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Evaluation of the Clarity, Usefulness and Willingness to adopt a Joint Military Nursing Professional Practice Model by Military Nurse Leaders

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Abstract

The goal of this project was to evaluate the clarity, usefulness and willingness to adopt a Joint Military Nursing Professional Practice Model by military nurse leaders into the military health system. This paper specifically examined leader feedback and perceptions prior to implementation of the Joint Professional Practice Model (JPPM) into designated pilot sites within the Military Health System (MHS) Nursing environment. This project includes Chief Nursing Officer (CNO) discussions reflecting the clarity of definition of model components, usefulness of the model and its components, and willingness to adopt the JPPM. This information will be used to modify the new JPPM prior to implementation and develop educational material for the successful deployment and adoption of a JPPM into practice settings across the military health system.

Evaluation of the Clarity, Usefulness and Willingness

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In 2017, the National Defense Authorization Act (NDAA) (H. R. Rep. No. 114-840, 2017) directed hospitals from all three services (i.e., Army, Navy, Air Force) to align their standards of nursing excellence across the military health system (MHS). Army Nursing, along with the other services, was challenged to revisit their existing professional practice model and refocus it into a refreshed model that would accomplish this directive. A glimpse at the existing military nursing professional practice models (PPMs) yielded a unique perspective of each service's medical system and how they were aligned to support a certain operational environment whether by land, air, or sea. To work toward the mandated re-alignment, the decision was made by leaders of each Nurse Corps to develop a new model that would merge these separate professional practice models into one joint professional practice model (JPPM) for nurses across the entire MHS. The purpose of this project was to provide an overview of the new proposed PPM to Army Nurse Corps leaders and examine leader feedback about the clarity and usefulness of the model, as well as the willingness of included leaders to adopt a new model.

According to Mislan et al. (2021), a professional practice model (PPM) is considered a key element in establishing an environment which fosters exemplary professional practice. The value of such a model goes beyond the surface of creating consistent practices and reaches into the interface between the nursing structures and processes in the organization where the mission, values, philosophies, and professional practice elements that drive those processes exist. The development and implementation of a nursing PPM can be a daunting task, particularly in a large, complex health system with nurses practicing in a variety of roles and locations around the globe (Winslow et al., 2019). To address the complexities of such a task, a group of tri-service

nurse leaders formed a representative working group to focus specifically on the development of a JPPM. This working group was challenged to engage nurse leaders at all levels and across all services to support the evidence-based development of a single JPPM.

Professional Practice Models

Professional practice models promote accountability and governance of the profession at every level ensuring nurses are empowered and demonstrate ownership of their own practice (Aiken et al., 2008; Breckenridge-Sproat et al., 2015). The PPM creates a framework that articulates the professional care provided by the nurse to achieve the highest quality outcomes while striving for excellence. It also reflects how nurses practice, collaborate, communicate, and develop professionally to best integrate mission, vision, values, philosophy, and theories of their organization with nursing practice (McCaughey et al., 2020). It has been shown that nursing practices which maximize the nurse's scope of practice and potential are best accomplished with a professional practice model that is fully integrated where nurses work (American Nurses Credentialing Center [ANCC], 2017). Evidence of the impact of these models is seen in health systems who have adopted Magnet® standards. Compared to their non-Magnet counterparts, hospitals adopting the uniform practices, required by the Magnet standard, experience lower patient mortality rates and improved outcomes in care, to name a few (Friese et al., 2015).

Hospitals with Magnet® status demonstrate that professional nursing practice in a hospital setting promotes autonomy in decision making, control of the practice environment (e.g., being able to plan and organize care delivery), consistent proactive communication with physicians, and accountability for care delivery (Jost & Rich 2010). Furthermore, professional practice models are most effective when clearly linked with the organization's mission, vision, and value statements to create a culture that motivates employees to achieve a higher purpose (Mensik et

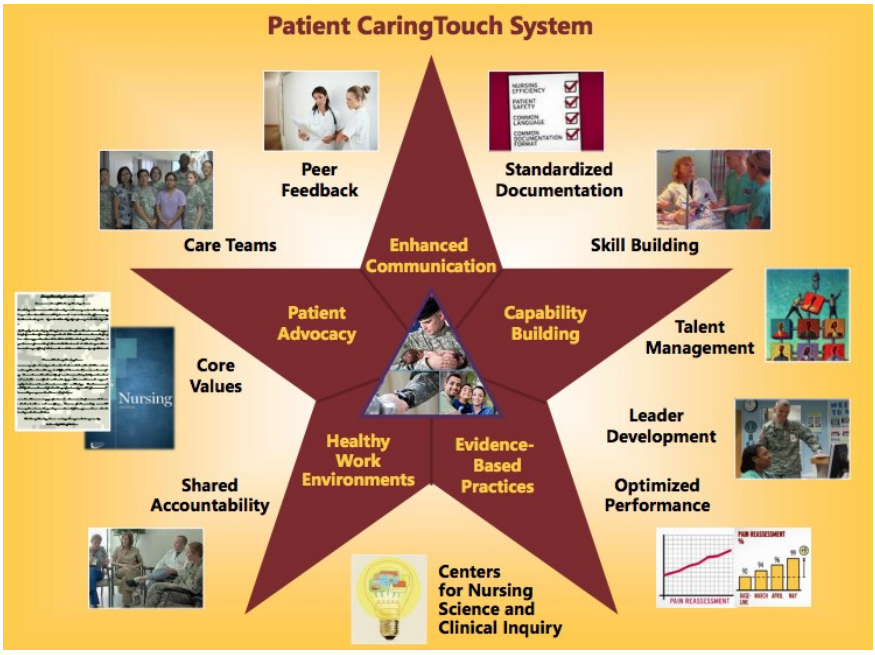
al., 2017). A professional practice model not only influences nursing practice, but it is also the interface of nursing with all other departments and disciplines of the healthcare system. The successful implementation and sustainment of a PPM requires the cooperation, support, and attention of leaders from multiple levels of the healthcare organization (Mensik et al., 2011).

