Early Career RNs’ Perceptions of Quality Care in the Hospital Setting

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Abstract

The purpose of this study was to explore early-career registered nurses’ perceptions of high-quality nursing care in hospitals. The study findings contribute to ongoing work intended to explore and define what quality nursing care is and how it ultimately impacts patients. The final sample analyzed for this article consisted of 171 narrative responses from hospital-based registered nurses. We used Krippendorff’s technique for qualitative content analysis to identify themes. Three themes emerged as integral to high quality nursing care: registered nurse presence, developing relationships, and facilitating the flow of knowledge and information. Development of nursing quality indicators should focus on nursing processes in addition to patient outcomes. Such a focus would better capture the complexity of hospital nursing care.

Keywords

content analysis; health care administration; health care, acute / critical; nursing; quality improvement; quality of care

Defining Quality Health Care

In the quest to continually improve health care there have been a number of organizations (i.e., The Robert Wood Johnson Foundation, Agency for Healthcare Research and Quality, National Quality Forum), health care providers, and researchers whose goals are to develop, validate, and support definitions, measures, and indicators of quality health care. These measures and indicators of quality can then be used to inform consumers, practitioners, and

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policy makers about the quality of care provided within specific hospitals and throughout the wider health care system.

A variety of quality indicators have been created and are currently in use. For example, the National Committee for Quality Assurance has established the Healthcare Effectiveness Data and Information Set (HEDIS) as a widely disseminated and implemented tool to measure performance and quality of care. The HEDIS indicators include measures such as whether a patient with an acute myocardial infarction received a beta blocker or not, or whether a child had well child visits in years 1, 4, 5, and 6 (National Committee for Quality Assurance, 2010). Other examples are those developed at the Agency for Healthcare Research and Quality (AHRQ): prevention quality indicators, inpatient quality indicators, pediatric quality indicators, and patient safety indicators. One difference between the HEDIS quality indicators and AHRQ’s quality indicators is that AHRQ assigns accountability to specific providers. For example, the AHRQ patient safety indicators (U.S. Department of Health and Human Services, 2006) use measures such as pressure ulcers, with the nurse as the responsible health care provider.

Some outcome measures used to define quality care are discipline specific, such as the nurse-sensitive patient outcomes (NSPO) identified and developed by the National Quality Forum (2007). The fifteen NSPO identified by the National Quality Forum use administrative databases to retrospectively report on distal patient care outcomes (i.e., falls, central line catheter infection rates, smoking cessation counseling for heart failure, and others). Although these outcome measures are important indicators of quality nursing care, they might fail to adequately capture or measure several important aspects of quality nursing care occurring in the hospital setting. Therefore, a more comprehensive range of nursing care quality indicators should be established.

To be able to develop a range of discipline-specific quality indicators, the profession of nursing needs to define what high-quality nursing care is. This will become even more important as pay-for-performance initiatives and payments to hospitals move to include nurse-sensitive and nurse-specific processes of care (Bodrock & Mion, 2008; Clarke, Raphael, & Disch, 2008). The purpose of this study was to explore early career RNs’ perceptions of high-quality nursing care in the hospital setting. The results of this study will contribute to the ongoing work related to defining high-quality nursing care and developing additional nursing care quality indicators by validating previous findings and providing new knowledge on how early-career RNs perceive high-quality nursing care.

Methods

Data for this study were collected in November of 2008 from early career RNs working in a hospital. These RNs were licensed between August 1st, 2004, and July 31st, 2005, and with 4 or fewer years of practice experience we considered them to be early career RNs. Additionally, according to Benner’s (1984) framework of novice to expert, these RNs would have been in the competent or proficient stage of development with fewer than 5 years of experience. The participants were drawn from a sample of RNs participating in a larger, longitudinal panel survey exploring the work experiences and behaviors of newly licensed RNs (Kovner et al., 2007).

We had two aims with this study: The first aim was to describe RNs’ QI experiences (Kovner et al., 2010), and the second aim, which is reported in this article, was to explore RNs’ perceptions of high-quality nursing care. Following the quantitative section of the survey exploring QI experiences, participants were asked to respond to the following open-ended statement: Please tell us what you think high-quality nursing care is.

