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Author names and affiliations: Vázquez-Calatayud, Mónica (1); Oroviogioicoechea, Cristina (2); Saracibar Maribel (3); Pumar-Méndez, María J. (4).

(1) Vázquez- Calatayud M (RN, MSc, PhD candidate). Faculty of Nursing, University of Navarra. Area of Nursing Research, Training and Development, Clínica Universidad de Navarra, Pío XII, 36, 31008. Pamplona (Navarra). Spain. Email: mvazca@unav.es

(2) Oroviogioicoechea C (RN, MSc, PhD). Faculty of Nursing, University of Navarra, Spain. Area of Nursing Research, Training and Development, Clínica Universidad de Navarra. Pío XII, 36, 31008. Pamplona (Navarra). Spain. Email: corovio@unav.es

(3) Saracibar M (RN, MSc, PhD). Faculty of Nursing, University of Navarra, Irunlarrea, 1, 31008. Pamplona (Navarra). Spain. Email: mis@unav.es

(4) Pumar-Méndez María J. (RN, MSc, PhD). Faculty of Nursing, University of Navarra. Irunlarrea, 1, 31008. Pamplona (Navarra). Spain. Email: mpumarme@unav.es

Corresponding author:

Mónica Vázquez-Calatayud

Area of Nursing Research, Training and Development

Clínica Universidad de Navarra

Avda. Pio XII, 36, 31008 Pamplona (Navarra)

Email: mvazca@unav.es

Telephone: +34 948 255400 Ext. 2609

Abstract

Although the concept of ‘Transforming care’ is promising for improving healthcare, there is no consensus in the field as to its definition. The aim of this concept analysis is to develop a deeper understanding of the term ‘Transforming care’ within the nursing discipline, in order to facilitate its comprehension, implementation and evaluation. We performed a comprehensive literature review on electronic databases such as Medline (PubMed), Cinahl (Ebsco), Cochrane Library, PsycINFO (Ovid), Web of Science, Wiley- Blackwell, ScienceDirect and SpringerLink, and used Walker and Avant’s approach to analyse the concept. From the 20 studies selected for this analysis, three main attributes of ‘Transforming care’ were identified: patient-centredness, evidence-based change, and transformational leadership-driven. We suggest an operational definition to facilitate the implementation of the concept in practice. Furthermore, we propose that implementation is guided by the following key ideas: 1) fostering a culture of continuous improvement; 2) encouraging bottom-up initiatives; 3) promoting patient-centred care; and 4) using transformational leadership. Lastly, the evaluation of ‘Transforming care’ initiatives should assess care processes, and professionals’ and patients’ outcomes.

Keywords: Concept analysis, Quality of nursing care, Transforming care, Patient’s safety.

1. Introduction

Care is the essence of nursing and can be defined as a “phenomena related to assisting, supporting, or enabling experiences or behaviours toward or for others with evident or anticipated needs to ameliorate or improve a human condition or lifeway” (Leininger 2001, p.46). In order to further enhance nursing care quality, ‘Transforming care’ is being promoted. This concept arose in 1999 in the international arena as a result of the shortage of nurses, the high turnover of nursing staff, complex working environments and the decline in direct patient care hours (Stefancyk, 2009a). Such factors, coupled with the evidence showing the close relationship between the quantity and the quality of care and nurse and patient outcomes, have urged the development of approaches to advance processes of change within nursing (Burston, Chaboyer, Wallis, & Stanfield, 2011). Among these approaches, ‘Transforming care’ has been suggested as having a significant impact on organisations, professionals, nursing care, and patients. Indeed, this has even been linked to improvements in care efficiency, adoption of innovation, cost-saving, and working environments (Lee, Shannon, Rutherford, Peck, 2008; Rutherford, Bartley, Miller, Moen, & Peck, 2008; Viney, Batcheller, Houston, & Belcik, 2006). Similarly, ‘Transforming care’ strategies have increased both practitioner and patient satisfaction, as well as patient safety (Chaboyer, Johnson, Hardy, Gehrke, Panuwatwanich, 2010; Scott-Smith and Greenhouse, 2007).

Although the concept of ‘Transforming care’ has often appeared in the literature, little conceptual work has been performed and no universally accepted definition has been proposed. This absence of a common language for ‘Transforming care’ has complicated its practical implementation and evaluation, issues that have been identified behind the slowness of its spreading albeit existing experiences suggest positive results (Burnston et al. 2015). Thus, if ‘Transforming care’ is to be effectively introduced and developed, its meaning should

be clarified and specified. Pursuant to this objective, the present study focuses on analysing the concept of 'Transforming care' in nursing.

