

## Overview of the Magnet Recognition Program®

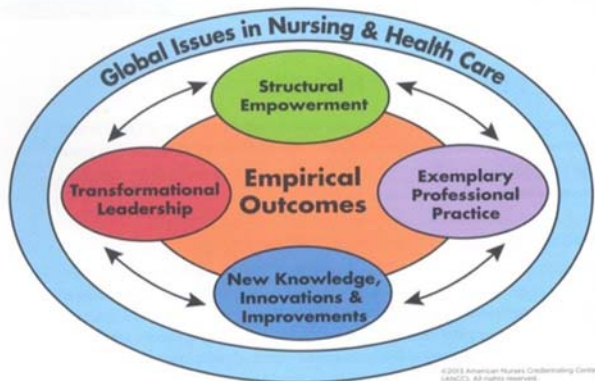
### History

The Magnet Recognition Program® (MRP) was developed by the American Nurses Credentialing Center (ANCC) to recognize health care organizations demonstrating excellence in nursing, innovations in healthcare and patient outcomes. The program generated from a research study conducted in 1983 and led by the American Academy of Nursing involving 163 institutions (AAN) in 1983 to identify characteristics of nursing environments supporting nurse recruitment and retention and those nurses providing optimal patient care. Outcomes of the study revealed that 41% of the hospitals demonstrated positive characteristics promoting recruitment and retention and was recognized as a “Magnet Facility.”

Based upon this study, the American Nurses Association (ANA) approved a proposal for the Magnet Hospital Recognition Program for Excellence in nursing services provided by ANCC. In 1994, the University of Washington Medical Center became the first ANCC Magnet-designation. Thereafter, the provision of the credential extended to long-term care facilities and healthcare organizations outside the United States (US). In 2002, the official name changed to the Magnet Recognition Program®. Since that time, healthcare organizations worldwide obtain designation through enculturation of the Magnet Model®. Once supported by the evidence-based 14 Forces of Magnet, the model is comprised of five components and supported by approximately 100 standards of excellence endorsed by the ANA and published research (see Figure 1). As one of the five components, Empirical Outcomes serves as the core of the model requiring designating facilities to demonstrate quantifiable outcomes related to evidence-based interventions and innovations led and co-led by nurses at all levels throughout the organization.

### Magnet Model

FIGURE 1. MAGNET MODEL



### Defining the Magnet Model

Below is a brief definition for each of the five components within the Magnet Model. As part of the designation and redesignation process, organizations submit numerous examples of quality, evidence-based practice and research initiatives through written documentation exemplifying application of the Magnet Model (please refer to *BHLEX Magnet Roadmap, p. 18 for various examples of initiatives submitted during 2015-18*). These examples demonstrate enculturation of ANA/ANCC standard throughout inpatient and ambulatory settings:

- **Transformational Leadership:** Initiated by the COO/CNO, nursing leadership shares and inspires a strong vision for nursing and effectively communicates and collaborates with nursing to improve care delivery and patient and family centered outcomes.

- **Structural Empowerment:** Organizational support and internal resources are accessible and effectively **utilized by nursing and interprofessionals to:** 1) facilitate flow of information; 2) participation in unit and house-wide work groups and decision-making; 3) professional development; 4) community involvement; and 5) reward and recognition.
- **Exemplary Professional Practice: Nursing and interprofessionals demonstrate collaboration** through use the BHLEX Model of Care (professional nursing practice model) to translate national standards and evidence-based initiatives into practice and improve outcomes
- **New Knowledge, Innovations & Improvements:** Nursing leads the transformation of care delivery through the conduct of nurse-led and co-led and **interprofessional** research, application of published evidence to implement new and revise practices, and utilize process models to redesign workflow and improve outcomes.
- **Empirical Outcomes:** Majority of the written documentation requires demonstration of improved nursing and patient outcomes through evaluation of interventions pre/post-intervention. Nationally benchmarked data for RN satisfaction, nurse sensitive indicators and patient experience outcomes for all qualifying inpatient and ambulatory units are submitted. **Many of these data demonstrate the level of interprofessional involvement and impact on measurable outcomes.**

### *Why Become Magnet?*

While the Magnet Model illustrates how nurses at all levels (particularly clinical/direct care nurses) lead and shape their professional practice, significant emphasis is made on the collaboration of nursing and the interprofessional care team to develop and evaluate interventions supporting improvements in practice and outcomes. Involvement and engagement of interprofessional team members is critical for success. It is important for all disciplines to understand the measureable benefits for all key stakeholders. Benefits published in recent literature include the following:

