNP in surgery works parallel to physician colleagues, other advanced practice providers such as CRNAs, Physician assistants, nurses and allied health staff. In the complex environment of surgery, the FNP can limit competition by encouraging collaboration and focus on the common goal and vision for positive patient outcomes. The FNP recognize the value of other members of the surgical team, increases continuity of care by decreasing fragmentation and reducing “silos” in practice. The FNP in surgery is an empowering member of the team who adds value and strengthens the health care system. The FNP promotes communication and understanding and a high-performance team atmosphere. The FNP in surgery facilitates successful team development by accompanying the interdisciplinary team through Tuckman and Jensen’s (1977) stages of forming, storming, norming, performing and adjourning.

The FNP in the 1:1 clinical care model offers a unique contribution to improve patient and system outcomes to the interprofessional team working with the outpatient surgical population. An efficacious team caring for a surgical patient shares the purpose of successful patient outcomes, reciprocal trust, respect for all members of the team, honor unique skill sets

The FNP in outpatient surgery is a voice to ensure psychological and physical safety in the operating room. They play a role in conflict resolution through the use of emotional

intelligence and tactfulness through maintaining composure in stressful situations, self-reflection, and empathy.

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

Utilizing the 1:1 clinical care model, the FNP in surgery brings the unique perspective of health through wholeness and not through the absence of disease. This fundamentally different perspective focuses on health promotion and disease prevention while strengthening the health system, enhancing perioperative partnerships, improving performance outcomes and increasing patient satisfaction. This patient-centered care model is respectful of and responsive to individual patient needs, preferences, and values, honoring the patient as a whole during their experience of surgery. Following along with the IOM (2001) recommendations this essential and clinical care model meets the criteria for equitable, patient-centered care, quality improvement, and utilization of informatics (IOM, 2001; IOM 2003).

The overarching goals of Healthy People 2020 include:

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote healthy development and healthy behaviors across every stage of life (HHS, 2010, p.1)

While surgery typical is seen as a tertiary measure in disease prevention, the utilization of an FNP in the outpatient setting improves health outcomes and creates an environment of health and healing which enhances wellness for the patient, families, and interdisciplinary team members. The operating room is a place of eliminating disease, but the environment itself is not always healthy. The FNP who models healthy behaviors promotes a healthy physical and social environment and prevents error in outpatient surgery is exemplifying the goals of Healthy People 2020 thus fulfilling the seventh Essential of Doctoral Education for Advanced Practice Nursing (AACN, 2006).

Essential VIII: Advancing Nursing Practice

Nurse Practitioners represent the largest group of advanced practice nursing providers (AANP, 2011). The role of nursing and scope of practice for advanced practice providers, such as FNPs, continues to evolve and develop as the healthcare delivery system, patient populations, and global integration change the definition of creating wellness and wholeness. Increasingly connected, FNPs are leaders and change agents in a complex health system. The FNP in outpatient surgery acts as a navigator, patient advocate, service coordinator, and provider of comfort who improves service provision and patient outcomes. Strategic practice changes such as the implementation of the 1:1 clinical care model are necessary for the success of this complex changing health system. The FNP brings clinical expertise, organizational, economic, and leadership skills to the outpatient surgical setting. The FNP maintains high clinical practice standards and drives quality improvement while incorporating aspects of business, politics, public health and evidence-based and metis based practice knowledge. The FNP in outpatient surgery works in collaboration with other advanced practice doctorate prepared nursing

professionals such as Certified Registered Nurse Anesthetist (CRNA) and fulfills the IOM (2001) recommendations of utilization of evidence-based, patient-centered care, with support for interdisciplinary collaboration (IOM, 2001; IOM 2003). The 1:1 clinical care model in outpatient surgery improves the effectiveness of FNPs by working to the full extent of their scope of practice and in full partnership with physician counterparts (IOM, 2010). As a result, Advanced Nursing Practice achieves the eighth Essential of Doctoral Education for Advanced Practice Nursing (AACN, 2006).

The Institute of Medicine (2001) Six Aims for Healthcare Improvement include recommendations for safe, effective, patient-centered, timely, efficient and equitable care. These aims align directly with the 2003 IOM Core Competencies of Health Professionals and the AACN (2006) Essentials of Doctoral Education for Advanced Nursing Practice. The 1:1 Clinical Care model embodies these goals in the outpatient surgical practice. A goal of this scholarly project is to articulate the role an FNP has in promoting positive patient and system outcomes in the surgical setting. The 1:1 clinical care model is designed with the community in mind, the FNP takes on a holistic approach when viewing a patient undergoing surgery but also the needs of the multidisciplinary team and coordination of care within the healthcare delivery system. Economically, this model provides the benefit of increased efficiency and productivity in outpatient surgery with reduction of readmission and complications resulting from the surgical procedure. Incorporation of an FNP in the care of an outpatient surgical patient ultimately has a significant impact on health care outcomes for the patient and healthcare delivery community. This model is an example of a quality improvement initiative to improve the care of the outpatient surgical patient.

