Navigating Nursing's Future

By

Sue Johnson

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Preface/Dedication

This book is dedicated to all the nurses who make the world of healthcare a better place.

You make a positive difference, and I am proud to recognize you as colleagues and leaders. You are the navigators who will guide our profession onward and upward. Take care of yourselves because we cannot succeed without you!

Special thanks to my two guiding stars who helped me navigate these tumultuous healthcare waters: Pamela Dickerson, PhD, RN, NPDA-BC®, FAAN and Eric Wurzbacher, BS.

Foreword

Sharon M. Weinstein, MS, RN, CRNI-R®, FACW, FAAN, CSP®

"Nursing is not just a profession; it is a lifelong journey of navigating the complexities of human care, where the course we chart today shapes the future of health for generations to come."

This timeless truth reflects the essence of nursing and the immense responsibility we hold as stewards of change. As you turn the pages of this book, you will embark on a journey that challenges you to be the navigator of your own future, guided by the transformative power of nursing's past and propelled by the limitless possibilities of its future.

In this timely work, Sue Johnson takes us on that journey of self-empowerment, reflection, and strategic foresight. With each page, she invites us to navigate the course of nursing's future much as we have navigated its past.

The history of nursing has always been about navigating uncharted waters. From the early pioneers such as Florence Nightingale, who introduced the importance of sanitation, to the remarkable theorists like Jean Watson and Hildegard Peplau, who shaped nursing as a profession grounded in the human experience, nursing has long relied on frameworks that guided the course toward improving patient care. These nurse theorists were the compass that set our direction, guiding us toward a vision of compassionate, patient-centered care that resonates to this day. They understood that nursing was not just about tasks and treatments but about understanding the broader context of health—factors beyond the hospital room to shape the well-being of individuals, families, and communities.

As we continue our journey, we must recognize that nursing's purpose is not static. It is evolving, shaped by the forces of modern technology and the realities of the world we face today. The *metaphor* of the nursing profession as a vessel—whether it be a small skiff, a great ship, or even a powerful fleet—reminds us that we have always had the power to steer our profession, even in turbulent waters. We are called to steer toward health equity, champion access to care for all people, and advocate for the social determinants of health that shape the health outcomes of individuals and populations.

Health equity has become a central pillar of nursing practice. Today, it is not enough to merely address the needs of patients; we must understand and confront the systemic barriers that hinder access to care and perpetuate disparities. Social determinants of health, such as socioeconomic status, education, and environmental factors, significantly influence health outcomes. As nurses, we have the knowledge and the unique vantage point to advocate for change on these issues, bringing attention to the upstream factors that affect the most vulnerable populations. Nurses, in their roles as caregivers and community leaders, can be the stewards of a more just and equitable healthcare system.

This book also addresses the vital role that technology and artificial intelligence (AI) play in advancing nursing practice. Technology is no longer a passive tool; it has become an active participant in shaping our future. Nurses are integrating digital health tools into their practice, leveraging electronic health records (EHRs), mobile health apps, telemedicine, and AI-driven diagnostics to improve patient outcomes. These advancements allow us to work more efficiently, deliver better care, and engage in continuous learning. AI, in particular, promises to revolutionize nursing practice by enhancing decision-making, personalizing patient care, and reducing human error. Imagine a world where AI systems support nurses in making real-time clinical decisions, providing predictive analytics, and

offering tailored care plans that align with each patient's unique needs.

But with these innovations comes an ethical responsibility: to ensure that technology serves all populations equally without exacerbating existing disparities. The forecast for nursing practice is a future where technology empowers us, but our commitment to human-centered care remains the compass guiding our actions. It is crucial that we do not lose sight of the human touch in an increasingly automated world. The future of nursing is one in which technology and compassion coexist, complementing each other to create a healthcare system that is both efficient and deeply empathetic.

Sue Johnson offers a map for this future—a vision of nursing where we are both the pilots and the navigators of our profession. Through her words, we are reminded that we are not passive passengers in the evolving landscape of healthcare; we are in control of the wheel. By embracing the past, learning from the present, and shaping the future with intentionality and innovation, we can continue to chart a course toward better care, greater equity, and a brighter future for all. Before we chart that course, we must check the forecast, and each chapter offers the reader a chance to determine the usefulness of the information in their practice.

As we take the helm, let us do so with purpose, resilience, and the collective power of our profession to transform healthcare for the better. This book is not just a guide but a call to action. And more than ever, the time to act is now!