Current Army Model

The Army's current professional practice model, The Patient Caring Touch System (PCTS) was first implemented in 2011 (see Figure 1). The Army Nurse Corps (ANC) created and implemented this new professional practice model after an extensive review of literature and evaluation of successful military and civilian nursing practice models (Breckenridge-Sproat et al., 2015). The PCTS was designed to be the permanent model of nursing practice for each Army medical institution regardless of changes in nurse leadership and clinical nurse rotations (Franklin et al., 2014).

Figure 1

The Patient CaringTouch System (PCTS)



At its inception, the PCTS was an innovative framework for the delivery of nursing care that was successful in aligning strategic and patient centric priorities (Breckenridge-Sproat et al., 2015), while being designed to further reduce variation in care processes and improve outcomes of nursing care (Horoho, 2011). Under the operation of the PCTS, Army healthcare experienced positive outcomes. The system as a whole, as well as each individual facility, noted a decline in medication administration errors, as well as improved compliance with required pain reassessment following pain medication administration (Breckenridge-Sproat et al., 2015).

This model has six core components that are specifically aimed at increasing the use of evidence-based practice, fostering healthy work environments, enhancing communication, improving patient outcomes, and reducing practice variation across military hospitals. The core components of the PCTS are: optimized performance (measurement of meaningful nursing-sensitive indicators), care teams (a model for delivering care), peer feedback (a way to increase reflection on practice), skill building (aimed at improving knowledge and nurse competence), shared accountability (implementing a shared governance structure), and core values (guiding principles for providing care). Each of these components were implemented in Army healthcare facilities as the standard requirement (Breckenridge-Sproat et al., 2015).

Development of the New Model

Like the Army, other services within the military health system each has a PPM in place or employs specific components of a PPM. Despite similarities in these existing models, the tri-service working group determined there was no single service model that would bridge the overall healthcare mission of all three services and create a collaborative togetherness that is sought under the Defense Health Agency. Therefore, leaders determined that an entirely new PPM was required.

To best understand how to proceed with the task, it was essential to first understand the professional practice models already implemented in each service. The working group looked at similarities and differences in the existing, service-specific models. To guide the development of the overarching PPM the working group determined that a JPPM would need leadership involvement and input from each service to promote ownership and buy-in of the model to empower nursing practice. They also sought to create a model that could be easily articulated, defined, and described by all nursing staff across the MHS, without regard to individual, service-specific jargon. The working group envisioned that cohesion in this type of shared model of practice would allow nurses across the military health system to realign mindsets and practices. Looking beyond the implementation, the goals included ensuring the components of the JPPM would facilitate the levels of excellence required to achieve Magnet®, Baldridge, or other acknowledgements of excellence.

PPM Core Component Development

Evidence indicates that developing a professional practice model can be a monumental undertaking, but is essential to ensure the mission, vision, and values of an organization are facilitated in the day-to-day practice and provision of healthcare (Slatyer et al., 2016). The best PPMs are not only evidence-based but have full buy-in by stakeholders and leaders, ensuring the model is agreed upon by eliminating barriers to achieving full support and widespread adoption (Newhouse et al., 2005). Core components of a PPM vary amongst models and are important to investigate and evaluate for their contributions. Consistent themes for professional nurse practice model concepts and components include facilitating leadership, promoting nurse autonomy, maximizing the nurses' scope of practice, creating a healthy work environment, ongoing

professional development, grounding the practice in evidence and research, and patient centered care (Jost & Rich, 2010).

Following review of existing models and aligning the goals of tri-service leaders, an extensive literature review was performed by the JPPM evidence-based development team. The group determined the unique needs of military nursing. Using those unique criteria, the evidence-based practice (EBP) team representatives developed a five-component model (see Figure 2) by evaluating the literature and determining which key aspects of nursing practice were the most important when creating a JPPM.

Figure 2

The Military Joint Professional Practice Model

The model incorporates four components that represent broad nursing environments: 1) Leadership Development, 2) Evidence Based Practice, 3) Healthy Work Environment, 4) Quality & Safety, with an additional fifth component that is unique to the nursing environment specific to military nursing: 5) Operational Readiness. Component definitions were agreed upon after an extensive literature search was conducted using multiple databases including PubMed, CINAHL,

Embase, Joanna Briggs, and Scopus. Military-specific literature was searched to inform the military specific component of Operational Readiness.

Operational Readiness is the military specific component of the JPPM. The requirement to satisfy the operational readiness of peacetime and war-time readiness is one aspect of military nursing that sets the professional responsibilities apart from civilian nursing counterparts. Readiness measures the military services medical asset's ability to perform their wartime task (Bridges, 2010).