The FNP brings a much-needed perspective to that of the highly technical environment of surgery. This 1:1 clinical care model creates a healing space filled with caring and intention. One that Jean Watson describes as sacred space. FNPs have the honor of accompanying patients through their unique journey to achieve wellness. Implementation of an FNP as part of the multidisciplinary team in the surgical setting provides a safe, cost-effective and efficient solution to improve the surgical patient's experience and positive system outcomes.

From this scholarly project I have sustained a passion of the surgical process which started as a child, watching my grandfather, a general surgeon, dissect formaldehyde preserved creatures noting the present anatomic landmarks, or suturing an orange at our kitchen table learning that citrus too has epidermal, dermal and subcutaneous layers. As a child, he took me into an OR in Fort Wayne, Indiana, placed me at the head of the bed with the Anesthesia team who allowed me to peak over the drape to see a heart beating inside a person's chest. This leaves a lasting impression upon a child who grew up to assist him in the operating room on missions trips to the Dominican Republic and later, I took my first Registered Nursing job as an operating room circulator at Mayo Clinic, Rochester, Minnesota. These experiences have manifested in a passion for the operative environment and a lifetime of curiosity and wanting to learn and do more. Surgical nursing is not just a job or career; it is my passion and calling. I have been uniquely prepared to serve through medicine specifically in the surgical setting. This scholarly project strives to enhance and improve the outpatient surgical experience. As an FNP, I aim to continue to follow my passion and calling in the outpatient surgical setting by implementing a 1:1 FNP/Surgeon clinical care model.

I have learned that this is a fairly non-tradition practice setting for a Doctorate prepared FNP but the unique perspective in which we are trained to honor the person as a whole, acknowledging energetic presences and creating a caring, healing, sacred space with background knowledge rooted in metis and evidence-based practice is much needed in the sometimes rough, very technical environment of surgery. The next step toward implantation includes networking and finding a location interested in a trial of the 1:1 clinical care model or finding a location where this model is practiced and gather patient outcomes data to be published related to the use of the 1:1 clinical care model. I hope that through this scholarly project, the model will be trialed, implemented and result in enhanced wellness and satisfaction for the patient, their families, the multidisciplinary team and the healthcare system.

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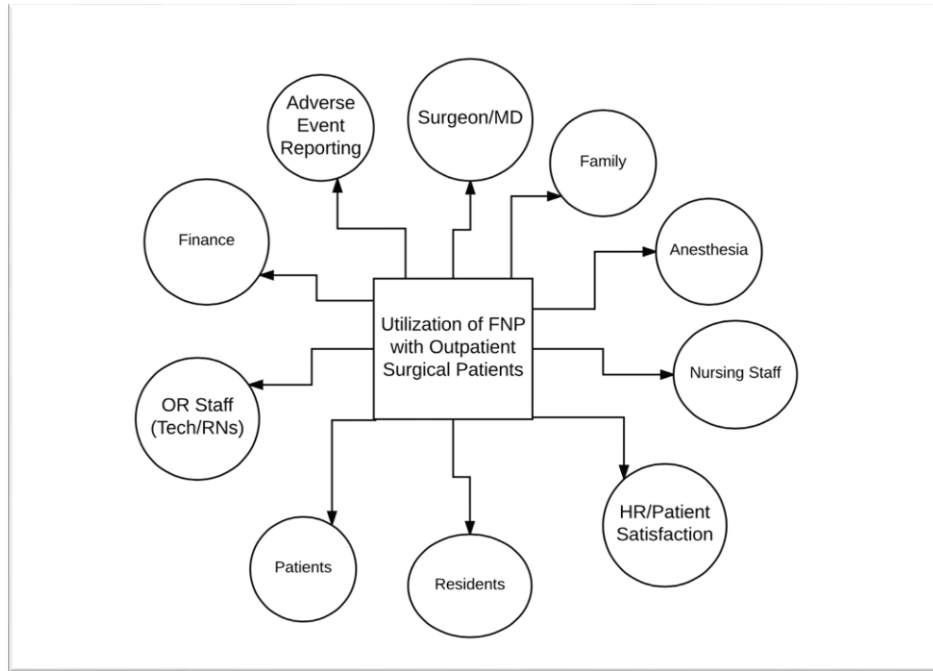
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Appendix A: Power Map