Sample

After obtaining approval from the University Committee on Activities Involving Human Subjects, the survey was mailed to 730 RNs randomly selected from a nationally representative sampling frame of 1,694 RNs who worked in hospitals. Of the RNs who received the mailing, 460 completed and returned the QI questionnaire, for a 69.4% response rate, with 184 participants responding to the open-ended question. After review, 13 responses were removed because the participants did not address the open-ended question related to their perceptions of high-quality nursing care. Responses that were removed were related to demographic updates or general comments about the QI questionnaire, such as, “I answered the questions based on the job that I had on October 1, 2008.” Narrative responses from 171 participants were included and analyzed for this article.

Participants were predominantly White, non-Hispanic (81.2%), and women (88.8%). Minority representation included White Hispanic (2.9%), Black non-Hispanic (5.3%), Asian (5.9%), other (4.7%), and men (11.2%). Almost half (44.7%) of the participants held bachelor’s degrees, whereas the remaining had associate’s degrees (50.0%) and nursing diplomas (4.1%). The majority of participants worked on general/specialty medical/surgical units (35.3%), step-down/transitional care units (7.1%), or intensive care units (17.3%). The remaining participants (40.3%) worked on units such as labor and delivery, the operating room, postanesthesia care, or other units.
the participants, 60% were less than 34 years old, with the youngest being 24 and the oldest 61; the median age was 31 years. There were no systematic differences between those who did not write narrative responses to the open-ended question and those who did respond when comparing age, ethnicity, degree type, or hospital unit where they worked most often.

Analysis

Krippendorff’s (2004) technique for qualitative content analysis was used to identify themes. Qualitative content analysis was used because it is a method that allows meaning to be found through evaluation of textual content (Hsieh & Shannon, 2005). We used dendrograms (tree-like diagrams used to demonstrate hierarchical clustering), which helped us to sort data with similar characteristics and meanings, and also served as an audit trail clarifying where and how the data were clustered and how the themes emerged (Krippendorff).

The first and second authors read the comments in their entirety before analyzing the data to get a sense of the whole. Following this initial reading, the first and second authors independently reread each respondent’s comments line by line, creating codes. This was an inductive, iterative process whereby comments that had similar meaning and characteristics received the same code, whereas other comments with different meanings generated new codes. After independently creating codes for the data, the first and second authors met to compare codes, work out discrepancies in meaning attributed to each code, and finalize a set of common codes that then became the data clusters in our dendrograms. We used ATLAS-ti computer software (2006) to code and help organize the data. The first author subsequently recoded the entire data set using the agreed-on codes that were now our final data clusters. The second author selected portions of the coded data to verify its validity to the predetermined codes; there was high agreement between the coders. The first and second authors then developed more abstract themes to better capture the meanings of each of the data clusters. All the data, data clusters, and themes were carefully recorded and tracked using dendrograms in accordance with Krippendorff’s (2004) technique.

Findings

Content analysis of these data revealed three themes that early-career RNs conceptualized high-quality nursing care as integrating several process-focused interpersonal skills, such as developing presence, building relationships, and communicating information.

Theme 1: RN Presence

The theme RN presence contains three data clusters: care is about being at the bedside, RNs need the flexibility to spend time with patients, and workload matters. Each of the data clusters contains similar but different conceptualizations about RNs being with, spending time with, and having a presence with their patients.

Care is about being at the bedside. RNs were very concerned about their inability to be with patients. The responses indicate that failure of the RN to be at the bedside has a significant impact on quality care. Organizational and system-level processes such as documentation and ineffective health care information technologies were noted as creating additional burden and taking the RNs away from being with their patients. One RN noted that high-quality nursing care is “[n]ursing care in an environment that focuses more on bedside nursing, less on documentation and paperwork.” Another RN stated,

Both of my employers have instituted complete computer charting within the past year. . . . I have found the computer charting to be “easier” in some aspects but it does take significant time away from patient care. . . . I feel I miss out on important conversations and teaching while I am navigating the computer.

RNs need the flexibility to spend time with patients. Equally important to being at the bedside is the ability to spend time with patients, but not necessarily at the bedside. RNs perceived that quality care is attributed to knowing your patients, which occurs when there is time to explore who a patient is and what the hospitalization means to him or her. One RN wrote, “To be able to be present for a patient and to do a thorough assessment. To take the time to know the patient and their history. If only it was possible in today’s busy world.” Another RN noted, “Being able to relate to your patient and understanding their medical and emotional needs. Having the time to implement them.” A third nurse stated, “High quality nursing is having the time to place into practice your evidence-based knowledge. This includes caring for people’s physical, spiritual, and emotional needs. All of these things affect a patient’s health and wellness.”