Sharon M. Weinstein, MS, RN, CRNI-R®, FACW, FAAN, CSP®

Introduction

The author has been a registered nurse for over 50 years and has observed the evolution of health care and nursing during that time as a practitioner, educator, leader, family member, and patient in the United States. Nursing today continues to evolve, but this does not always benefit its practitioners or its clients. After exploring how we arrived at the current state, we must forecast our future for the benefit of those we serve, ourselves and our profession. It's time to lead, follow or get out of the way!

Smithsonian Institution

Overview-Navigation

Definition: "the act or science of finding a way from one place to another" (Cambridge University press, 2024)

Navigation in the 1700s required different instruments to traverse oceans and seas. Angle-finding devices enabled mariners to find latitude, but longitude was elusive until a seaworthy clock was invented. As the United States joined other maritime powers in the 1800s, the country made major contributions to safe sea travel, including a navigation encyclopedia, a sea-going chronometer, and

line of position navigation. Since then, navigation has advanced to encompass air and space travel, and innovators have developed navigation technology to affect everyday life. For example, a farmer uses his GPS to guide his tractor resulting in greater efficiency and employs satellite navigation to reduce costs, reduce environmental impact and maintain high crop yields. (Smithsonian Institution, n.d.).

Why is this important for healthcare and nursing?

The simple answer is we are navigating a complex landscape, and technology can help us succeed if we use it beneficially. Before we explore this aspect of healthcare and nursing practice, we must understand where we are today and how we got here.

Chapter 1
U.S. Healthcare and Nursing - Navigating a Historic Perspective

Healthcare has existed in some form since before the United States existed. Navigating healthcare in the 1700s relied on folk remedies and women to help with childbirth. The medical and nursing professions didn't exist. Mortality, especially for infants and children, was high and diseases like diphtheria, smallpox and dysentery were rampant. There was no government health regulation or attention to public health (Griffin, 2020).

In 1750, the first hospital was established in Philadelphia and the first American M.D. degree was awarded in New York City in 1770. Lack of hygiene and poor housing conditions in the 1800s brought epidemics of childhood diseases- chickenpox, whooping cough, measles, and mumps. In the Civil War, diseases killed more soldiers than battles. A few bright spots developed. Surgical techniques and Army hospitals progressed due to the United States Sanitary Commission and the U.S. Army Medical Department. Health-related agencies began, and states started pouring money into healthcare.

Statistical data was collected and analyzed. Healthcare was provided as 'fee-for-service' where payment was due when care was delivered. The American Medical Association (AMA) encompassed nearly half of the country's physicians by the start of the nineteenth century (Griffin, 2020).

In the early nineteenth century, most health insurance initiatives were led by non-government organizations. The American Association of Labor Legislation (AALL) proposed that working class and low-income citizens receive sick pay, maternity benefits, and a death benefit of $50. Costs of these benefits were to be shared between states, employers, and employees. Some medical societies were concerned about physician compensation resulting in AMA's lack of support for the bill. Private insurers also opposed the legislation because people wouldn't buy additional policies. They feared that this would undermine their business and cut their profits. This opposition left the bill without enough support to move forward (Griffin, 2020).

The Progressive Party promoted a National Health Service that would provide public healthcare for the unemployed, disabled, and elderly. The AMA and other organizations strongly opposed this plan, and compulsory healthcare was not supported by members of the American working class. In 1916 the Progressive Party dissolved and with it support for public healthcare disappeared. In World War I Congress passed the War Risk Insurance Act to cover servicemen for injury or death. It was later amended to financially support their dependents. The program ended after the War in 1918, although survivors and their families continued to receive payment (Griffin, 2020).

In the 1920s hospitals and doctors charged more than their patients could afford. A program in Dallas began providing teachers with healthcare for a pre-paid monthly fee. This program spread to schools across the country, resulting in the birth of Blue Cross/Blue Shield. Its success resulted in multiple insurers entering the market. The Great Depression of the 1930s left the unemployed and elderly without

health insurance. Since the AMA opposed any plan for a national health system, President Roosevelt created the Social Security Act of 1935 to provide public support for these two groups. The program also let states develop provisions for people who were disabled or unemployed (or both) (Griffin, 2020).