Following core-component identification and building the JPPM, the next task, the impetus of this project, was ensuring clarity of the model, understanding of the model, and willingness to implement the model. The project reviewed the process by which the operational readiness of the Army Nursing component was assessed utilizing military specific literature and agreed upon the following by the operational readiness subgroup.

The new model recognizes all nurses in each branch of service and across all environments to include the civilian workforces to represent the total nursing force (TNF). The total nursing force is the combination of military and civilian registered nurses, licensed practical/vocational nurses, including medics, technicians, hospital corpsmen, airmen, nursing assistants, and others who work together to provide nursing care to patients.

The model represented in Figure 2 reinforces the opportunity for each of the services to place the patient in the center of care, as seen in the middle of the diagram, to focus on people, readiness, and leadership while aligning to form a single PPM. Leadership is one of the key components that overlaps in each of the services and will prove to be a vital element to garner acceptance and improve practice. Leadership is important in every aspect within a military setting and especially in a healthcare environment where readiness is the mission and primary

focus of each service. Turning the focus to people plus readiness creates a compelling, and very different model, than that of civilian organizations and addresses the needs of the military services to focus on readiness of the mission.

Purpose Statement

The purpose of this project was to provide an overview of the new proposed PPM to Army Nurse Corps leaders and invite their feedback and assessment regarding the clarity and usefulness of the model, as well as the willingness of those leaders to adopt a new model. This review and feedback opportunity was a critical element towards initiating the adoption and implementation of the model. Feedback obtained from Chief Nursing Officers (CNOs) at designated sites also aided the development and refinement of educational materials to assist introduction of the JPPM in future Army facilities.

Review of Literature

Professional practice models are designed to specifically guide organization's nursing leadership toward collaboration in decision making while ensuring positive outcomes for patients and families (Slatyer et al., 2016). When integrated successfully, a professional practice model ensures that important nursing values and the way in which care is delivered are aligned between leaders and practicing nurses (Duffy, 2016). Integration of professional practice models assist with improving health outcomes and strengthen professional nursing practice by providing opportunities for ongoing research that will provide empirical evidence of their value (Duffy, 2016). They further guide and support nurses in the delivery of care within the delivery environment; however, it is also suggested that a stagnant PPM (i.e., one that does not evolve with organizational changes), does not serve nor elevate the practice. According to the literature,

a PPM is a critical component when considering their relation to and impact on improving clinical outcomes (Slatyer et al., 2016).

Traditionally, PPMs are comprised of five core components that each build on the other while supporting nursing autonomy, empowerment, innovation, and high-quality patient care (American Nurses Credentialing Center [ANCC], 2014). The five components include (a) the organizational mission, vision and values or philosophy; (b) nursing professional roles, responsibilities, and relationships (typically derived from nursing theory); (c) a patient care delivery system (PCDS); (d) governance and decision making; and (e) a system of recognition/reward (Duffy, 2016).

Important factors to consider when implementing widespread change across a healthcare system to achieve intended outcomes entails resilient leadership, evidence-based change management methodologies, and highly engaged nurses (Mislan et al., 2021). According to Mislan, large-scale change that supports the advancement of the profession of nursing across an enterprise can be facilitated through the development of a nursing professional practice model. Another important aspect is assessing leader and organizational readiness, which is a key element in establishing a newly developed professional practice model. Providing leader feedback on the usefulness and feasibility, support and buy-in profoundly impacts the ability of the new model to be implemented. Jost and Rich (2010) elaborates noting that establishing the PPM is only the first step, but ensuring the PPM supports day to day practice is key for implementation and sustainment.

Creating a culture of excellence is a prerequisite for any healthcare organization hoping to achieve status as a high reliability organization (HRO) (Chassen & Loeb, 2013). HROs are organizations that have been shown to improve the quality, safety and efficiency of the

organization by focusing on 5 key principles that relate specifically to safety: 1) sensitivity to operations (*i.e*, heightened awareness of the state of relevant systems and processes); (2) reluctance to simplify (*i.e*, the acceptance that work is complex, with the potential to fail in new and unexpected ways); (3) preoccupation with failure (*i.e*, to view near misses as opportunities to improve, rather than proof of success); (4) deference to expertise (*i.e*, to value insights from staff with the most pertinent safety knowledge over those with greater seniority); (5) and practicing resilience (Veazie et al., 2019).

Paramount to achieving success is meeting service cultures expectations; having a set of guiding principles such as a PPM can assist in establishing and managing performance expectations. These expectations derived from the PPM will inform practice behaviors including compassionate care, strong ethical values, accountability, and responsibility, which will ultimately lead to a profession that exemplifies collaboration and flexibility (Ribeiro et al., 2016). To be considered a profession, nursing must portray certain characteristics including an identifiable body of knowledge that can be transmitted via formal education, autonomy of decision making, authority over practice, and accountability for outcomes (Slatyer et al., 2016). The ideal PPM integrates all the characteristics of a profession with a philosophy of nursing and is theoretically based while also incorporating the operational elements of nursing practice.

While a common foundation is vital to the professional culture of each of the services, the more important factor is the professional culture itself, particularly as it pertains to each service. Slatyer et al. (2016) reasoned the combination of professional culture, nursing theory, and practice must support the vision of nursing in their practice to achieve a culture of excellence. Regarding implementation of changes in professional practices, the literature was reviewed to

ascertain methodologies for implementation and gauge readiness of the environment to implement a new model.