#### Nursing & Interprofessionals:

- Fosters empowerment to communicate concerns regarding practice and outcomes, participate in shared decision-making and engage in ongoing evaluation of the impact through the shared governance infrastructure and efficient access to leadership;
- Promotes clinical autonomy within the scope of practice for each discipline;
- Secures resources promoting professional development through life-long learning; and
- Provides access to internal and external resources supporting work-life balance and personal and professional well-being; and o Reduced work-related stress and increased satisfaction of practice environment resulting in lower RN turnover.

#### Patients:

- Increased adoption of safety standards and practices when receiving healthcare;
- Reduced opportunities of missed nursing care;
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- Increased delivery of evidence-based nursing care and medicine;
- Higher levels of satisfaction regarding the hospital experience compared to national benchmarks;
- Reduced incidence of mortality, failure to rescue, fall rates, hospital acquired conditions (e.g. CAUTI, CLABSI, C-Diff, MRSA) and pressure injuries.

#### Organization:

- Increased nursing satisfaction as compared to national benchmarks supporting lower RN turnover;

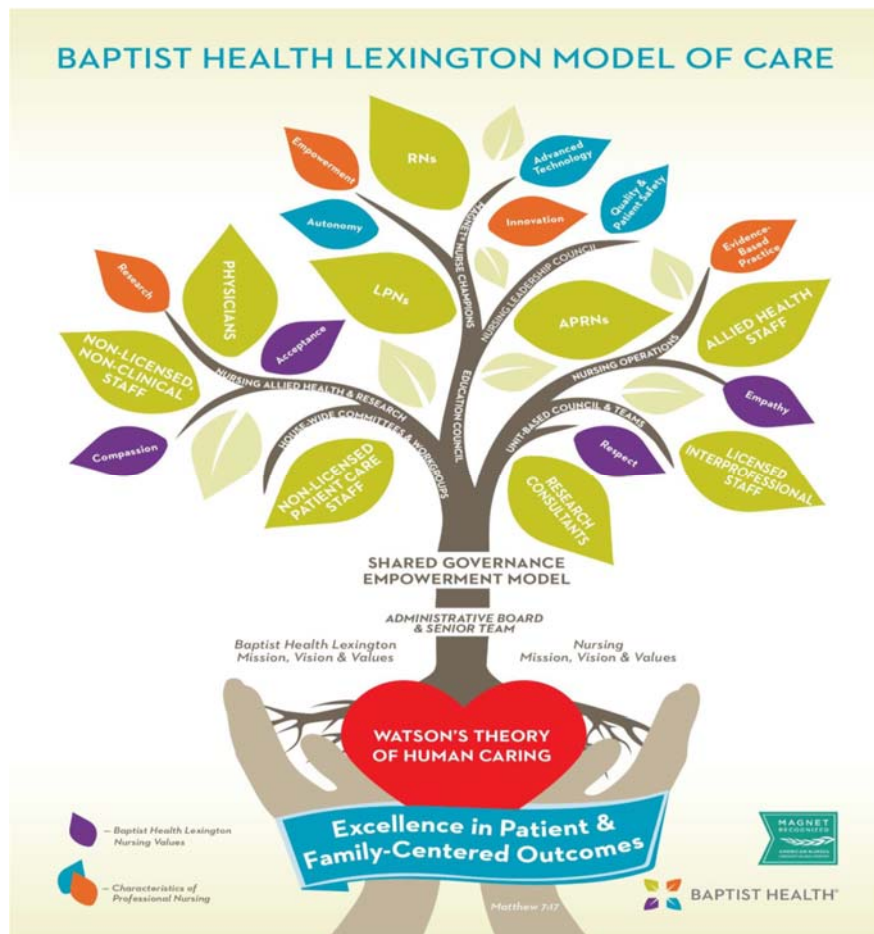
- Improved clinical outcomes reported to organizations externally;
- Decreased length of stay through provision of evidence based care and care coordination led by nursing and the interprofessional team;
- Higher net inpatient outcome.