2. Methodology

A concept analysis method was utilised to clarify the meaning and significance of 'Transforming care' in the nursing literature. Walker and Avant's concept analysis method (Walker & Avant, 2011) was selected because it is a rigorous and inductive method, which allows the clarification of the use, nature, and properties of the concept, and fosters its understanding. This method, as described in Table 1, consists of eight phases, in which the uses of the concept and their consequences are identified, their attributes and empirical referents are defined and a model case is constructed, so that a deeper understanding within the nursing discipline can be developed.

To support the present concept analysis, bibliographical searches were performed using electronic databases including Medline (PubMed), Cinahl (Ebsco), Cochrane Library, PsycINFO (Ovid), Web of Science, Wiley- Blackwell, ScienceDirect, and SpringerLink. The terms combined for electronic searches were '*Transforming care*', '*Transforming healthcare*' and '*Nursing*'. The term '*Transforming Healthcare delivery*' was not used because it focuses on the transformation of the healthcare system, an issue that is outside the scope of this analysis. The results were filtered by year of publication (limiting the searches to the last 16 years taking into account that the 'Transforming care' concept first appeared in 1999) and language (both English and Spanish). Complementary searches in Google Scholar and on the Internet (the *Institute for Healthcare Improvement* website -www.ihl.org, and the *Institute of Medicine* website -www.iom.edu-) were performed.

Once the search was carried out on electronic databases, the next step was to select the studies. The initial searches yielded 1,548 citations. After eliminating duplicates and

screening the titles of these citations, 114 papers were left for abstract review. Abstracts were reviewed for publications with relevant titles, and the following inclusion criteria were applied:

- Studies focused on ‘Transforming care’ in nursing.
- Articles that report literature reviews or empirical studies with qualitative, quantitative or mixed-method designs. While quantitative and mixed-method studies could provide information regarding empirical referents and consequences of the concept ‘Transforming care’, literature reviews and qualitative studies were expected to be especially relevant for the identification of its attributes.
- Grey literature such as editorials, essays, practical guides, thesis or vision statements that provide information to determine which uses have been given to the ‘Transforming care’ concept and which attributes and antecedents have been associated with it.

According to the recommendations of Walker & Avant (2011), all possible studies to help clarify the concept were included, without despising any study for their methodological quality. Papers that focussed on concepts which may be closely related to ‘Transforming care’ but did not explicitly refer to it were excluded.

After applying inclusion and exclusion criteria, 13 citations were retained. In addition to the electronic search, a hand search of the issues of the last five years was carried out in the journals most relevant to the topic in the international context: *Journal of Advanced Nursing*, *Nursing Administration Quarterly*, *Journal of Nursing Management*, *International Journal of Nursing Studies*. Thus, four papers were added to the existing ones. Moreover, reference lists of the selected articles were also reviewed through the snowballing technique, identifying 3 additional relevant studies.

Finally, a total of 20 papers were included and reviewed for the concept analysis. The review process consisted of an individual and complete analysis and synthesis of the articles. Each paper was content analysed, looking for antecedents, consequences, and attributes. After completion, descriptive themes emerged as attributes of the concept. A summary of the studies found and their main features have been provided and are presented in Table 2.

3. Findings

In this section, findings emerging from the analysis will be presented based on the steps suggested by Walker and Avant's method (2011), which has already been depicted in Table 1.

3.1. Uses of the concept

The third step in Walker and Avant's analysis method (Table 1), helps delimit the scope of the concept and its meaning. The concept 'Transforming care' appeared in the late 20th century in the United States and spread to other countries, such as Australia, as a framework for improving patient safety. Since then, the concept has been used consistently through different clinical settings (hospital units, emergency services, intensive care units and outpatient facilities) as a framework to improve care quality and safety by fostering its continuity, comprehensiveness, patient-centredness, and inter-professional evidence-based orientation (Burnston et al., 2015; Devine et al., 2015; Chaboyer et al., 2010; Martin et al., 2007; Roussel et al., 2012; Rutherford et al., 2008).

With this overall focus, three approaches to 'Transforming care' have been identified: the Studer Group® and 'Transforming care at the bedside' (TCAB) in the United States of America and the Productive Ward in the United Kingdom (Burston et al., 2011). Table 3 presents the characteristics of the three approaches regarding patient-centred, leadership and evidence-based enhancement. As can be seen in Table 3, although characteristics of three approaches may overlap, there is a critical difference that influences the effectiveness of their

use by managers and leaders. The main difference between these uses of the ‘Transforming care’ concept resides in their approach to generate and drive change. Indeed, although all of these approaches to the concept are sustained by engagement of frontline staff, TCAB brings this engagement forward by adopting a bottom-up approach to identify priority problems and the changes that may be needed. The Productive Ward approach to the concept implies that ‘Transforming care’ should be generated at the sharp-end of the organisation.