Conceptual/Theoretical Framework

Change is an essential part of any organization but implementing change has its own challenges and difficulties. A detailed framework for addressing these concerns is outlined in Kotter's 8-step process for change (Kotter, 2021). Kotter (2012) discusses that more than seventy percent of organizations' efforts fail at successful change. Some of the root causes for those failures too often have to do with not implementing a successful strategy to achieve their desired results for change. Organizations can increase their likelihood of a successful transformation in adopting change by committing to a strategy and then adhering to that strategy. Kotter's extensive study of change has been a leading component globally across many organizations and is constantly shifting. According to Laig et al. (2021), it is considered as an emergent approach to change when it is necessary in organizations.

An important consideration when implementing a new PPM for nursing is how the implementation is operationalized. In theory the new PPM should greatly influence the organizational culture while overseeing the delivery of care by nursing. It is essential to create, monitor, and support the system-wide change that will occur within the Army and other services. There are many models that support widespread change within organizations in order to be successful. Kotter's model is widely popular and demonstrates successful outcomes by providing a structured framework that supports widespread change across organizations. For this reason, it will be used to assess the readiness of the leaders to adopt the change being implemented. The 8-step model (see Figure 3) outlines what the teams must develop and implement to ensure their vision and strategy is adopted.

Figure 3

Kotter's 8 Step Model for Change

According to Kotter's model, there are six key characteristics for a clear vision. It should be "imaginable, desirable, feasible, focused, flexible and communicable" (2012, p. 2). An unclear vision could be misleading and create confusion among stakeholders within an organization. In Kotter's model, the first step, called "*create a sense of urgency",* involves generating a sense of purpose around a common goal that brings the team together. The second step *build a guiding coalition* who will be responsible for operationalizing the model to help support the change. Step 3 *form a strategic vision* by deciding what to do, but more importantly by getting stakeholder feedback on what should be done. This project examined CNO feedback to make needed changes to the model. Based on the feedback received, edits will be made to refine and develop educational materials for staff during the adoption of the JPPM. Kotter advises that in step three is where the change will occur by creating buy-in.

Acceptance of the newly formed PPM by the CNOs was one of the most important aspects of this project, so it was crucial to incorporate that feedback when assessing leader

feedback and acceptance of the newly formed PPM. Step 4 *enlist a volunteer army* for the needed change to occur; those committed to the project who will assist in propelling change throughout the process. Step 5 galvanizes other leaders to *enable action by removing barriers* that may exist and creates a sense of ownership. *Generate a short-term win* (Step 6) of leader buy-in and engagement sets the stage for moving forward with the vision of the new model as Kotter discusses in the literature. Steps 7 and 8 (i.e., *sustain acceleration* and *institute change*) will be used to launch the JPPM to the staff at the designated pilot sites. A change in culture happens in the final step of the process and a new culture is created by anchoring new practices for sustained change. Following Kotter's 8-step model will allow for the adoption of the new model to take shape within the pilot sites and helps facilitate a new joint culture within the Army.

Methods and Procedures

Participants/ population

The target population for this project included the leaders responsible for introducing and facilitating adoption of the JPPM at select Army and Joint Nursing facilities. The identified leaders were the Chief Nursing Officers of those facilities and/ or their leadership teams. Table 1 identifies the facilities included in this project across the MHS who will be provide feedback on the JPPM. This project focused on the Army specific and two blended locations that are primarily known as Army centric based on history, culture, and location. The first four facilities listed in Table 1 may have agreed to participate more quickly than other sites due to availability, access, and connection to Army leadership.

Table 1

JPPM's Pilot Facilities

Base/Location/MTF Size	MTF Name	Primary Service

Fort Hood, Texas, Large	Carl R. Darnall Army Medical Center	Army
Fort Hood, Texas, Small	9th Hospital Center	Army
Joint Base Fort Sam Houston, Texas, Large	Brooke Army Medical Center/San Antonio Military Medical Center (BAMC/SAMMC)	Joint Base - Blended
Bethesda, Maryland, Large	Walter Reed National Military Medical Center	Joint Base-Blended
Ramstein Air Base, Germany, Large	86th Aeromedical Evacuation Squadron 86th Medical Group	Air Force
Wright Patterson Air Base, Dayton, Ohio, Medium	88th Medical Group	Air Force
Naval Hospital Camp Pendleton, California, Medium	Navy Medicine Readiness and Training Command (NMRTC)	Navy

Setting

The setting of the two Army and two Joint Base – blended facilities included in this project are: two tri-service hospitals where the nursing assets belong to three separate services but work within one facility, one moderate-sized Army hospital, and one detached Army hospital center. These facilities' environments are significantly different in scope, size, and nursing assets. Nurses and nurse leaders in the hospital environment experience a traditional hospital environment, while the 9th hospital center is known to be a more mobile agile hospital that can be ready to deploy on short or no-notice to any combat environment. During non-deployed mission time, the daily work of the leaders and nurses of the 9th Hospital Center, is geared toward soldier readiness and providing experiences that aid in improving nursing skills. The staff spend a majority of non-deployed time focused on the training and readiness skills, while supporting the larger hospital with personnel resources to maintain nursing skills. These sites were chosen strategically for initial implementation based on their size and location. Likewise, ensuring that initial roll-out is appropriate and feasible to these distinct environments is essential prior to taking on the larger JPPM roll-out to the remaining facilities and units.