**What is the BHLEX Model of Care/Shared Governance Infrastructure?**

The Model of Care is a graphic illustration that represents professional nursing practice at BHLEX. It's components comprise our infrastructure, resources and support (including members of the interprofessional team) to coordinate and provide care on a consistent basis. The center focus of nursing practice is to nurture excellence in patient and family-centered outcomes. Nurturing excellence in outcomes is much like nurturing a young plant that grows into a tree:

- It all starts with drawing our strength from our roots, which is the BHLEX & Nursing mission, vision and values along with Watson's Caring Theory of Human Caring (2008).
- Nursing practice is founded upon the infrastructure (referring to the trunk and branches of the tree) provided through direction and leadership from our Administrative Board and Senior Team and the shared governance empowerment model.
- Using the infrastructure in place, nurses at all levels and members of the interprofessional healthcare team (noted on the large leaves) play a vital role in maintaining and sustaining excellence through active participation on councils, teams and workgroups at the unit and house-wide level (noted as the branches of the tree).
- The RN remains the coordinator of care noted at the top of the tree.

The characteristics of our professional practice are illustrated in the colorful leaves on the tree. Our faith-based values demonstrate that nurses will be recognized by their fruits. Matthew 7:17 every good tree bears good fruit.



## ***Overview of the Jean Watsons' Theory of Human Caring***

Nursing at BHLEX adopted Dr. Jean Watson's Theory of Human Caring in 2003. All felt that this theory most clearly aligned with the Mission, Vision, and Values of the Hospital and of nursing in particular.

The **Core Practices:** Evolving from Carative to Caritas (Watson, 2008, p. 34)

- Practice of loving-kindness and equanimity
- Authentic presence: enabling deep belief of other (patient, colleague, family, etc.)
- Cultivation of one's own spiritual practice toward wholeness of mind, body, spirit-beyond ego
- "Being" the caring-healing environment
- Allowing miracles (openness to the unexpected and inexplicable life events)

*Core Concepts of the Theory:*

- **A relational caring for self and others** based on a moral/ethical/philosophical foundation of love and values.
- **Transpersonal caring relationship:** going beyond ego to higher "spiritual" caring created by "Caring Moments:"
  - Moral commitment to protect and enhance human dignity
  - Respect/"love" for the person—honoring his/her needs, wishes, routines, and rituals
  - Caring consciousness of self as person/nurse and other as person—connection as human beings
  - Heart-centered/healing caring based on practicing and honoring wholeness of mind-body-spirit in self and each other
  - Inner harmony (equanimity) maintaining balance
  - Intention of "doing" for another and "being" with another who is in need
  - "Authentic Presence" (honoring/connecting human to human)
- **Caring Occasion/Caring Moment:** Heart-centered encounters with another person. When two people, each with their own "phenomenal field"/background come together in human-to-human transaction that is meaningful, authentic, intentional, honoring the person, and sharing human experience that expands each person's worldview and spirit leading to new discovery of self and other new life possibilities.
- **Multiple ways of knowing** through science, art, aesthetic, ethical, intuitive, personal, cultural, spiritual.
- **Reflective/meditative approach:** increasing consciousness & presence to humanism of self and other
  - Understanding self through reflection/meditation (journaling, the arts, meditation, etc.).
  - What is the meaning of caring for the person/families/myself?
  - How do I express my caring consciousness and commitment to my patients/clients? To colleagues? To the institution? To the community and larger world?
  - How do I define self, nurse, person, environment, health/healing, and nursing?
  - How do I make a difference in people's life and suffering?
  - How do I increase the quality of people's healing and dying process?
  - How can I be informed by the clinical caritas processes in my practice?
  - How can I be inspired by Watson's caring theory in my practice?
- Caring is inclusive, circular, and expansive: Caring for self, caring for each other, caring for patients/clients/families, caring for the environment/nature and the universe.
- Caring changes self, others, and the culture of groups/environments.

- Ten Carative Factors redefined as Caritas Processes:
  1. Practice loving kindness.
  2. Instill faith and hope and honor others.
  3. Nurture individual spiritual beliefs and practices.
  4. Develop helping – trusting – caring relationships.
  5. Promote and accept the expression of positive and negative feelings.
  6. Use creative scientific problem-solving methods for caring decision making.
  7. Perform teaching and learning that address individual needs and learning styles.
  8. Create a healing environment for the physical and spiritual self which respects human dignity.
  9. Assist with basic physical, emotional, and spiritual human needs.
  10. Allow room for miracles to take place.