Workload matters. RNs perceived that workload impacted their ability to be at the bedside and spend time with their patients. The participants described workload as being...
important to the delivery of high-quality nursing care. They reported that high patient-to-nurse ratios are detrimen
tal to quality care: “After 8 years of practice as a tech, urgent, and ED nurse I can honestly say that the #1 factor
in providing high quality nursing care is improving the ratio of nurse to patient.” Some RNs saw low patient
ratios as high-quality care:

Having enough staff to care for patients. My floor
seems to be always understaffed. Having 7 and 8
patients is not giving high quality of nursing. You
cannot spend the time you need. Lots of errors,
declining health in a patient is not seen in time.

When the patient to nurse ratio increases, quality
nursing care decreases, and patient safety is chal-
lenged. I have sister who is a new grad RN in the
ER [emergency room]. Her hospital has just made
budget cuts and has let go of their secretarial and
environmental staff. The ER nurses now do all
three jobs. The impact has taken a terrible toll on
their quality of patient care and staff satisfaction.

Being present with the patient at the bedside, having
the time and flexibility to spend time with patients, and
having a workload that facilitates both, is high-quality
nursing care to the RNs who responded to the survey.
Nursing care cannot be provided without nurse–patient
interactions. It is within these interactions that RNs are
able to provide the therapeutic interventions that facilitate
healing, recovery, and positive patient outcomes. If RNs
are unable to be present with their patients, these interac-
tions suffer, and subsequently so does the quality of care.

Theme 2: Developing Relationships

The second theme that emerged from the data was the
interpersonal relationships that RNs foster with their
patients. RNs spend much of their time with patients
providing emotional support and assisting them with
some of the most personal and intimate activities of liv-
ing, such as bathing and toileting. In addition, RNs spend
time with patients while the patients are experiencing
pain, stress, and trying to cope with high levels of uncer-
tainty and anxiety. The respondents reported that rela-
tionships that result from and that are fostered during
these situations are aspects of high-quality nursing care.
In this theme there were four data clusters: trust between
RNs and their patients, focusing on the patient, treating
the patient as if he or she were family, and being an adva-
cocate for the patient. Each of the data clusters demon-
strates the importance of RNs developing relationships or
creating interpersonal connections with patients and
patients’ families.

Trust between RNs and their patients. RNs found that
interpersonal connections with patients that facilitated
the patients trusting or feeling comfortable with the
care they were receiving was one aspect of high-quality
care. As one RN stated, “They feel trust in our services
and know that as knowledgeable nursing professionals
we will do our best for their health and speedy recov-
ery.” Another RN commented, “First, maintaining
patient safety and health while including [the] patient
and families in [the] care plans. Building relationships
which allow patients and families to feel confident in
the care received and trust their caregivers.” Another
RN described actions that create trust, leading to high-
quality care:

It is caring for your patient in a way that meets
their medical and emotional needs efficiently—
and being passionate about the well-being of
the patient. It’s also about holding a patient’s hand
during a scary procedure rather [than] going on
break, or taking an extra 10 minutes explaining
instructions to them in a way they understand—
rather than running out the door because it’s quit-
ting time.

Focusing on the patient. Another facet of high-quality
care is related to the interpersonal connection between
the RN and the patient that revolves around the need of
the RN to focus on the individual patient’s needs. Quality
care is recognizing and addressing these needs:

There are times when the patient urgently needs to
use the restroom, and that patient doesn’t care
who’s the provider, who’s the NA [nursing assis-
tant], and who’s the RN. The patient needs to go.
The RN must be willing to help the patient to the
commode or restroom instead of saying, “Oh, I’ll
get the aide. This isn’t my job.”

Treating the patient as if he or she were family. Providing
care to patients as if they were part of the RN’s family
was important in conceptualizing high-quality nursing
care. As one RN stated, “High quality nursing care is car-
ing for each and every patient as if they are your own
mother, father, sibling, grandparent, etc.” The idea that
part of the RN’s role is to consider how he or she would
act differently if it were the RN’s loved one who was in
the hospital was evident in the responses: “High quality
nursing care is doing everything you are physically and
mentally capable of doing to maintain patient health and
safety. Giving care to strangers that you would give to
your loved ones.” RNs in the acute-care setting are
extremely adept at developing relationships in very short
periods of time with a variety of patients.
Being an advocate for the patient. The responding RNs felt strongly that high-quality nursing care could not occur unless RNs were strong advocates for their patients. One RN stated, “To be the patient advocate and voice.” RNs in the acute-care setting spend more time with patients than any other provider, and are generally more familiar with the complexities of the health care system than their patients. To advocate for patients, RNs must know their patients’ situations and must develop relationships with them. One RN described the delivery of high-quality nursing care as requiring the RN “[t]o be a good listener and provide comfort and support. To act as an advocate for the patient.” The RNs indicated that the relationships with their patients mandated they speak up and advocate when needed.