At this time Henry Kaiser, a prominent industrialist, contracted with a physician to provide pre-paid healthcare to some of his workers and their families. His pre-paid group practice in the early 1940s became the Kaiser Permanente Health Plan, a pre-courser to today's managed care HMOs and PPOs. The 1940s also began employer-sponsored health insurance. Since some employers didn't offer health insurance, those workers and disabled and unemployed people continued to be at-risk for health issues. Universal health care never gained support nationally (Griffin, 2020).

The 1950s saw medical advances from Penicillin to the Polio vaccine and organ transplantations. The price of hospital care doubled, and health insurance coverage stayed about the same. By 1960 national health expenditures accounted for 5 percent of the Gross Domestic Product (GDP). Finally, President Johnson signed the Social Security Act of 1965 which became today's Medicare and Medicaid. When Richard Nixon became President, he believed that the marketplace would add to the system of private insurers for workers to have health insurance through their employers and take Medicare on retirement. Although this did not come to fruition, Nixon did manage to expand Medicare in the Social Security Amendment of 1972 and establish the Health Maintenance Organization (HMO) Act of 1973 (Griffin, 2020).

President Reagan reduced regulations and healthcare privatization gained prominence. In 1986 he signed the Consolidated Omnibus Budget Reconciliation Act (COBRA) that allowed former employees to stay enrolled in their previous employer's health plan if they paid the full premium. It was expensive, but did provide health insurance to recently unemployed people with pre-existing conditions who may

not have been able to purchase private insurance otherwise. In the 1990s President Clinton proposed a healthcare plan that combined universal coverage and the private insurance system. The complexity of the bill, increasing national deficit, and opposition from big business doomed this legislation. His actual healthcare contributions were:

1. the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that set privacy standards for individuals and
2. the Children's Health Insurance Program (CHIP) of 1997 which expanded Medicaid assistance to "uninsured children up to age 19 in families with incomes too high to qualify them for Medicaid" (Griffin, 2020).

Employer-offered HMOs were offered to reduce healthcare costs to both insurers and employees. Insurance companies began to gain more control about how people received healthcare. When George W. Bush became President in 2001, he wanted to include prescription drug coverage in Medicare. His idea became the Medicare Prescription Drug, Improvement and Modernization Act of 2003 which is often called Medicare Part D. The program has had wide usage although enrollment is voluntary. President Obama used the existing private insurance model to extend coverage to millions of Americans. After multiple revisions, he signed the Patient Protection and Affordable Care Act (PPACA) in 2010. This legislation is commonly called the Affordable Care Act and is the most significant update and expansion since the Medicare and Medicaid legislation of 1965. The first open enrollment period was not smooth, but 8 million people signed up in the ACA Marketplace. Although the law was controversial due to its individual and employer mandate, it enabled people with pre-existing conditions to obtain coverage. The law also provided immediate coverage for maternal and pre-natal care. The ACA has covered an average of 11.3 million people annually since it began. However, 8.5% of Americans (about 27.5 million) remain without healthcare coverage (Griffin, 2020).

President Trump sought to repeal and replace the ACA. The individual mandate that everyone have health insurance was removed in 2017. In 2018 states were allowed to add work requirements to Medicaid and beneficiaries had to prove they worked or went to school. The Trump administration also expanded short-term skinny plans that lacked essential benefits that were mandatory in the ACA. Federal spending on advertising ACA exchanges was cut along with ACA Navigators who helped people through the enrollment process. In spite of these actions, the ACA enrollment has been fairly steady. The ACA expanded healthcare to more people but did almost nothing to contain medical costs. This resulted in increases in facilities expenses and prescription costs. The ACA also devastated private individual health plans, leaving limited provider networks as the only option for individual plans. By 2020, neither political party was willing to collaborate on healthcare legislation to expand coverage and reduce costs. (Griffin, 2020).

Navigating Nursing - A Historic Perspective

While physicians and the AMA have been integrally involved in healthcare since the early nineteenth century, nursing has not had the same experience. As mentioned earlier, in the early years of the United States there were no trained nurses and healthcare occurred in the home by family members, relatives and friends. In the 1800s industrialization resulted in the proliferation of urban centers and hospitals began to grow to serve people without the resources to provide their own care. Not all hospitals provided the same level of care. Hospitals of religious orders provided quality care, but other facilities varied from good to poor. Some physicians realized that nursing care was integral to the patient's well-being and provided lectures and training for women who cared for maternity patients (Whelan, n.d.).