Sample

Participants this project are three CNOs which attended the real-time presentation and a fourth CNO that viewed the recorded presentation. The four CNO participants represent a total of 4,250 nurses across the pilot sites.

Intervention

A presentation introducing the new model was given to the CNOs from three of the four designated pilot sites scheduled to attend, representing a nursing staff of 4,250 individuals in a roundtable discussion format was held. The presentation was created to: 1) provide an overview of the new model; 2) obtain feedback on the components which make up the new model; and 3) determine model usefulness and clarity. The CNOs were asked a series of questions broken down into three sections from the leader questionnaire (see Appendix A). The first section focused on whether the model is clear and easy to understand and if the definitions for the component tables have good rationale. The second section of the questionnaire focused on a willingness to adopt the new model by nursing staff and finally the third section focused on the usefulness of the model in practice. Following the presentation of the JPPM to the CNO leaders, there was a brief roundtable discussion to allow any questions to be answered. Participants were then asked to complete a questionnaire to assist in refining the five components that comprise the new model and will assist in the development of education materials that will be used to educate nursing staff. There were no validity and reliability assessed. The questionnaire contained no personal information nor any self-identified information therefore there was no threat to confidentiality.

Instrumentation and Measures

Instrumentation for this project was an eighteen-item questionnaire provided in the form of an electronically formatted questionnaire. The questionnaire (see Appendix A) was

administered by QR code and linked to a Microsoft Forms survey, allowing ease of access for users. Eleven of the questions were administered using a Likert scale with the remaining seven questions being open-ended to gain qualitative feedback from participants. The questionnaire's design was based on information received from the program review of the Army's PPM for PCTS. It consisted of review questions that were developed by the EBP team to evaluate the clarity, usefulness and willingness to adopt a Joint Military Nursing Professional Practice Model by military nurse leaders. Clinical nursing specialists and researchers provided their expert opinion to ensure the focus of the questionnaire was on targeting clarity and usefulness of the model in practice. The instrument was tested for end-user understanding by sending it out to nursing staff at various military medical facilities; those staff nurses then provided feedback on the questions needed to target the information of interest from the designated population. The questionnaire was intended to systematically elicit feedback and perception of the JPPM, its usefulness and feasibility into practice. The 11 quantitative questions comprised of summary rating scales and seven open ended qualitative questions to assess for themes from the CNOs following the discussion. The open-ended qualitative questions allowed CNOs to elaborate on the model's alignment to the practice setting, challenges that they may foresee with implementation, missed opportunities to strengthen the model, how likely they were to implement the model, the level of resourcing needed or anticipated to implement the model and finally, the utility in adopting the model. Currently there are no other reporting instruments used to measure the clarity, usefulness, and willingness to adopt the JPPM.

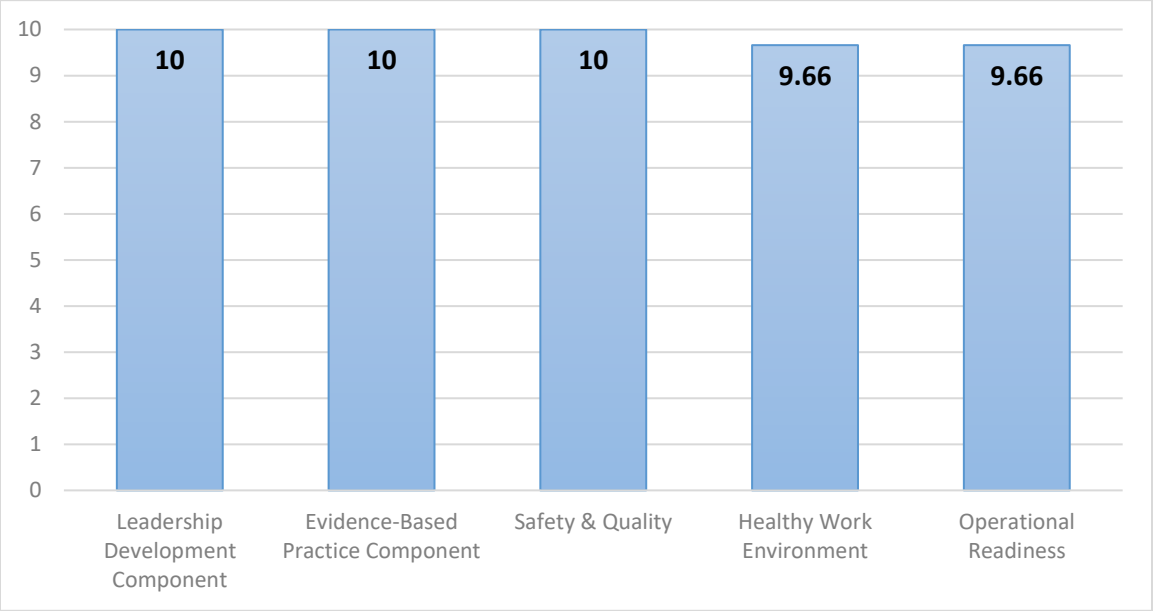
Results

Descriptive statistics were used to summarize the responses from the CNO questionnaire following the JPPM presentation. The JPPM review questions provided ordinal level data,

describing the level of agreement or concurrence with the clarity, understanding and willingness to adopt the model. Questions were answered on a Likert scale of 1 to 10, where 1 equaled “not clear” and 10 equaled “full clarity”. Based on review of the data, the leaders responsible to facilitate introduction of the JPPM agree the definition and rationale for each component are clear as evidenced by the data presented in Figure 4. See Appendix B for the quantitative results.