Appendix B: AORN PowerPoint Presentation

1:1 Clinical Care Model: Implementation of Family Nurse Practitioners in Surgery

Michelle D. Johnson, RN, CNOR,
DNP Candidate
NUR 822 Seminar III

AUGSBURG
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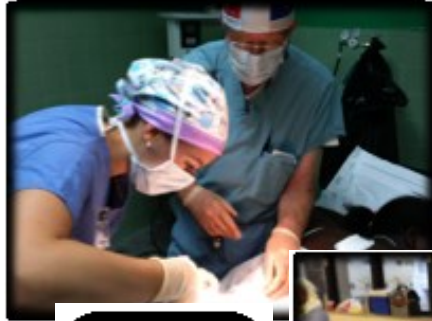
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Objectives

- Explore a 1:1 clinical care practice model with Family Nurse Practitioner (FNP) delivered services in the surgical setting
- Evaluate benefits of incorporating an FNP in surgery through a review of current literature
- Gain a deeper understanding of perioperative nursing practice through application of nursing theory
- Discuss previous experiences with FNP delivered care and explore suggestions for the future



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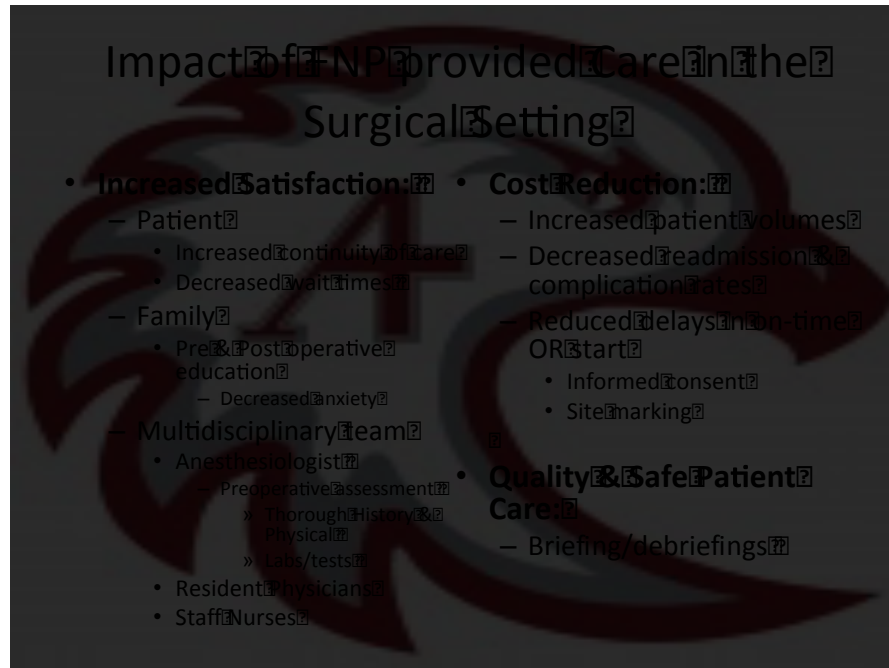
The Problem



**EXPECT
DELAYS**



Images retrieved from <http://www.alternet.org/economy/aboard-global-gazillionaire-gray-train> and <http://www.constructionlawtoday.com/2010/12/construction-contracts-top-10-terms-deadlines-and-delays/>



Literature Review

1:1 NP to Surgeon Clinical Care Model

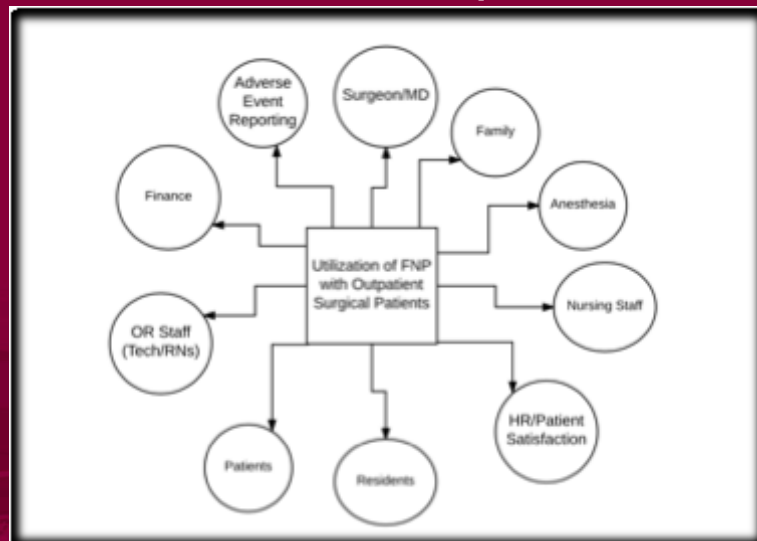
- Horn, P., Badowski, E., & Klingele, K. (2014). Orthopaedic clinical care model in a pediatric orthopaedic setting. *Orthopaedic Nursing*, 33(3), 142-146. doi:10.1097/NOR.0000000000000046
 - Nationwide Children's Hospital- Columbus, OH
- **Results:**
 - Increased patient volume
 - Surgical Volume increased 18%
 - New patients increased 3%
 - Reduced wait times
 - Improved patient satisfaction
 - Increased clinic revenue
 - Improved continuity of care
 - Decreased patient health education barriers
 - Increased scheduling and mentorship flexibility/opportunities
 - Less patient confusion regarding procedures
 - Decreased calls regarding at-home care