The Civil War saw a need for capable nurses to care for the sick and wounded. These nurses had little, or no training and their service set the stage for future nurse training programs. In 1873 three nurse education programs were established in the United States based on Florence Nightingale's ideas of educating women about health and health promotion. These programs were:

1. Bellevue Hospital's New York Training School.
2. the State Hospital's Connecticut Training School; and
3. the Massachusetts General Hospital's Boston Training School (Whelan, n.d.).

The success of these "Nightingale schools" led to the development of numerous nurse training programs and by 1900 there were between 400-800 such schools in the country. Each school was either owned by or affiliated with a hospital to provide students with clinical experience during their 2-3 years of training. Students provided the majority of hospital patient care while receiving lectures on patient care and health subjects. At the end of the program, graduating students received a diploma that enabled them to seek employment as

a trained nurse. These labor-intensive courses continued through the mid-twentieth century and, as patient care became more complex, the amount of theoretical instruction increased and the time spent performing care delivery decreased (Whelan, n.d.).

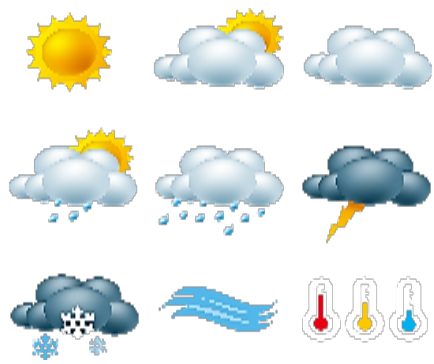
The growth of nursing programs and nurses began the early elements of a profession. Nursing professional organizations were organized in the 1890s. One of these, the American Society of Superintendents of Training Schools for Nurses later became the National League of Nursing Education, and the Associated Alumnae of the United States became the American Nurses Association. In the early twentieth century, the National Association of Colored Graduate Nurses (NACGN) and the National Organization for Public Health Nursing (NOPHN) were created. State nurses' associations were organized which helped pass state nurse registration acts to regulate the growing profession and created a licensing system for practicing nurses. This was an achievement when women had little political power and recognized nurses as RNs (Whelan, n.d.).

Racial segregation continued until the mid-twentieth century and Black nurses had a separate education system, professional organization, and were employed to care for Black patients. White graduate nurses were only employed by hospitals as supervisors since student nurses provided the majority of direct care for patients. Individual patients employed most graduate nurses to deliver care in the patient's home. They were independent practitioners who contracted with those able to pay for their services and continued to provide care when the patient entered the hospital if he/she could afford to pay for their own nurse. The cost of private duty was high, and nurses were hired on an ad hoc basis which could adversely impact their income. Some nurses cared for poor and disadvantaged populations outside the hospital environment. One nurse, Lillian Wald, founded the Henry Street Settlement House in New York City in 1893 which led to the public health movement across the country (Whelan, n.d.).

In the mid-twentieth century, hospitals began hiring nurses on a permanent basis as regular staff members. This reduced the number of private duty nurses and increased hospital control over practicing nurses there. Nurses also served in the military, as nurse anesthetists, and as nurse-midwives. However, by the 1950s, hospital staff nursing was the main nursing employment site. (Whelan, n.d.).

Nursing education also evolved from traditional hospital training schools to community college Associate Degree programs. These programs occurred in higher education institutions, could graduate more nurses, and often cost less than traditional diploma programs. Although these programs continue today to prepare nurses, late twentieth century research studies indicated that baccalaureate preparation would improve patient outcomes. As a result, T*he Future of Nursing Report* by the National Academies of Sciences, Engineering, and Medicine recommended that 80% of nurses have a baccalaureate degree by 2020 (National Academies of Sciences, Engineering, and Medicine, 2016). [Note: This was achieved.]

In the twenty-first century, nursing has increased specialization both inside health facilities and within the community. Advanced practice nurses have grown and deliver cost-effective, safe, and efficient healthcare services in multiple settings. Shortages continue to occur, and nurses are not always available to meet the demand for their skills (Whelan, n.d.).