Figure 4

Component clarity of definition and rational

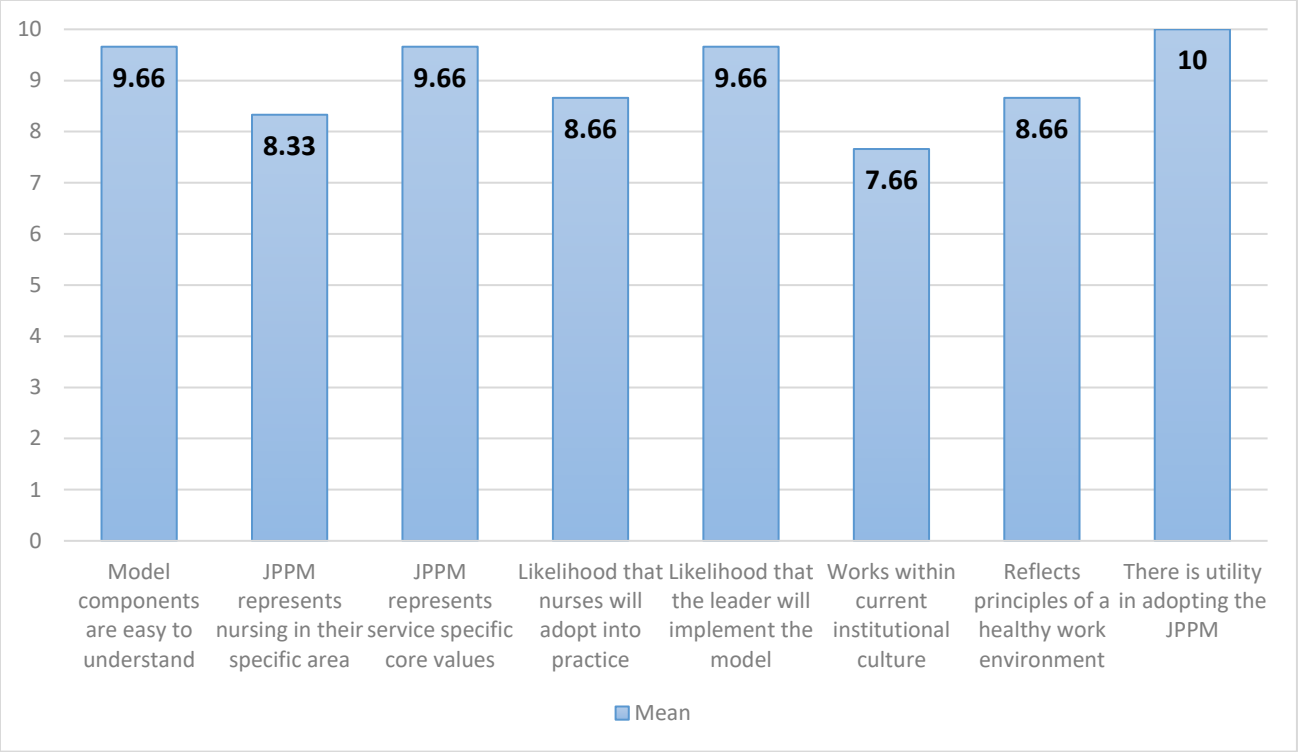


Note. Information represents responses to the questionnaire outlining component definitions represented in the scale.

Leaders surveyed agreed the model was easy to understand, representative of their unique nursing areas and institutional cultures, had a high likelihood for nurse adoption and leader implementation, and it was reported they felt there would be outstanding utility to adopting the JPPM.

Figure 5

JPPM Understanding and Alignment to Practice



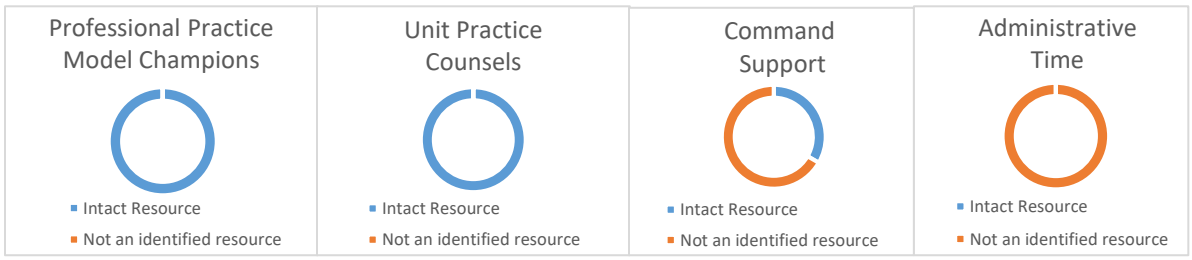
Note. Information represents understanding, feasibility, and willingness to adopt into practice.