In essence, the concept of ‘Transforming care’ is emerging. It has been consistently used to denote a framework to promote patient-centred, inter-professional, and evidence-based care that facilitates continuous quality and safety improvements. It should be noted that the flexible character of the concept of ‘Transforming care’ allows for its application to a wide range of clinical settings and situations.

3.2. Defining attributes

As shown in Table 1, the defining attributes of a concept is the fourth stage of the Walker and Avant’s model (2011). Determining which attributes are most frequently associated with ‘Transforming care’ allows for a more accurate and profound insight into the concept. From the 20 studies analysed, it can be stated that the concept of ‘Transforming care’ has three main attributes: patient-centredness, evidence-based change, and transformational leadership-driven (see Table 2 and Figure 1). Each of the defining attributes revealed in the analysis is described in the following sections.

3.2.1. Patient-centredness

In the literature, this attribute indicates that the focus is on the patient and that the care exists for his or her benefit. This attribute determines that the ‘Transforming care’ approach incorporates patients’ and families’ needs, preferences and values into the prioritisation and development of care improvements (DiGioia, Embree, & Shapiro, 2011; Chaboyer et al., 2010; Martin et al., 2007; Nelson and Massey, 2010; Scott-Smith and Greenhouse, 2007;

Stefancyk, 2008a,b; Rutherford et al., 2008; Roussel et al., 2012; Upenieks et al., 2008; Valente, 2011; Zager and Walker, 2005;). Indeed, 'Transforming care' advocates for participatory processes of change in which stakeholders are empowered to take part in decision-making in relation to their care (Burston et al., 2015).

3.2.2. *Evidence-based change*

Evidence-based change is another attribute of 'Transforming care', which has been identified in 16 of the 20 studies reviewed for this analysis. This highlights that the proposed changes have to be selected, implemented, refined and escalated on the base of evidence from the perspective of 'Transforming care'. 'Transforming care' includes not only research but also the experience of professionals and patients as sources of evidence. The changes implemented are not isolated instances of quality improvement projects. Rather, 'Transforming care' is a new approach to the delivery of care and, therefore, it facilitates sustainability (Burnston et al., 2015; Devine et al., 2015; Lee et al., 2008; Lee and Upenieks 2008; Martin et al., 2007; Nelson and Massey, 2010; Rutherford et al., 2008; Roussel et al., 2012; Stefancyk, 2008a,b; Stefancyk, 2009a,b,c; Upenieks et al., 2008; Valente, 2011; Viney et al., 2006). Since new evidence is being continually made available, this attribute provides 'Transforming care' with endless possibilities and, thus, with potential for greater effectiveness (Lee and Upenieks, 2008; Rutherford et al., 2008; Upenieks et al., 2008).

3.2.3. *Transformational leadership-driven*

The attribute of Transformational leadership-driven has been identified in all the studies reviewed for this concept analysis. It implies two key features: firstly, that a particular leadership style should be adopted if 'Transforming Care' is to be fully developed; and that this leadership role should be held by front-line nursing managers so as to enable improvements to emerge bottom-up rather than top-down (Martin et al., 2007; Nelson and Massey, 2010; Rutherford et al., 2008; Upenieks et al., 2008).

Transformational front-line nursing leaders are characterised as being visionary, creative, flexible in changing situations and influential through the use of ideas (DiGioia et al., 2011; Martin et al., 2007; Rutherford et al., 2008; Scott-Smith and Greenhouse, 2007; Viney et al., 2006). By means of empowering stakeholders and fostering their participation in changes, the transformational leader promotes awareness of the need for change and subsequently commits to implementing change (Burston et al., 2015; Roussel et al., 2012; Stefancyk, 2008a,b). Therefore, it would assist their sustainment, essential for ‘Transforming care’ (Burston et al., 2015).

The defining attributes of ‘Transforming care’ are illustrated in the *model, related, borderline* and *contrary* cases presented in the following sections.

3.3. Model case

A model case, as defined in Table 1, is especially useful to illustrate how the concept is operationalised (Walker & Avant, 2011). Box 1 features an example of a model case.

Box 1. Example of a model case

Mary, a nurse manager working in a cardiology inpatient unit, identified an area for improvement regarding double recording; nurses registered data such as medication, fluid therapy or balance on a paper form, even though all these facts were already recorded on the computer.

Through a series of interviews, Mary found that nursing staff, as well as nursing managers, wanted to eliminate the double recording. The purpose of the double recording was to make information available for team rounding and for physicians requesting information. Findings from the interviews demonstrated double recording was time-consuming, decreased direct patient care time, and entailed potential risks associated with incomplete documentation. Furthermore, Mary observed during rounds that nurses had insufficient information about patients and were not involved in decision-making. In addition, an audit of the computerised nursing records demonstrated a lack of completeness and gaps in patient evaluation.