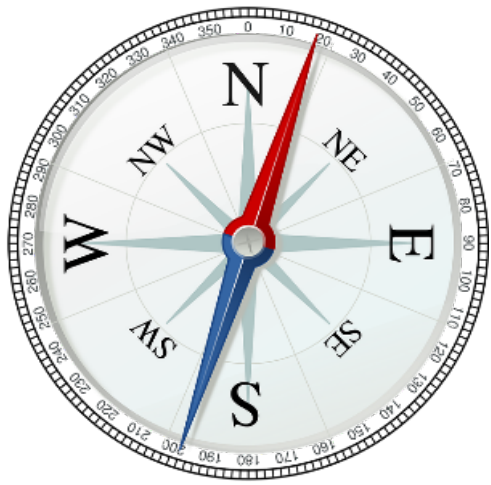


Nursing Weather Forecast for Navigation

Each chapter has a weather forecast for the reader to determine the usefulness of the information in their practice.

1. Nursing began in the home and community. Where do you see it in the next 5 years? 10 years? Where do you see your practice in that time period and why?
2. After reading this, what is your perspective about health insurance and legislation related to health coverage? Why?
3. What is your future forecast (prediction) based on your responses to the above questions?

Chapter 2
Navigating Patient Care



Patient care has dramatically changed over the years in practice, location and impact. This chapter will explore the theoretical basis of nursing and how various care models impact care delivery.

Nursing Theories

Nursing theory is the foundation to guide nurses' actions in caring for their patients. Theories create guidelines for specific and broad nursing practices. The first nursing theory was Nightingale's Environmental Theory. This Theory identified five environmental factors important to the patient's well-being and overall health:

1. Fresh air.
2. Light or direct sunlight.
3. Pure water.
4. Cleanliness or sanitation; and
5. Efficient drainage.

These factors were essential to decrease morbidity and mortality and limit the spread of contagious diseases. They are still relevant today (Gaines, 2023).

Although healthcare facilities incorporate nursing theories in their policies and procedures, nurses may use more than one theory in their daily practice. Nurse educators use theories to design course curriculums based on educational principles and evidence to teach students the knowledge and skills to care for their patients. Nurse researchers use theories to guide research that creates best practices, explain existing knowledge, and predict potential clinical problems. Each theory has four specific concepts:

1. Person-the recipient(s) of nursing care.
2. Health-the degree of well-being or wellness experienced by the person or client.
3. Environment-the external and internal surroundings that affect the person or client, including the health care setting and the physical environment; and
4. Nursing-the qualities and actions of the nurse who delivers care (Gaines, 2023).

Using these four concepts, nursing theories are divided into three levels:

1. Grand Nursing Theories based on broad, complex, and abstract ideas often reflecting the experience of the nurse theorist.
2. Mid-Range Nursing Theories drill down into specific nursing areas; and
3. Nursing Practice Theories which are narrower and focus on a specific patient population. These theories directly affect patients more than the other two theories. Nightingale's Environmental Theory is a good example.

It is helpful to review the concepts of major Unites States nursing theories as illustrated in the following table of twelve nurse theorists:

Nurse Theorist	Name of Theory	Major Concepts
Hildegard Peplau	Interpersonal Nursing (Grand Nursing Theory is sometimes listed as Middle Range Theory)	**Person**: The individual in instable equilibrium tries to reduce anxiety caused by needs. **Environment**: not defined **Health**: implies moving forward toward constructive, creative, personal, productive and community living **Nursing**: involves problem-solving and functioning cooperatively with others to make health possible
Virginia Henderson	Nursing Need Theory (Nursing Practice Theory)	**Person**: The individual has biophysical needs and mind, and body are interrelated. **Environment**: settings where the individual learns unique patterns for living, including family relationships **Health**: the individual's ability to function independently **Nursing**: The nurse does for the individual what he would do for himself with the necessary knowledge, will, and strength. The nurse helps the individual gain independence as rapidly as possible.
Faye Abdellah	Twenty-One Nursing Problems (Nursing Practice Theory)	**Person**: The person has physical, emotional, and sociological needs. The person is the only reason for nursing to exist. **Environment**: the home or community of the person **Health**: a state mutually exclusive of illness **Nursing**: 21 problem areas guide care to meet the person's needs, alleviating impairment,