Results from the qualitative portion of the questionnaire provided information that most facilities already have established PPM Champions as well as unit practice counsels (UPCs). These champions are mid-level professional nurses responsible for translating the JPPM into meaningful information. It is their key role to facilitate communication and have a deep understanding of the science that contributes towards the evidence as well as facilitate the implementation of the JPPM at their assigned locations. Figure 6 provides a visual representation of resource allocations in the areas shown. Command support, a vital component of the culture, did not seem to be an intact resource at two out of three facilities, and three out of three facilities noted they have no allocated or available administrative time to facilitate the introduction and implementation of the JPPM (Figure 6). This information allows for adjustments and

intervention at pilot sites during the initial roll out as feedback to address deficiencies and set up successful integration of the model into practice.

Figure 6

Asset presence to facilitate model implementation



Note. Information represents resources available to support the implementation of the JPPM. Blue represents fully staffed resources without constraints. Orange represents not fully staffed and resource constrained. Each circle represents the relative percent of assets allocated to support each component during implementation.

Discussion

The CNOs who provided feedback of the JPPM across the Army Medical Department (represented in Figure 1) concurred and accepted the new model. They found it clear, useful and were willing to adopt the new model into practice. In review of the discussion during the presentation as well as questionnaire results, CNOs noted it is important for the model and standards to be flexible and not prescriptive. They argued that ensuring attention was paid to nomenclature (i.e., naming) and maintaining broadness would make it less restrictive and more widely accepted to implement across the services. Their comments were addressed individually, and feedback was provided to the entire group of CNOs. Overall, results were supportive of the model and indicative that the model had appropriately encompassed the values and priorities of the nursing care embodied in the Army specific facilities. Leaders voiced their support and

willingness to implement, but also clearly communicated a need for command support and administrative time.

Leaders in the role of CNO have a deep appreciation for the administrative work required to initiate new models and ideas in the clinical environment while maintaining the ongoing clinical focus. The stress noted with unanimous reports of needed resources should garner the attention of implementation leaders who may consider full time employee (FTE) allowance or additional resources to facilitate a successful implementation. Command support should also be requested prior to implementation, ensuring that the nursing environment has the support required to assist key nursing leaders in their mission of JPPM implementation.

Momentum during initial implementation is the key element to sustained performance of a practice model. The results of the questionnaire reinforced the importance of administrative support and the need for command support; all of which, if not addressed prior to implementation, may result in less than effective results. In addition to receiving information on the readiness and understanding of the model, further information from the questionnaire will be used to assist in the refinement of training materials used to educate nursing staff during the pilot of the JPPM. The data from the pilot project will be used to inform the broader project.

Ethical Considerations

This project's focus was an evidence-based questionnaire designed to facilitate understanding of a larger Internal Review Board (IRB)-approved project. As such, Bellarmine University's IRB approval was not required prior to initiating the DNP Project.

Limitations

The limitations of this project are related to review questions used to determine leader willingness, usefulness and clarity - of the JPPM. The small number of participants, and the

inclusion of only Army-specific facilities were significant limitations of this project. While there is a need to ensure that individual military services feel represented and will implement the model, this is ultimately a shared-service model. Additional resources should be allocated at a later date to conduct similar assessments in the other service-related facilities to ensure there is a shared endorsement. Ultimately, all services' participation will be important, if not a measure of success itself.

Significance and Potential Implications

It is important to assess clarity, usefulness, and willingness to adopt change when implementing any project, but more importantly leader readiness to make widespread change. Kotter (2012) implies organizations that are more successful at change determine the organization's commitment by assessing leader readiness. Research has shown the closer an organization adheres to change readiness factors, the more likely it can achieve success in change initiatives (Laig et al., 2021). Change readiness factors can have a direct influence on readiness for change and the organization's stakeholders change perception. It takes a considerable amount of time, effort, and a change in culture and commitment for nursing to advance this initiative and sustain it in the future. There is great potential in having all three nursing services aligned under a joint professional practice model. The emergence of the JPPM will promote and improve quality of care across the military platforms while supporting the principles of a high reliability organization.

This review strategy and concept supports the nursing essentials while emphasizing nursing science by highlighting the importance of complex practices with complex issues. Key skills include the development of clinical practice guidelines, designing evidence-based interventions, and evaluating practice outcomes**.** Evaluating and improving practice outcomes for

organizations hoping to achieve Magnet status is an important principle to work toward in order to demonstrate improvements in clinical practice and the relationship between a sound JPPM and the improvement of nurse specific indicators that result in quality measures (ANCC, 2014).

Conclusion

The implementation of a Joint Professional Practice Model across the services will provide a framework that supports nursing practice throughout the military health system in any environment and enhances care whether in a military treatment facility, ship, aircraft, or in a deployed setting. Feedback received from nurse leaders indicates a strong willingness and motivation to move forward with deployment of the JPPM at pilot sites. Once instituted, an assessment of each pilot site should be conducted to analyze success of the implementation prior to mass adoption across the MHS.

Quantitative data and feedback suggest it is necessary to review and respond to the CNOs comments prior to implementation to ensure their comments were addressed and noted for follow up. The success of implementation will be dependent upon addressing ongoing feedback received from leaders at each site and maintaining momentum throughout the change process. The commitment of each leadership team is crucial to creating and maintaining the momentum necessary to achieve wide-scale change with positive outcomes and quick wins. That commitment will be strengthened by providing support and addressing leadership gaps/challenges to help remove barriers during implementation in each military treatment facility. By doing so, it will strengthen adoption by all three services and lead to a successful change.