Mary led the design of a process of improvement. She talked to the head of the medical team and both agreed on working together to implement strategies to enhance communication between them and involve the patient during team rounds and to use the computerised record. In order to identify strategies, evidence was reviewed, the communication process and information registered by staff were analysed, and help from the patients and other units and professionals involved was requested.

The strategies identified were mainly to develop and implement a protocol for communication in team rounds, in which patients were involved, and training sessions given by nurses of the unit for the medical team to understand the content and how to access the nursing records. Nurses were fully involved in the implementation process along with the medical team. This resulted in enhancing the nurses' commitment to the implementation and follow-up of the change. In addition, the patients were empowered to take part in decision-making in relation to their needs during the rounds.

Once implemented, the change was evaluated in order to ascertain its impact and the possible opportunities for improvement. As before, observations of the team rounds and an audit of the computerised records were done. Briefings on patient status before the team rounds and the use of the computerised record improved nurses' involvement in patient decision-making. Double recordings were reduced and as a consequence documentation was less time-consuming, freeing time to be with the patients and the percentage of clinical incidents were also reduced. Team morale and essential values for nursing were strengthened through the change process. Results from the practice environment evaluation showed an improvement in collaboration with doctors and nurses satisfaction both in their work and support from managers.

In the case presented in Box 1, the three identified defining attributes of 'Transforming care' are evident. It describes how the nurse manager proposes a patient-centred improvement process through the improvement of the efficiency of care processes. It also highlights how both the design and the implementation of the improvement process incorporates evidence of different sources including professionals' perspectives. Those strategies were evaluated *post-hoc*. Finally, the use of transformational leadership to bring about the change on the part of

the nurse manager is also implicit because the process includes nursing values as a strategy for enhancing nurses' involvement and commitment.

3.4. Related case

A related case is, as described in Table 1, a scenario that is similar to the concept but does not share the defining attributes (Walker & Avant, 2011) (Box 2).

Box 2. Example of a related case

In response to a financial crisis, managers at a hospital decided to merge two units that worked differently in order to optimise both material and human resources. To achieve this, the hospital management board designed a plan based on evidence, nurses were trained, and the staff in both units were involved in its implementation. For both units, the project leader conducted workshops to introduce the plan and to engage the staff, establishing the need for change. In parallel, some of the most experienced nurses identified some issues, which were deemed important to unify work routines. Patients, however, did not take part in this change process. The design of this strategy was not a specific improvement in the quality of patient care, but a change in working processes at all levels.

In this process, managers at the strategic level appealed to the values of the nursing profession to aid in the understanding of the change and adherence of the staff to the plan. Hence, leaders promoted nursing staff commitment to implementing the change initiative.

In the case introduced in Box 2, an example of the concept of transformation of healthcare is presented. As in 'Transforming care', the concept of 'Transformation of healthcare' supports the idea that proposed changes should be based on evidence. However, the development of 'transformation of healthcare', as is clear in the case presented in Box 2, does not necessarily mean an improvement process in the quality of care or that the change has to be patient-centred, both of which are key characteristics of 'Transforming care'. Moreover, despite the fact that transformational leadership did occur, it was not developed by front-line nursing managers but by managers at the strategic level, and thus it cannot be considered as an example of transformational-leadership driven change, as 'Transforming care' claims.

Therefore, the concept of ‘Transformation of healthcare’ does not share the three attributes of ‘Transforming care’, as this approach conceives them.

3.5. Borderline case

A borderline case contains some, but not all, of the identified defining attributes or one attribute may differ significantly (Table 1). In Box 3, an example of a borderline case is presented.

Box 3. Example of a borderline case

Mary, a nurse manager working in an inpatient cardiology unit, found, through daily observation, the need to improve patient care by decreasing the time nurses spent recording the delivery of care.

At the same time, a constant complaint from the patients was that the staff dedicated a little time to caring for them. Mary thought that by reducing time spent recording would increase time spent with patients and decided to develop an improvement plan to reduce it. She ignored the fact that improvement in this aspect of practice was not prioritised by the nurses or the multidisciplinary team of that unit and designed an improvement plan based on evidence. To design this plan she reviewed the literature and consulted other leaders who had already implemented this change in their units. The plan basically consisted in introducing specific strategies that had been tested and implemented on a variety of units and could be adapted to her unit. Hence, although the development of care improvement was focused on the patient benefit and based on research and on expert nurses’ and patients’ opinions, the leader neither empowered nursing staff nor involved them in the change process. Therefore, nurses did not feel committed to change implementation and follow-up and the initiative was not successful.