Nurse Theorist	Name of Theory	Major Concepts
		or restoring or increasing self-help ability
Ida Jean Orlando	Nursing Process Theory (Grand Nursing Theory is sometimes listed as Mid-Range Nursing Theory)	**Person**: Humans in need are the focus of nursing practice. **Environment**: not addressed **Health**: a sense of helplessness shows a need for nursing **Nursing**: Nurses meet the person's need for help interactively and in a disciplined manner based on their training.
Martha Rogers	Science of Unitary Human Beings (Grand Nursing Theory)	**Person**: an energy field and unified whole that cannot be predicted by knowledge of its parts **Environment**: an energy field that coexists and is integral to the human field **Health**: characteristics and behavior from human and environmental fields-Health and illness are part of the same continuum. **Nursing**: an art (creative use of science to better people) and a science (body of knowledge derived from scientific research and logical analysis)-Nursing exists to serve people.
Dorothea Orem	Self-Care Theory (Grand Nursing Theory is sometimes listed as Mid-Range Nursing Theory)	**Person**: distinct individual who performs self-care (ADLs) **Environment**: promotes personal development to meet future demands **Health**: Self-care deficit determines when nursing is needed. **Nursing**: interpersonal therapeutic relationship and

Nurse Theorist	Name of Theory	Major Concepts
		regulatory technologies to maintain and promote life processes using nursing process
Imogene King	Theory of Goal Attainment (Grand Nursing Theory)	**Person**: a social being who has a need for health information, need for care to prevent illness, and need for care when unable to help self **Environment**: background for human interaction **Health**: allows person to grow and develop to attain certain life goals **Nursing**: helping person to maintain health by collaborating with the person in a mutual goal-setting process
Betty Neuman	Health as Expanding Consciousness (Grand Nursing Theory)	**Person**; a layered, multidimensional being-physiological, psychological, socio-cultural, spiritual, and developmental. **Environment**: all the external and internal forces surrounding a person with which the person interacts at any given time **Health**: equated with wellness when more energy is available than needed. Illness occurs when less energy is available than needed. **Nursing**; addresses the whole person by interventions to reduce stressors
Calista Roy	Roy Adaptation Model (Grand Nursing Theory is sometimes listed as Mid-Range Nursing Theory)	**Person**: bio-psycho-social being that interacts with a changing environment-includes individuals, groups, and society as a whole

Nurse Theorist	Name of Theory	Major Concepts
		Environment: has three components- focal (internal or external that immediately confronts the individual), contextual (all stimuli contributing to focal effects), and residual (effects that are unclear in the current situation) **Health**: a state and process of becoming whole and integrated **Nursing**: promotes adaptation in four adaptive modes- physiological needs, self-concept, role function, and interdependence
Jean Watson	Philosophy and Theory of Transpersonal Caring (Grand Nursing Theory)	**Person**: a human being as a fully functional integrated self **Environment**: society that provides values to determine behavior and goals to strive toward **Health**: unity and harmony in body, mind, and soul-a high level of physical, social, and mental functioning leading to daily functioning or leading to the absence of illness **Nursing**: transpersonal caring between the nurse and the person
Madeline Leininger	Transcultural Nursing (Grand Nursing Theory is sometimes listed as Mid-Range Nursing Theory)	**Person**: Human beings are caring and able to be concerned about others' needs, well-being, and survival. **Environment**: not defined- speaks of social structure, worldview, and environmental context **Health**: state of well-being that

Nurse Theorist	Name of Theory	Major Concepts
		is valued, culturally defined, and practiced **Nursing**: a learned humanistic and scientific profession providing caring and culturally congruent care
Patricia Benner	Novice to Expert (adaptation of the Dreyfus Model of skill acquisition) (Nursing Practice Theory)	**Person**: patient and family **Environment**: situations where the patient and nurse are interacting **Health**: patterns of clinical situations **Nursing**: developmental movement from task focus to recognition of components of a situation, pattern recognition, focus on whole situation, and intuitive grasp of relevant issues based on knowledge and experience

(Gaines, 2024; Nurseslabs, 2024; Petiprin, 2023)

Theories have evolved over time, but each of these has earned a place in the lexicon of nursing practice. With this in mind, it's time to look at nursing care models and their impact on clinical practice including outcomes and patient (client)/nurse satisfaction.

Nursing Care Models

Nursing care models provide structure as frameworks that organize the scope of care delivery on the assigned shift. On a chaotic unit where multiple clinicians provide services to patients, use of a model helps nurses organize and deliver efficient safe care in a complex environment. Several care models have been utilized in different healthcare settings with varying success (Fuqua, 2022).