Literature Review

- **FNP & preoperative assessment** (Barnett, 2005)
 - The implementation of an FNP in the outpatient surgical setting
 - Increases the operating rooms efficiency
 - Faster turn-over times and ensuring on-time starts
 - Accurate and thorough information and documentation (History & Physical)
 - » Cost efficient measures
 - » Increased patient safety
 - » Opportunity for increased patient volumes
- **Financial Consideration** (Cowan, et al., 2006)
 - Reduced length of stay
 - Increased continuity
 - Enhanced multidisciplinary team planning
 - Positive impact on outcomes
 - Expedited discharge
 - No effect to readmissions or mortality
 - Improved hospital profit & reduced cost
 - \$1,591 profit per day for each patient

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Power Map



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Conceptual and Theoretical Framework

Jean Watson

Theory of Human Caring and Transpersonal Caring Science (TCS)

- The Art of Caring in Health and Healing
- Caring-Healing Environment
 - Energetic presence
 - Higher level of energy in the healing relationship
- Intentionality and increased consciousness
 - Nursing embodies caring yet caring is enhanced when consciousness is increased (Cowling, Smith, & Watson, 2008)
 - Intentions
- The Art of presence
 - Authentic presence
 - Self-care practices


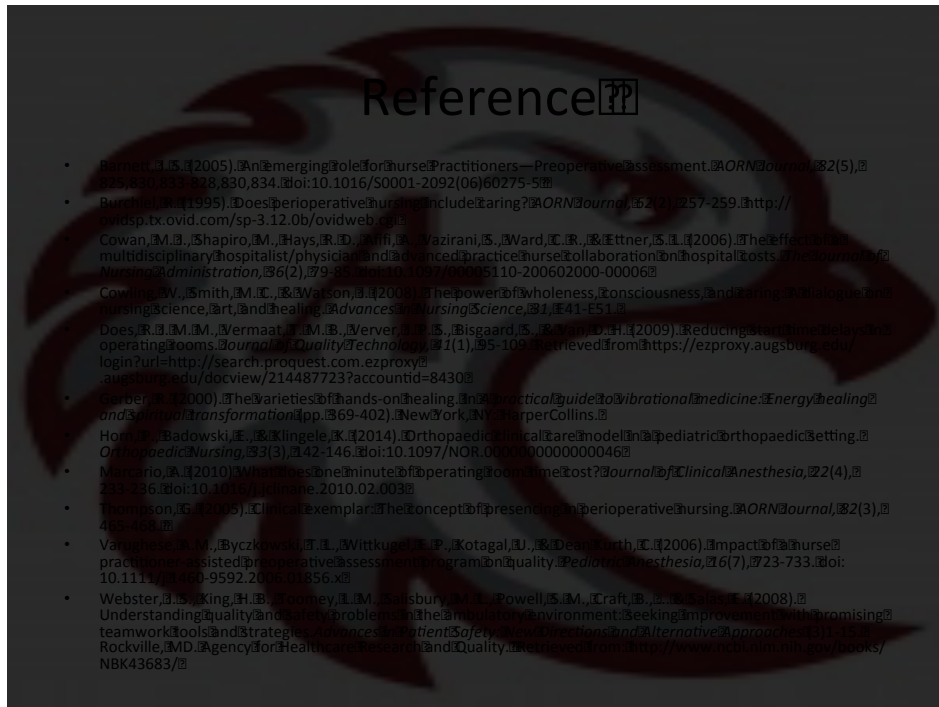


Image retrieved from <https://www.emaze.com/@AZZIOZIC/JEAN%26%20WATSON>



Conclusion





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Discussion

- Do Family Nurse Practitioners have a place in surgery? Why or why not?
- How have you seen FNP's utilized in the surgical setting?
- Do you think a FNP would benefit your practice area?
- How have you seen nursing elevate the patient's experience during surgery?
- Questions/Comments?