In the case presented in Box 3, the nurse manager proposed a patient-centred process of improvement, considering the patient’s perspective and focusing on their benefit. Moreover, the improvement process was evidence-based, since their design and implementation incorporated different sources of evidence such as research, expert consultation and patients’ perspective. However, in this case, since she intervened on her own and did not seek other professionals’ perspectives or involvement, the transformational leadership style adopted in ‘Transforming care’ was not present.

Therefore, in this borderline case, all the defining attributes of the phenomenon are included except for one, transformational leadership.

3.6. Contrary case

A contrary case, as is defined in Table 1, is the opposite of the concept. Walker and Avant (2011) advocate the use of these cases as a part of the internal dialogue used to examine the defining attributes. In Box 4, an example of a contrary case is presented.

Box 4. Example of a contrary case

Mary, a nurse in charge of an inpatient area, orders a change to be undertaken with the aim of optimising resources, without considering the fact that this change may have a negative impact on patient safety. Due to this, the change is not supported by the staff affected. The discontent towards the proposed change surprises Mary, who neglected to explore the opinion of the staff involved. Despite this resistance and opposition, Mary introduces a change for which no well-founded dissemination or implementation strategy has been planned.

In the case presented in Box 4, none of the defining attributes of the concept of ‘Transforming care’ are present. A patient-centred improvement process is non-existent because the selection of the change did not consider its consequences on the patient or the patient’s perspective. Evidence was not used to design the strategies for the change, and no transformational leadership was developed, as the person responsible for the inpatient area made a decision without involving the staff. In addition, she did not address the opposition that the proposed change generated.

3.7. Antecedents and Consequences

According to Walker and Avant (2011), identifying antecedents and consequences of a concept helps to contextualise it, thus furthering its understanding. The present concept analysis identified several antecedents and consequences of ‘Transforming care’ that have appeared recurrently in the literature (see Table 2 and Figure 1).

Among the antecedents of 'Transforming care' is the existence of the need for care improvement; awareness of the improvement needs; and favourable organisational contexts that demonstrate decentralised organisational structures and positive cultures of change. The need for care improvement refers to the presence of a care area headed for change if the quality and safety of care are to be enhanced (Rutherford et al., 2008). In order for 'Transforming care' to occur, this need for care improvement must not only exist but be felt by front-line nursing managers and staff so that they become committed to the proposed changes (Rutherford et al., 2008). This feeling is what is implied in the antecedent 'awareness of the improvement need'. Finally, the development of 'Transforming care' initiatives is reliant on the existence of favourable organisational contexts that demonstrate decentralised organisational structures and organisational cultures that encourage change (Chaboyer et al., 2010; Martin et al., 2007; Rutherford et al., 2008). Decentralised organisational structures allow the development of bottom-up initiatives, such as those promoted by 'Transforming care', because stakeholders are empowered to participate in the design and development of the changes.

With regards to the consequences of 'Transforming care', the analysis of the literature revealed that these could be classified into three categories of improvement: related to care processes, professionals, and patients' outcomes. Care processes refer to the positive impact of 'Transforming care' on care performance, including improvements in the continuity, efficiency, and costs of care. These improvements are mediated primarily by reductions in time-wasting tasks, or in other words, activities that absorb resources but create no value (Chaboyer et al., 2010; Martin et al., 2007; Rutherford et al., 2008; Viney et al., 2006).

The category of improvement related to professionals includes; positive changes in both staff attitudes towards daily work and also teamwork. The former improvement refers to the 'vitality' of staff (Rutherford et al., 2008, p. 4). This term is used to allude to a high levels of

positive attitude and commitment towards the daily work of nursing staff, which favours the recovery of their 'joy of working' and, in turn, the quality of care (Martin et al., 2007; Scott-Smith and Greenhouse, 2007; Upenieks et al., 2008; Viney et al., 2006). Teamwork changes associated with 'Transforming care' refer to improvements in the working environment that support the empowerment and inspiration of front-line staff, multi-professional teams, managers and patients to partner together for the advancement of care (Lavoie-Tremblay et al., 2013; Lee et al., 2008).

These positive changes in care processes and professionals, trigger further improvements related to patients' outcomes. Indeed, the most important outcome associated with 'Transforming care' are enhancements in patient safety and patient and family satisfaction (Burston et al., 2015; Chaboyer et al., 2010; Martin et al., 2007; Rutherford et al., 2008; Scott-Smith and Greenhouse, 2007; Stefancyk, 2008 a,b; Valente, 2011; Viney et al., 2006).