Theme 3: Facilitating the Flow of Knowledge and Information
A final theme that emerged as fundamental to high-quality nursing care was related to the exchange of knowledge and information. There were three data clusters within this theme: informed by an evidence base, RN knowledge and education, and teamwork and communication. Each of the data clusters relates to different aspects of the flow of knowledge and information. Knowledge and information have broad conceptualizations in this theme, including individual RN knowledge of nursing care, as well as information about his or her patients’ situations; knowledge of the science supporting best practices through evidence; and the exchange of this knowledge and information with patients and other health care providers through team interactions.

Informed by an evidence base. Our findings indicate that RNs perceive evidence-based practice (EBP) to be a component of high-quality nursing care. One RN stated, “High quality nursing care is evidence-based care provided in a safe environment with adequate staff and equipment/technology.” Another wrote, “High quality nursing care is practicing using the latest information in regards to evidence-based data, being wholly empathetic to your patient’s needs.” The sense that quality nursing care is more than simply implementing EBP was also expressed: “High quality care is care that is nurse driven by evidence based [practice], but does not neglect the human to human connection.”

RN knowledge and education. RNs are often discussed as and considered to be a homogeneous group. For example, patient satisfaction surveys most often ask about nursing care as a whole rather than asking about individual RN care. However, it is individual RN care and knowledge that often impacts patient outcomes. The responding RNs strongly suggested that individual RN education and competence were integral to high-quality care; that quality nursing care is not only using evidence to guide practice, but also having a knowledgeable and educated RN workforce, using phrases such as “[n]urses enrolled in routine education,” and “[e]ducated RN with a four-year degree.” Knowledge of both nursing science and individual patient situations is another aspect of high-quality care, in the sense that it allows individual RNs to take specific action for individual patients. One RN stated,

A high quality nurse notices changes in a patient before it is too late, recognizing the need to involve physicians and when you are in your scope of practice meshing new practices with experience/evidence and with top quality care and [a] true caring heart.

Another RN found that communication and continuing education were necessary to be prepared to provide high-quality care:

Safety first in an establishment that has a good consistent form of communication—especially in regards to continuing education for the nursing skills you use daily. So when you go into a patient’s room you feel prepared and not like you’re going on a “wing and a prayer.”

Teamwork and communication. The final data cluster for the third theme was related to how knowledge and information are transferred through teamwork and communication. In the acute-care setting, RNs work closely with a number of different providers and support personnel such as physicians, pharmacists, nurse aides, and ancillary staff. The RNs in this sample considered effective teamwork and communication part of high-quality nursing care. One RN stated,

High quality nursing care is working together as a team between all specialties and departments to provide the best possible care. High quality nursing care is being able to work with all levels of nursing administration to develop models of care that work, and implement policy and procedures that provide the best possible care.

Another stated, “High quality nursing care is a constant feedback loop; when there is input from multiple sources (patients, nurses, doctors) and analysis in a timely manner, performance and care can change and be measured again.” RNs also included patients as members of the health care team, and recognized the importance of patient–nurse communication: “High quality nursing care to me is being able to communicate effectively with
patients at the bedside.” In this study, facilitating the flow of knowledge and information were found to be key components of high-quality nursing care. The RNs’ comments suggested that the individual RN who uses EBP, stays current and up to date with the latest nursing science, and works effectively on interdisciplinary care teams will deliver high-quality nursing care.

Discussion

Three themes were identified in our study: RN presence, developing relationships, and facilitating the flow of knowledge and information. Although each theme represents a unique aspect of high-quality nursing care, the themes are interrelated and encompass central aspects of both the science and the art of nursing. RN presence expressed RNs’ desire to be with their patients at the bedside, their desire to have the flexibility to spend time with patients at their professional discretion, and the negative impact of high patient-to-nurse ratios on their ability to be present with their patients, each of which impacts the quality of nursing care delivered. Developing relationships reflected the importance of RNs’ developing trusting relationships with patients, focusing on patient needs, treating patients as if they were family, and advocating for their patients. Facilitating the flow of knowledge and information revealed RNs’ beliefs that an evidence base informs quality care, that individual RN knowledge and competence is important, and that high-quality nursing care is not possible without interdisciplinary teamwork and communication.