Appendix C: Public Narrative

Story of Self

My training as a surgical nurse started very young with influences from my grandmother, a nurse, and my grandfather, a surgeon. I guess you could say working in the surgical environment is in my blood. As a homeschooled child, my mother would seek out unique educational opportunities and ordered preserved creatures in formaldehyde in which my grandfather would dissect in our basement with surgical precision noting the present anatomic landmarks of an earthworm, shark, sea urchin and fetal pig. My introduction to suturing happened on an orange at our kitchen table learning that citrus too has epidermal, dermal and subcutaneous layers. I learned to start IVs and assisted in a birth and delivery at the age of sixteen on a medical missions trip to the Dominican Republic because the Dominican nurses thought I was a real nurse. I guess my translation of ‘perspective nursing student’ was a bit rough. Along with my first nursing job as an operating room circulator at Mayo Clinic- Rochester Methodist Campus, I had the opportunity to work side by side with my grandfather performing surgery in the Dominican Republic on multiple occasions. These experiences have manifested in a passion for the operative environment and a lifetime of curiosity and wanting to learn and do more. Surgical nursing is not just a job or career, it is my passion and calling. I have been uniquely prepared to serve through medicine specifically in the surgical setting. As a Family Nurse Practitioner (FNP) I strive to continue to follow my passion and calling in the outpatient surgical setting by implementing a 1:1 FNP/Surgeon clinical care model.

Story of Us

We are patients, we are healthcare providers, we are the anxious family members waiting to hear the outcome of a loved ones surgical procedure. No matter how “minor” the procedure may be, the reality is, it involves, fear, trust, and putting some aspect of a persons life in the hands of another.

The surgical community is its own culture with its own syntax and ways of being. Each specialty, operating room and surgeon has unique culture, norms and values. A FNP well-versed in the culture of that service, can educate and ensure cultural awareness of all involved resulting in an optimal surgical experience for the patient, family members and surgical team.

Story of Now

Now, the challenge is to be better, do better and to create a better, less fractured care delivery model for patients and their family undergoing outpatient surgical procedures. Through implementation of a 1:1 FNP/Surgeon clinical care model, there is increased continuity of care and revenue for the hospital and decreased adverse events and readmissions for patients with an overall increase in satisfaction of patients, families and the interdisciplinary team. We aspire to provide the best possible care to patients undergoing a surgical procedure and as FNPs, we supersede challenges present in the current care system to improve and create a superior surgical experience for patients undergoing an outpatient surgical procedure. There is room for improvement in the current healthcare delivery system and FNPs provide a solution.

Appendix D: Elevator Speech

Operating rooms (ORs) are one of the biggest financial engines and revenue creators of the healthcare locomotive (Marcario, 2010). Ineffective utilization of expensive OR time related to starting time delays is a major problem (Dose, Vermaat, Verver, Bisgaard, & Van, 2009). Obtaining a thorough and accurate history and physical of a patient preoperatively is essential to providing anesthetic and surgical care for the patient without delay (Varughese, Byczkowski, Wittkugel, Kotagal, & Kurth, 2006). Other possible delays include missing informed consent, site marking, documentation and lack of patient, family, and multidisciplinary team education. Lack of communication and distractions from paging and phone calls are some of the leading causes of error in the OR (Webster et al., 2008). These errors or delays in OR time result in costly consequences for the patient and healthcare institutions. Throughout the surgical experience, there are many opportunities for error and potential patient harm.

The Solution: Implementation of an FNP as part of the multidisciplinary team in the surgical setting provides a safe, cost-effective and efficient solution to improve the surgical patients experience.