3.8. Empirical referents

The final step of the concept analysis comprised of the identification of the concept's empirical referents (Table 1). These referents are 'categories of actual phenomena that demonstrate the occurrence of the concept itself' (Walker & Avant, 2011, p. 168). They are useful in practice because they give clear, observable measurements that help distinguish and differentiate the concept from other similar concepts and are extremely useful in instrument development (Walker & Avant, 2011). There are no instruments that comprehensively measure 'Transforming care'. However, there are several instruments and sets of processes and outcome indicators that evaluate particular attributes and consequences of 'Transforming care'. Table 4 includes six possible tools: Evidence-Based Practice Implementation Scale, Human System Audit transformational leadership short-scale, Healthcare Team Vitality Instrument, Nursing Work Index-Revised, indicators of changes in clinical practice and patient safety indicators (Aiken & Patrician, 2000; Chaboyer et al., 2010, Lee & Upenieks,

2008; Melnyk et al., 2008; Berger et al., 2012). As a comprehensive instrument has not been developed (Burston et al., 2015), these six tools can be combined to measure the presence of the concept.

4. Conclusions

In this concept analysis, the concept of ‘Transforming care’ has been examined by identifying its uses, antecedents, attributes, consequences and empirical referents. Based on the attributes and consequences, the following operational definition is proposed:

‘Transforming care’ is a framework to advance patient-centred processes of change aimed at enhancing the quality of patient care, based on evidence and joint decision-making, and driven by transformational leadership.

Having an operational definition will facilitate the application of the concept of ‘Transforming care’ in practice. For example, stakeholders may further their understanding of the meaning and purpose of ‘Transforming care’ and subsequently may become more capable of articulating plans for setting ‘Transforming care’ initiatives. Likewise, having an operational definition in place will facilitate the development of instruments that comprehensively assess ‘Transforming care’. For instance, the proposed definition suggests that such instruments should include at least three core dimensions representing the three main attributes of ‘Transforming care’, namely: patient-centredness, driven by transformational leadership, and evidence-based.

Findings regarding the consequences of ‘Transforming care’ also have implications for the development of instruments for the assessment of ‘Transforming care’. Indeed, the consequences identified suggest that such instruments should explore improvements related to care processes, professionals, and patients’ outcomes, as a result of the implementation of

‘Transforming care’. Specifically, among the potential improvements in professional outcomes, enhancement of the ‘vitality of the staff’ merits special attention because an objective change in the attitudes and commitment of nurses in their daily work will favour a boost in teamwork among the staff. This behavioural change can contribute to the sustainability of the quality of care.

The defining attributes identified for ‘Transforming care’ suggest that it is a complex issue that requires a considerable array of front-line managing skills in order to be implemented. Indeed, they need to be visionary, creative, flexible and influential leaders to ensure that stakeholders become sufficiently involved in order to bring about the change successfully. Further lessons and recommendations for managers and leaders who are considering implementing the ‘Transforming care’ approach have been elaborated from findings regarding the antecedents of this concept. For instance, to pave the way for introducing ‘Transforming care’, front-line managers and leaders should:

- Envision, understand, explain and boost the need for care improvement so it becomes widely felt by organisational members.
- Foster a culture of continuous improvement that facilitates organisational members recognition of and responsiveness to needs for care improvement.
- Focus the organisation’s attention on the patient’s experience of care to make care improvement a priority.
- Flatten organisational structures so as to allow for the development of bottom-up approaches for care improvement. Therefore for stakeholders at all levels in the organisation to be empowered to participate in the design and development of changes.

One limitation of this concept analysis is that much of what is known about the phenomenon of ‘Transforming care’ is derived from studies performed in particular contexts,

such as the United States of America and Australia. In this sense, it is uncertain if the operational definition of the concept can be used in other contexts with differing healthcare realities and practices. Hence, the application of this framework to other contexts may require further study and development.