RN presence is evident in the nursing literature (Benner, 1984; Bernardo, 1998; Melnechenko, 2003; Zyblock, 2010). In Benner’s framework of novice to expert nurse, “Presencing: Being with a patient” (p. 50) is identified as a key competency of the expert nurse. To develop presence, or have presence with patients, RNs must have the ability to be with their patients. The RNs in our sample focused on the process of care, of being present with their patients, but did not describe distal outcomes that might result from these processes. However, previous research exploring the relationship between RN time with patients and RN workload has demonstrated an impact on quality outcomes. For example, studies have shown that high patient-to-nurse ratios, which limit the amount of time an RN has to spend with her or his patient, leads to increased patient mortality and adverse outcomes (Kovner, Jones, Zhan, Gergen, & Basu 2002; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). In this study, the focus on process rather than on distal outcomes might have been a result of where these RNs were in their progression from novice to expert. Instead of outcomes, the responding RNs were focusing on the immediate or concrete needs of their patients.

Additionally, a nursing workforce shortage might add to RNs’ inability to spend time with patients and might adversely impact outcomes (Buerhaus et al., 2007). One large international study carried out in five countries with 43,000 nurses revealed that only 30% to 40% of RNs reported having enough staff to provide high-quality care (Aiken et al., 2001). A survey of RNs and chief nursing officers (CNOs) conducted in 2002 and 2004 by Buerhaus et al. (2005) found that “9 in 10 hospital-based RNs in both nursing surveys, and two in three CNOs also felt the time nurses spent with patients was affected negatively by the shortage” (p. 219). Given the mounting evidence of the importance of RNs being with their patients, the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement have developed an initiative called Transforming Care at the Bedside. The initiative is designed to empower bedside clinicians such as RNs to create effective and meaningful change that improves care and ultimately patient outcomes. One of the primary aims of the initiative is to increase the amount of time RNs spend at the bedside with their patients, with the hope of increasing time with patients to 60% (Institute for Healthcare Improvement, 2010).

The second theme that emerged in our study was developing relationships, which provides further evidence that nurse–patient relationships and interactions are enduring components of quality nursing care. Two studies conducted more than 10 years ago had similar findings to this study. Irurita (1999) found that exploring patients’ views of quality care was essential to the nurse–patient relationship; and Williams (1998) found that patients identified care as being of high quality when nurses recognized them as individuals with unique needs, listened to them, and accepted them as such. Because of the complex and subjective nature of interpersonal relationships, patient satisfaction might be one measure of this aspect of high-quality nursing care. The importance of RNs developing relationships with their patients is also cited as a critical component of quality care in the IOM’s quality aim of patient-centered care. According to the IOM, patient-centered care “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient” (Corrigan et al., 2001, p. 48). The consistency of our findings with previous research indicates that early career RNs’ perceptions of what constitutes quality nursing care—RN presence and developing relationships—has remained a core component of nursing care over time.

The third theme, facilitating the flow of knowledge and information, is a unique finding, and is closely related to interdisciplinary collaboration, communication, teamwork, and EBP. There is evidence that interdisciplinary teamwork and communication (Baggs & Schmitt, 1997; Boyle & Kochinda, 2004; Leonard, Graham, & Bonacum,
2004; Propp et al., 2010; Velji et al., 2008; Williams et al., 2010) and EBP (Miller et al., 2010) are related to quality care. In addition, the Joint Commission has indicated that 84% of organizations cited communication failures as the root cause of sentinel events (Joint Commission, 2002). Given this evidence, it is not surprising that teamwork and communication are also considered central components of RN education (American Association of Colleges of Nursing, 2008) and the delivery of quality care (Cronenwett et al., 2007).