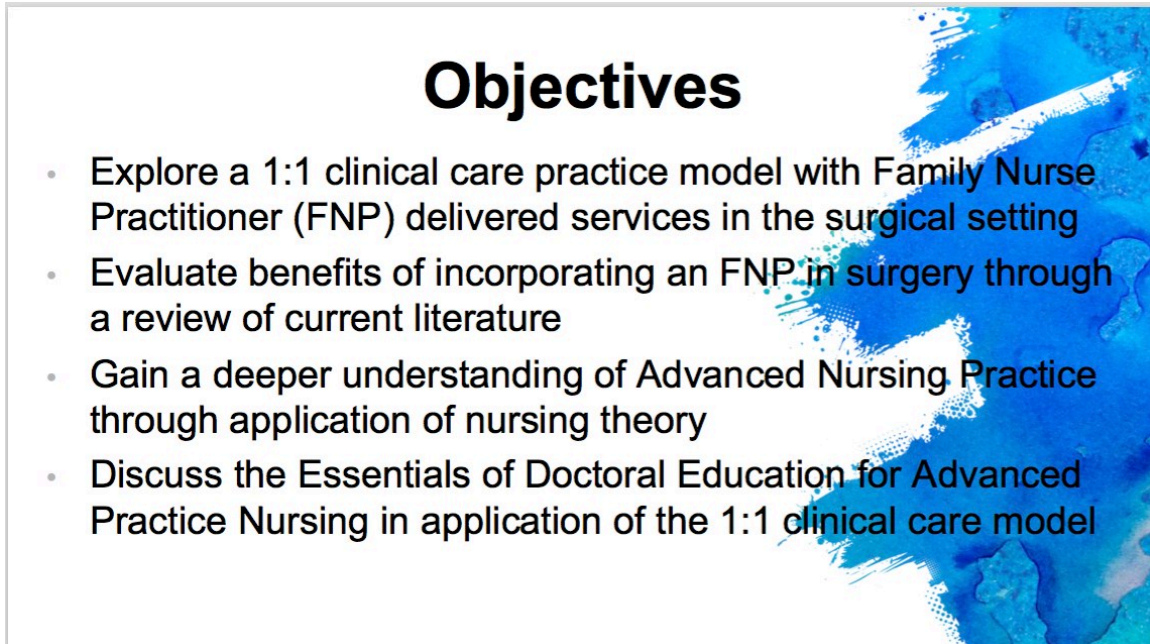
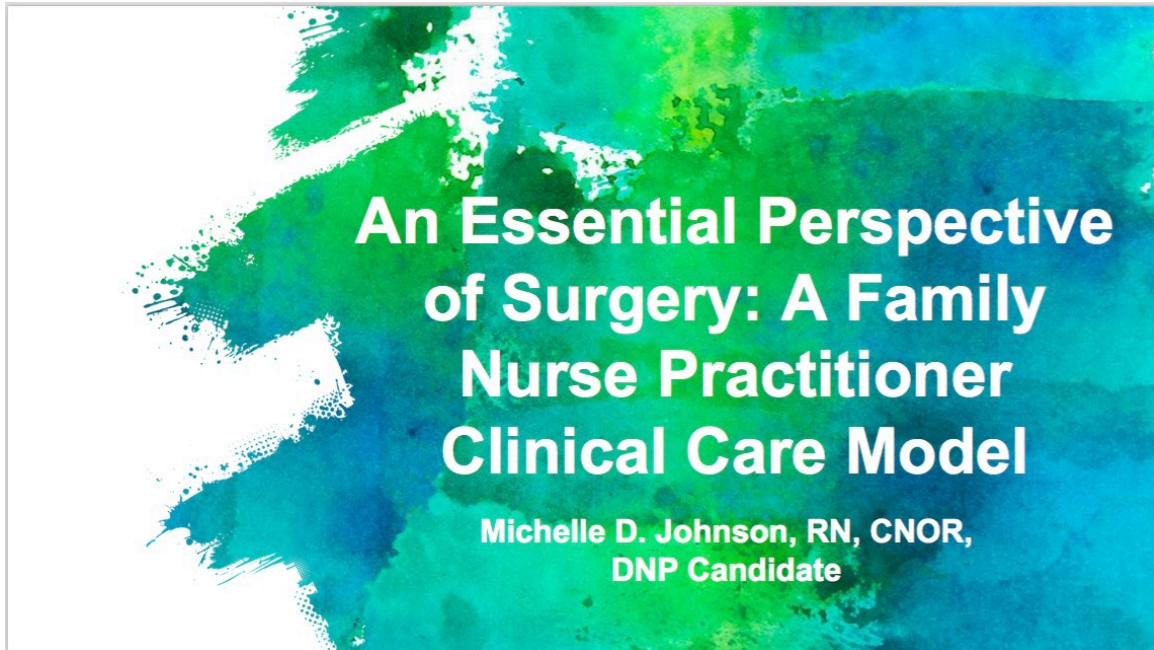
Appendix E: Essentials of Doctoral Education for Advanced Practice Nursing