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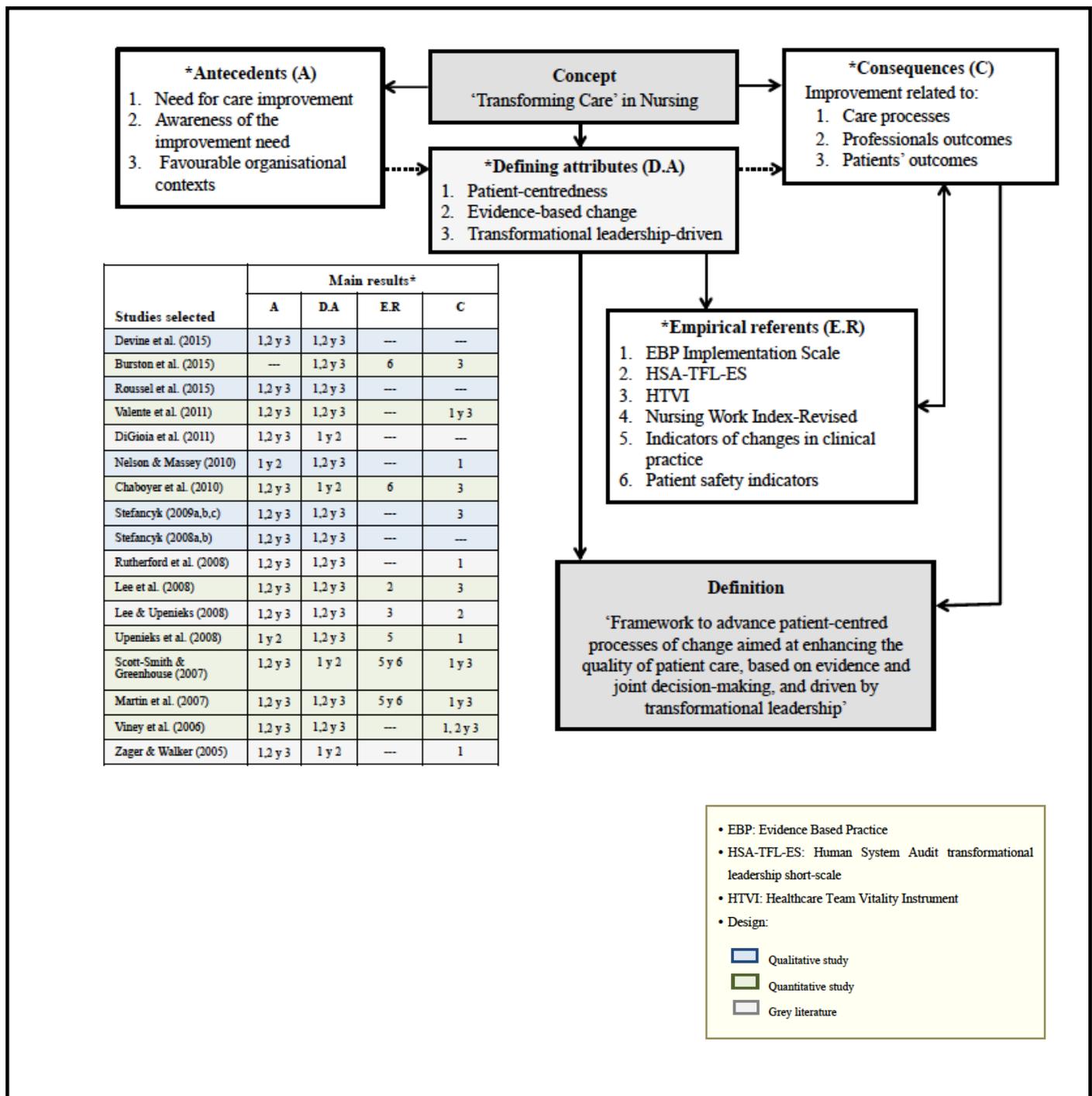
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Figure 1. Diagram of the results of the concept analysis of ‘Transforming care’ in nursing



Tables

Table 1. Phases of conceptual analysis by Walker and Avant (2011, p. 65)

Phases	Description
<i>1. Select a concept</i>	Concept selection and definition of the objective of the analysis.
<i>2. Determine the purpose of the analysis</i>	
<i>3. Identify all uses of the concept</i>	'Identify all uses of the concept that you can discover'
<i>4. Determine the defining attributes</i>	'Characteristics of the concept that appear over and over again'
<i>5. Construct a model case</i>	'An example of the use of the concept that includes all the critical attributes of the concept'
<i>6. Construct a borderline and contrary case</i>	Related case: is a similar example of the concept, but contains no specific critical attributes for the concept study.
	Borderline case: 'an example of the use of the concept in which some of but not all the critical attributes are present'
	Contrary case: is a clear example of what is not the concept.
<i>7. Identify antecedents and consequences</i>	Antecedents: 'must be present for the concept to happen'
	Consequences: 'occur as a result of the occurrence of the concept'
<i>8. Define empirical referents</i>	'Categories of actual phenomena that demonstrate occurrence of the concept itself'