However, effective communication and teamwork that leads to positive patient outcomes ultimately begins with the successful flow of knowledge and information. For example, an RN who knows about a change in his or her patient’s physiologic status does not necessarily ensure quality care for that patient; that knowledge and information needs to be shared with appropriate team members using effective communication techniques in a timely manner to make certain adverse outcomes are avoided. What knowledge and information RNs communicate, with whom they communicate, how they communicate, and when they choose to communicate are essential components of high-quality nursing care. How RNs facilitate this flow of knowledge and information has yet to be fully explored. Bedside RNs are often the catalysts for significant clinical interventions because of their ability to facilitate the flow of knowledge and information. There are no quality indicators that measure hospital-based RNs’ ability to facilitate the flow of knowledge and information to a multidisciplinary team. Therefore, data from this study points to the importance of developing measures and quality indicators to quantify this important responsibility.

Limitations

Our study had several limitations. Because the data were narrative responses collected via a self-administered survey, we were unable to explore respondents’ answers in depth or verify the study’s themes and findings with the respondents. To address this limitation, we compared our findings with those in the literature to enhance the validity of our findings. Another limitation was placing the open-ended qualitative question focusing on quality improvement education in these RNs’ basic nursing education program at the end of the survey. This might have encouraged the participants to think about quality in ways they had not previously done before. Finally, this study focused on the perceptions of early-career RNs. Mid-career or late-career RNs—those with 10 or 20 years of experience—might have different perceptions of quality nursing care, and readers should be cognizant of this when interpreting the findings from this study.

Implications

Our findings indicate that early-career RNs, or those RNs in the competent or proficient stage of Benner’s (1984) novice to expert framework, want the opportunity to be present with their patients. An important consideration for those in leadership or policy-making positions is to recognize and understand RN presence as an integral piece of quality care. Organizational processes, structures, and culture might hinder or prevent RNs from spending time with patients and thus contribute to poor quality care. To create the flexible and dynamic work environments and organizational cultures that allow RNs to provide high-quality care, we need additional research about organizational attributes, such as structures and processes that impact the nurse practice environment and facilitate flexibility in processes of nursing care that RNs deem important to quality. Information technology such as electronic health records or bedside computer charting might provide administrators with unique opportunities to increase flexibility and allow RNs more time with patients by decreasing the time spent on documentation. Another suggestion is to use technology to provide RN-level surveillance without an RN actually being present (Herdman et al., 2009). Although not constituting RN presence as described by participants in our sample, it would allow RNs the ability to stay connected with their patients even when they cannot be at the bedside; given the current and projected shortage of RNs, this might be one option to facilitate and support quality care.

Additionally, the RNs in this sample found developing specific types of relationships with patients as essential to high-quality care. These relational components of high-quality care are neither currently measured using standardized evaluation tools nor evaluated on a regular basis. For example, a key quality indicator and important NSPO for a surgical intensive care unit (SICU) is central line infection rates; however, another key quality indicator in that same SICU is how well RNs are able to provide emotional support for patients and family members, develop trust, and advocate for their patients. Unfortunately, these latter measures of quality nursing care are not captured in current quality indicators.

There is a need for additional research to understand how nurse–patient trust is created and maintained, and how to further facilitate patient-centered care. Work has been done to measure and evaluate quality of nursing care from the patient perspective by measuring patient satisfaction (Kutney-Lee et al., 2009), and from a more quantitative perspective by measuring nurse-sensitive patient outcomes (National Quality Forum, 2007; Needleman, Kurtzman, & Kizer, 2007). However, more work is needed to develop quality indicators of nurse–patient...
relationships such as trust and advocacy that practicing RNs perceive as important to high-quality care.

RN’s in our sample indicated that individual knowledge and competence, as well as interactions with patients and other team members, are central to high-quality nursing care. RNs often manage and coordinate care in the acute care settings by communicating essential information with various members of the health care team. However, there are no quality indicators that measure hospital-based RNs’ ability to facilitate the flow of knowledge and information as a member of interdisciplinary teams. The ability to manage care and communicate important changes in a patient’s status will become increasingly important as the acuity of patients increases and significant numbers of older adults with multiple morbidities begin accessing the health care system.

Finally, we know that current terminal outcome indicators do not represent all aspects of high-quality nursing care. A broader and more comprehensive set of nursing quality indicators is needed that also includes measures of nursing processes of care. Outcomes such as infection rates and falls, although perhaps easier to measure than RN presence, developing relationships, or facilitating the flow of knowledge and information, do not completely represent the delivery of high-quality nursing care in the hospital setting. Furthermore, more granular measures of nursing care that reflect individualized care relationships between an RN and her or his patient should be used as quality indicators. RNs play an integral role in the delivery of high-quality care in the hospital setting, and it is important that quality indicators fully capture the complexity of nursing care occurring at the bedside.

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