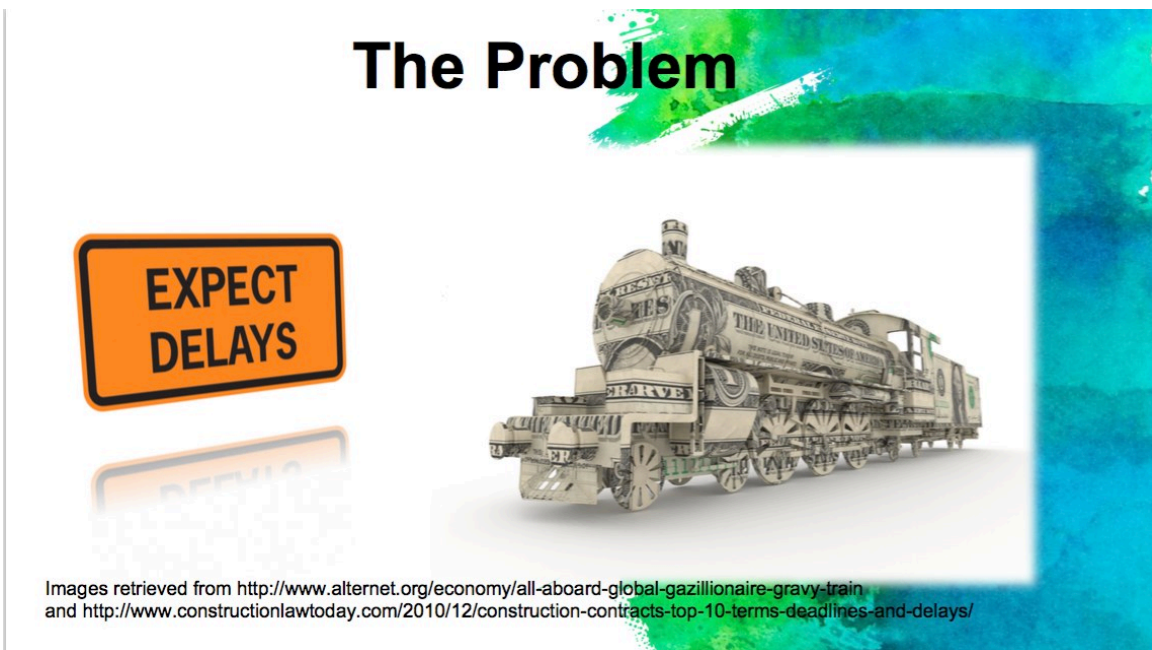
- I. Scientific Underpinning for Practice
- II. Organizational and System Leadership for Quality Improvement and System Thinking
- III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
- IV. Information System/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
- V. Health Care Policy for Advocacy in Health Care
- VI. Interprofessional Collaboration for Improving Patient and Population Health Outcomes
- VII. Clinical Prevention and Population Health for Improving the Nation's Health
- VIII. Advancing Nursing Practice (AACN, 2006)

Appendix F: Photograph of AORN Presentation



Appendix G: Final PowerPoint Presentation





Images retrieved from <http://www.alternet.org/economy/all-aboard-global-gazillionaire-gravy-train>
and <http://www.constructionlawtoday.com/2010/12/construction-contracts-top-10-terms-deadlines-and-delays/>

Impact of FNP- Provided Care in the Surgical Setting

Increased Satisfaction:

- Patient
 - Increased continuity of care
 - Decreased wait times
- Family
 - Pre & Post operative education
 - Decreased anxiety
- Multidisciplinary team
 - Anesthesiologist
 - Resident Physicians
 - Staff Nurses

Impact of FNP- Provided Care in the Surgical Setting

Cost Reduction:

- Increased patient volumes
- Decreased readmission & complication rates
- Reduced delays in on-time OR start
 - Informed consent
 - Site marking

Quality & Safe Patient Care:

- Briefing/debriefings

Literature Review

- Horn, P., Badowski, E., & Klingele, K. (2014). Orthopaedic clinical care model in a pediatric orthopaedic setting. *Orthopaedic Nursing*, 33(3), 142-146. doi:10.1097/NOR.0000000000000046

Increased ↑

- Patient volumes (surgical volume 18%, new patients 3%)
- Patient satisfaction
- Clinic revenue
- Continuity of care
- Scheduling and mentorship flexibility/opportunities

Decreased ↓

- Wait times
- Patient health education barriers
- Patient confusion regarding procedures
- Calls regarding at-home care

Literature Review

FNP & Preoperative Assessment

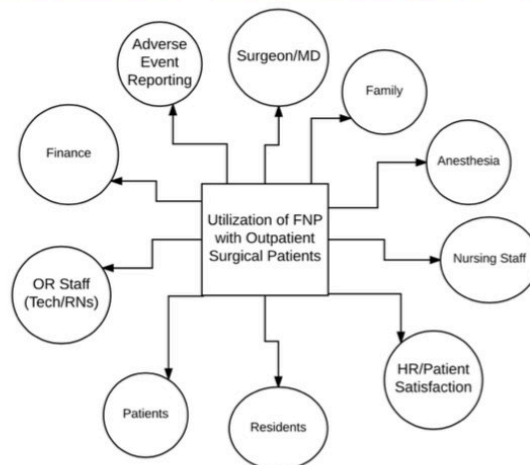
- The implementation of an FNP in the outpatient surgical setting
- Increases OR efficiency
 - Faster turn-over times and ensuring on-time starts
- Accurate and thorough information and documentation (History & Physical)
 - Cost efficient measures
 - Increased patient safety
 - Increased patient volumes (Barnett, 2005)