Table 2. Main characteristics of the studies identified

AUTHORS	COUNTRY	DESIGN	ANTECEDENTS	DEFINING ATTRIBUTES	EMPIRICAL REFERENTS	CONSEQUENCES
Zager & Walker (2005)	USA	Grey literature (essay)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Transformational leadership-driven. 	Not included	Excellence in the practice.
Viney et al. (2006)	USA	Quantitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Transformational leadership-driven. 	Not included	Enhanced satisfaction in nurses and patients. Reduction in number of times doctors are paged.
Martin et al. (2007)	USA	Quantitative (descriptive) Follow-up period: 2 years	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Recording of number of falls. Recording of nursing time spent on patient care.	Enhanced satisfaction in patients. Reduction in number of falls (9/1,000 patients/day-0/1,000 patients/day). Increase in nursing time spent on patient care (40%-55% in all units).
Scott-Smith & Greenhouse (2007)	USA	Quantitative (intervention type) Follow-up period: 6 months	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Survey before and after the programme (not included)	Enhanced satisfaction in patients. >Diet consumption (59-74%). >Number of patients with correct diet (69%-76%). >Number of educational interventions (0-36%). >Cost-efficiency in catering service <Use of pagers (18%)
Upenieks et al. (2008)	USA	Quantitative (prospective comparison)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Recording of nursing time spent on patient care.	Added value: increase in nursing time spent on direct care.
Lee & Upenieks (2008)	USA	Grey literature (guide)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Health Team Vitality Instrument	Improvement in teamwork and communication.
Lee et al. (2008)	USA	Quantitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	<i>Lominger Leadership Architect Card sort.</i> 360° evaluation.	Improvement in patient care.
Rutherford et al. (2008)	USA	Grey literature (guide)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Added value: increase in nursing time spent on direct care.

USA: United States of America

Table 2. Main characteristics of the studies identified (continuation)

AUTHORS	COUNTRY	DESIGN	ANTECEDENTS	DEFINING ATTRIBUTES	EMPIRICAL REFERENTS	CONSEQUENCES
Stefanczyk (2008a,b)	USA	Qualitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Not specified
Stefanczyk (2009a, b, c)	USA	Qualitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Reduction of fall index: 6-4.5/1,000 patients/day. Increase in patient satisfaction by 10 points.
Chaboyer et al. (2010)	Australia	Quantitative (observational)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Transformational leadership-driven. 	Recording of number of clinical incidents (medical errors, falls, and pressure ulcers).	Reduction of reported medication errors (46.3%-17.1%); falls (97%-51%) and pressure ulcers (91.3%-46.6%)
Nelson & Massey (2010)	USA	Qualitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Reduction in time spent in change-of-shift reports, reduced end-of-shift overtime, staff perceived improved information quality and satisfaction with the process.
DiGioia et al. (2011)	USA	Grey literature (guide)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Transformational leadership-driven. 	Not included	Not specified
Valente et al. (2011)	USA	Quantitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Reduction turnover rate (58%). Increase in time spent in direct patient (10%) and value-added care (10-15%) Improve patient and staff satisfaction.
Roussel et al. (2012)	USA	Qualitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Favourable organisational context. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Not specified
Burston et al. (2015)	Australia	Quantitative (cohort study)	Not specified	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Number of clinical incidents (falls and pressure ulcers).	A variable impact on patient outcomes (falls and pressure ulcers)
Devine et al. (2015)	USA	Qualitative (descriptive)	<ul style="list-style-type: none"> ▪ Need for care improvement. ▪ Awareness of the improvement need. ▪ Close alignment with the framework. 	<ul style="list-style-type: none"> ▪ Patient-centredness. ▪ Evidence-based change. ▪ Transformational leadership-driven. 	Not included	Not specified

USA: United States of America

Table 3. Characteristics of three approaches

<p>APPROACH / AIM</p> <p style="text-align: right;">CHARACTERISTICS</p>	Patient-centred	Leadership	Evidence-based enhancement
<p>Studer Group[®] Make the healthcare environment a better place for employees to work, clinicians to practice and patients to receive care.</p>	√	√ (top-down)	√
<p>Transforming Care at the Bedside Improve quality and safety of patient care, increase vitality and retention of nurses, improve effectiveness of the entire care team, improved patient's and family member's satisfaction</p>	√	√ (bottom-up)	√
<p>The Productive Ward Improve reliability, safety and efficiency of the care that all nurses deliver. Help ward teams to make time for patient care by using improvement skills to review ward environment and processes.</p>	√	√ (bottom-up)	

Source: Data from Burston et al. (2011)

Table 4. Possible tools to evaluate attributes and consequences of ‘Transforming care’

Attributes and consequences of ‘Transforming care’	Tools
Evidence based	EBP Implementation Scale (Melnik et al. 2008)
Supervisors’ transformational leadership	Human System Audit transformational leadership short-scale (HSA-TFL-ES) (Berger et al. 2012)
Staff vitality	Healthcare Team Vitality Instrument (Lee & Upenieks 2008, Upenieks et al. 2010)
Working environment	Nursing Work Index-Revised (Aiken & Patrician 2000)
Nursing time spent on direct care	Indicators of changes in clinical practice (Rutherford et al. 2008)
Patient safety outcomes	Patient safety indicators: reduction in the percentage of clinical incidents, medical errors, falls, and pressure ulcers (Chaboyer et al. 2010)