Functional Nursing

Process: Functional nursing became popular in World War II when nurses provided care to multiple wounded people in hospital settings. Nurses performed standardized tasks and procedures achieving proficiency through systematic repetition. After the War, this model persisted for many years. Functional nursing is also known as task nursing where the focus is on the task rather than on the patient (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Advantages: Many facilities used this model which was based on the scarcity of human resources in the industrial revolution. Functional nursing required a smaller number of professional nurses who were responsible for specific care tasks, such as medication administration, wound management, and hygiene and comfort care while reporting to the head nurse. Nurses learned specific skills and organizations believed that functional nursing translated into productivity and efficiency (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Disadvantages: This care delivery model lacked coordination between caregivers and patients who received non-holistic care. Communication between nurses was reduced as each focused on specific procedures rather than personalized patient care. Some activities were forgotten due to lack of planning. Accountability for care was difficult to determine when multiple professionals didn't deliver comprehensive care. There was an increased risk of healthcare-associated infections (HAIs) (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Patient Outcomes: Patients were not as fortunate when safety failures occurred resulting in higher accident rates and avoidable adverse events. They also didn't form a relationship with their nurses which resulted in insecurity about their care. Patients were dehumanized

and referred to by diagnosis, not name- "the appendectomy in 210". As a result, patient satisfaction decreased (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Nursing Outcomes: Nurses could not apply the nursing process which resulted in difficulties identifying patient needs and poor record keeping. The nurse did not have an overall understanding of the patient and his/her needs, resulting in inadequate assessment and care planning. Interaction and interpersonal relationships between team members were difficult to attain and poor team spirit occurred. Performing the same routine tasks daily reduced nursing motivation and satisfaction (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Primary Nursing Care

Process

Primary care nursing was developed in 1968 under Marie Manthey at the University of Minnesota Hospitals and makes the registered nurse responsible for assessing, planning, delivering, and evaluating the care of one or more patients from admission to discharge. Each primary nurse is assisted by associate nurses who provide care whenever the primary nurse is absent. These nurses may be primary nurses for some patients and associate nurses for others. The primary nurse is responsible for coordinating clinical decisions and supervising the patient's care during the hospitalization (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021) .

Advantages

Primary nursing reduces the number of nurses handling interventions and reduces the likelihood of errors occurring. It promotes the relationship between patients and nurses resulting in better continuity of care. It also empowers the identification of health outcomes, such as reduction in hospital-acquired infections. Primary nursing facilitates patient/family education and more efficient, effective discharge

planning. The facility experiences higher quality care, increased patient satisfaction, and maximum staff performance (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021) .

Disadvantages

Quality of care depends on the nurses' qualifications and some nurses will be unable to assume responsibility for coordination of equitable patient services. Primary nursing will require more nursing staff members and greater preparation of associate nurses. For the organization, this will involve greater investment in the staffing team. There is also a risk of emotional involvement of the nurse with the patient reducing objective assessment, planning, delivery of care, and evaluation (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Patient Outcomes

The patient knows the identity of his/her nurses and develops a relationship that promotes health gains. Communication among all members of the healthcare team and the patient/family is facilitated. Communication, collaboration, and patient/family involvement in his/her care enhances patient satisfaction. There is also greater communication and collaboration between the primary and associate nurses to ensure individualized care for the patient (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Nursing Outcomes

Nurses have greater autonomy in decision-making, can try creative approaches, and really get to know their primary patient and his/her needs beyond diagnosis. The nurse can spend time communicating with the patient and seeing the result of nursing interventions. Primary care is an opportunity for the nurse to maximize his/her performance and see the value of these autonomous interventions

(Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Total Patient Care

Process

Total patient care is also known as the case method or individual approach. In this care model, the nurse is responsible for delivering care to a group of patients during an assigned shift. Coordination of the care delivered to all patients on the unit is the responsibility of a single nurse, usually the head nurse, who supervises and evaluates the care provided and makes decisions during the process. However, care delivery to patients on the shift is delegated to their assigned nurse who is responsible for their care (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Advantages

Care is not fragmented during the shift and the patient can readily identify his/her assigned nurse. The relationship between the patient and nurse increases continuity of care and reduces errors and omissions. It requires greater proficiency by the nurse. For the organization, total patient care translates into higher quality care delivery (Parreira, Santos-Costa, Neri, Marques, Queiros, & Salgueiro-Oliveira, 2021).

Disadvantages

Coordination of care doesn't occur between shifts, and this may adversely impact the patient's care plan. The overall organization of care to meet the patient's needs depends on the nurse's view of his/her professional role and may prioritize the patient or performance of tasks. Outcome evaluation is difficult because this delivery model limits the nurse's actions during the shift based on his/her assigned patients. Various levels of care may be provided based on each nurse's