Literature Review

Financial Consideration

- Reduced length of stay
- Increased continuity
- Enhanced multidisciplinary team planning
 - Positive impact on outcomes
- Expedited discharge
- No effect to readmissions or mortality
- Improved hospital profit & reduced cost
 - **\$1,591 profit per day for each patient**
(Cowan, et al., 2006)

Power Map



Conceptual and Theoretical Framework

Jean Watson

PhD, RN, AHN-BC, FAAN



- *Theory of Human Caring & Transpersonal Caring Science (TCS)*
- The art of caring in health and healing

Image retrieved from <https://www.emaze.com/@AZZIOZIC/JEAN%C2%A0WATSON>

Conceptual and Theoretical Framework

Jean Watson, PhD, RN, AHN-BC, FAAN

- **Caring- Healing environment**
 - Energetic presence
 - Higher level of energy in the healing relationship
- **Intentionality and increased conscious awareness**
 - Nursing embodies caring yet caring is enhanced when consciousness is increased (Cowling, Smith, & Watson, 2008).
 - 8 Intentions
- **The art of presence**
 - Authentic presence and self-care practices

Methodology and Evaluation: Subjects & Clinical Setting

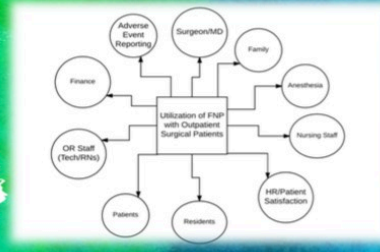


Image retrieved from www.aorn.org.

Image retrieved from <http://www.rochestercvb.org/listings/?action=display&listingID=892&menuID=96&hit=1>

Tools

- PowerPoint Presentation
- Public Narrative
 - Inspiration
 - Application
 - Challenge
- Elevator Speech
- Notecards
- Group Discussion



Image retrieved from <http://plannersweb.com/2013/02/what-does-a-discussion-look-like/>

Intervention & Data Collection

- Information Sharing
- Networking
- Collaboration
- Grey Literature
- Barriers
- Implications
- Feedback

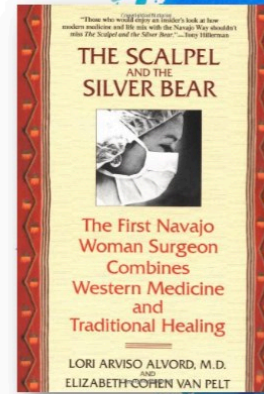


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Significance & Implication



Image retrieved from <https://kimdmooore.com/lead-a-life-of-significance/>

Essentials of Doctoral Education for Advanced Practice Nursing

- I. Scientific Underpinning for Practice
- II. Organizational and System Leadership for Quality Improvement and System Thinking
- III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
- IV. Information System/ Technology and Patient Care
- V. Technology for the Improvement and Transformation of Health Care
- VI. Health Care Policy for Advocacy in Health Care
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Conclusion

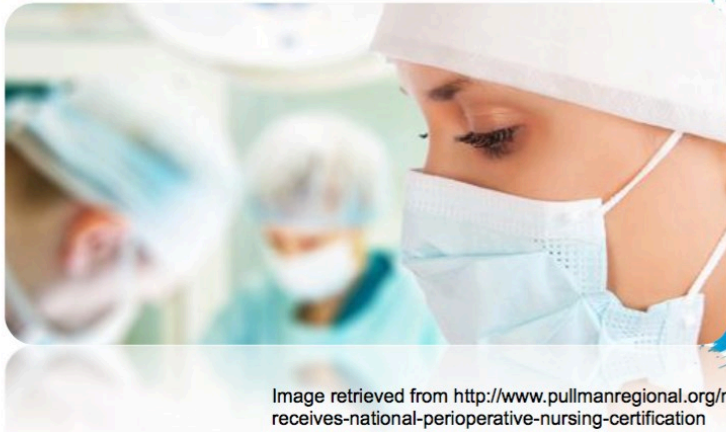


Image retrieved from <http://www.pullmanregional.org/news/pullman-regional-hospital-receives-national-perioperative-nursing-certification>

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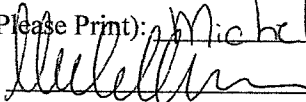
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