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Appendix A

JPPM Review Questions

Nursing Leader, Thank you for your time. We are asking for your feedback on the training, the training materials, the visual representation of the Joint Professional Practice Model (JPPM), and most importantly, the 5 components of this model. Please take a moment and think about the key elements, beliefs, and perspectives that define and represent professional practice and the approach to patient-centered care that you uphold in your institution. Then, consider the proposed JPPM and provide honest and constructive feedback so that the final model is one you are proud to adopt and endorse on behalf of your Service and your nursing workforce.		
Understanding Model Components		
When reviewing the graphical depiction of the JPPM, how easy is it to understand the model components?	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very difficult 10 = Very easy	Rating =
How well does this JPPM represent your philosophical view of your nursing practice?	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very dissimilar 10 = Very similar	Rating =
How well does the JPPM represent nursing practice in your setting? Please elaborate:		
Model components represent my service (Army, Navy, Air Force) core values.	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Completely disagree 10 = Completely agree	Rating = Service:_____
How clear is the definition and rationale for inclusion of the component: <u>Leadership Development?</u>	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very unclear 10 = Very clear	Rating =
How clear is the definition and rationale for inclusion of the component: <u>Evidence-Based Practice?</u>	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very unclear 10 = Very clear	Rating =
How clear is the definition and rationale for inclusion of the component: <u>Safety and Quality?</u>	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very unclear 10 = Very clear	Rating =

How clear is the definition and rationale for inclusion of the component: Healthy Work Environment?	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very unclear 10 = Very clear	Rating =
How clear is the definition and rationale for inclusion of the component: Operational Readiness?	|----------| 1 2 3 4 5 6 7 8 9 10 1 = Very unclear 10 = Very clear	Rating =
Are there any aspects of the JPPM that are challenging to understand? Please elaborate:		
From your perspective, are there core components that are missing? Please elaborate:		
Willingness to Adopt the Model		
How likely are the professional nurses in your health care setting to adopt this model?	|----------| 1 2 3 4 5 6 7 8 9 10 1= Very unlikely 10= Very likely	Rating=
How likely are you to implement the model within your facility/area/scope of influence? Please elaborate:		
What level of resourcing is present to transition to and fully adopt this model into practice (champions, unit practice councils, administrative time, etc.)? Please elaborate on availability of resources for transition and adoption:		
Feasibility [Depends on in-person vs virtual training]		
Usefulness		
How likely is this JPPM to work within your current institutional culture?	|----------| 1 2 3 4 5 6 7 8 9 10 1= Very unlikely 10= Very likely	Rating=
How well do the components of this JPPM reflect principles of a Healthy Work Environment?	|----------| 1 2 3 4 5 6 7 8 9 10 1= Very dissimilar 10= Very similar	Rating= Missing principles: _____
How will this model support nursing practice? Please elaborate:		
Is there utility in adopting this model into practice? Please elaborate:		

Appendix B

Questionnaire Results

When reviewing the graphical depiction of the JPPM, how easy is it to understand the model components?	Mean Response: 9.66 (n=3)
How well does this JPPM represent your philosophical view of your nursing practice?	Mean Response: 9.66 (n=3)
How well does this JPPM represent your philosophical view of your nursing practice?	Mean Response: 9.66 (n=3)
How well does the JPPM represent nursing practice in your setting? Please elaborate:	Mean Response: 8.33 (n=3)
Model components represent my service (Army, Navy, Air Force) core values	Mean Response: 9.66 (n=3)
How clear is the definition and rationale for inclusion of the component: Leadership Development?	Mean Response: 10 (n=3)
How clear is the definition and rationale for inclusion of the component: Evidence-Based Practice?	Mean Response: 10 (n=3)
How clear is the definition and rationale for inclusion of the component: Safety and Quality?	Mean Response: 10 (n=3)
How clear is the definition and rationale for inclusion of the component: Healthy Work Environment?	Mean Response: 9.66 (n=3)
How clear is the definition and rationale for inclusion of the component: Operational Readiness?	Mean Response: 9.66 (n=3)
Are there any aspects of the JPPM that are challenging to understand? Please elaborate:	Qualitative Response: "no" x 1 response
From your perspective, are there core components that are missing? Please elaborate:	Qualitative Response: "no" x 3 responses
How likely are the professional nurses in your health care setting to adopt this model?	Mean Response: 8.66 (n=3)
How likely are you to implement the model within your facility/area/scope of influence? Please elaborate:	Mean Response: 9.66 (n=3)
What level of resourcing is present to transition to and fully adopt this model into practice (champions, unit practice councils, administrative time, etc.)? Please elaborate on availability of resources for transition and adoption: Qualitative Response: "Professional Practice Model Champions" x 3 responses; "Unit Practice Counsels" x 3 responses; "Command Support" x 1 response	
Are there additional resources that are necessary? Qualitative Response: "we need to ensure we are sensitive to operations"; "resources"; "funding"	
How likely is this JPPM to work within your current institutional culture?	Mean Response: 7.66 (n=3)
How well do the components of this JPPM reflect principles of a Healthy Work Environment?	Mean Response: 8.66 (n=3)
How will this model support nursing practice? Please elaborate:	Qualitative Response: "execution is the key"
Is there utility in adopting this model into practice? Please elaborate:	Mean Response: 10 (n=3)