Patient Engagement Through Informed Nurse Caring

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Abstract: Caring in nursing is well established as fundamental to the nurse–patient relationship. Swanson (1991) defines caring as a "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). The care provided by nurses should be informed (Swanson, 1993). The Nursing Alliance for Quality Care suggests that engaged patients enter into a partnership with nurses though which there is a mutual sharing of information (Sofaer & Schumann, 2013). Efforts to increase patient engagement may be enhanced through informed nurse caring. The purpose of this article is to discuss the promotion of patient engagement as informed caring practice, within the framework of a middle range theory of caring (Swanson, 1991, 1993) well suited for practical application.

Keywords: patient engagement; informed caring; caring; patient-centered care; Swanson; NAQC

Global efforts focused on health-care reform have underscored the essential nature of the phenomenon commonly referred to as *patient engagement* as a precursor to improved health and financial outcomes (Edgman-Levitan, Brady, & Howitt, 2013; Laurance et al., 2014). The *Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association [ANA], 2015) articulates the nurse's obligations to foster patient self-determination and to advocate on behalf of patients who are unable to do so for themselves. Numerous authors have identified the promotion of patient engagement and related concepts (Chaboyer et al., 2016; Sofaer & Schumann, 2013; Tobiano, Marshall, Bucknall, & Chaboyer, 2016) as critical in meeting these obligations. Caring is widely recognized as central to therapeutic nurse–patient relationships, and the literature often implies caring as an element inherent in attitudes and actions focused on patient engagement. Little explicit discussion exists regarding the nature of these efforts as fundamental expressions of caring. This gap represents a critical opportunity to explicate the direct link between caring practices and positive clinical and financial outcomes. The purpose of this article is to discuss the promotion of patient engagement as informed caring practice, within the framework of a middle range theory of caring (Swanson, 1991, 1993) well suited for practical application. The article will conclude with implications for nurses in multiple roles and settings.

Background

An abundance of literature regarding patient engagement and related concepts has emerged in recent decades. However, lack of a common definition and diverse terminology present challenges

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to health-care providers focused on promoting optimal patient outcomes (Barello, Graffigna, & Vegni, 2012; Barello, Graffigna, Vegni, & Bosio, 2014; Gallivan, Kovacs Burns, Bellows, & Eigenseher, 2012). Examples of related terms used interchangeably with patient engagement include patient participation, patient empowerment, patient involvement, self-management (Barello et al., 2014), and patient activation (Hibbard, Stockard, Mahoney, & Tusler, 2004). Despite lack of a consistent label, nurses by virtue of their roles are potentially well positioned to contribute to improved health outcomes by personally committing to a patient focused attitude and by acting accordingly.

In 2010, the leaders of several national nursing organizations identified the need for a united voice in order to maximize nursing's potential to impact health-care safety, clinical outcomes, and value through advocacy and contributions to health-care policy (Kurtzman, Dawson, Johnson, & Sheingold, 2010). This recognition led to the formation of the Nursing Alliance for Quality Care (NAQC), a partnership with broad representation from leading national nursing and consumer advocacy organizations, along with other key stakeholders (Sofaer & Schumann, 2013). Membership included:

- American Association of Colleges of Nursing
- American Academy of Nursing
- American Association of Retired Persons
- American College of Nurse Midwives
- American Nurses Association
- American Organization of Nurse Executives
- American Academy of Nurse Practitioners
- Association of Nurses in AIDS Care
- Association of periOperative Registered Nurses
- Consumers Advancing Patient Safety
- Institute of Pediatric Nursing
- Mothers Against Medical Error
- National Council of State Boards of Nursing
- National League for Nursing
- National Organization of Nurse Practitioner Faculties
- National Quality Forum
- Nurse–Family Partnership (Schumann, 2013).

The NAQC was initially funded by a Robert Wood Johnson grant and housed at the George Washington University School of Nursing (Kurtzman et al., 2010). The ANA assumed management of the alliance in 2013, in order to enhance sustainability through maximized resources and relationships (ANA, 2013).

The NAQC is committed to the promotion of patient and family engagement as an essential element of improved safety and quality in health care (Schumann, 2017; Sofaer & Schumann, 2013). Following NAQC inception and recognizing nursing's essential role in promoting patient engagement, alliance leaders embarked on a multiphase process involving (a) formation of a Patient Engagement Subcommittee, whose initial activities included an environmental scan and a literature review on the existing status of patient engagement; (b) development of a set of *Guiding Principles for Patient Engagement* (Figure 1) by the NAQC Board of Directors; (c) mobilization of a national panel of experts to develop a comprehensive white paper to guide the promotion of patient engagement by nurses across all roles and settings; and (d) organization and leadership of a national consensus conference, partially funded by a grant through the Agency for Healthcare Research and Quality, to solicit multidisciplinary feedback and provide education prior to finalizing the white paper (Schumann & Falk, 2013). In addition to the guiding principles, key components of the white paper included a strategic plan and logic model for implementation (Sofaer & Schumann, 2013). Finally, the white paper proposed the following definition:

> Patient engagement is the involvement in their own care by individuals (and others they designate to engage on their behalf), with the goal that they make competent, well-informed decisions about their health and health care and take actions to support those decisions. (Sofaer & Schumann, 2013, p. 5)

The guiding principles advocate an approach for all clinicians, including nurses, to foster patient engagement. Further, the NAQC identifies changes in awareness and behaviors among nurses that can maximize nursing's contribution to increased patient engagement. While the work generated by the NAQC regarding patient engagement holds relevance across disciplines, the scope and applicability to nursing practice distinguishes the guiding principles as a strong foundation for this discussion. Further, they suggest several critical dimensions of implications for practice.

Numerous nursing scholars have focused on the concept of caring as it informs and exemplifies nursing practice. Cook and Peden (2017) note that there is a lack of consensus among nurses regarding caring as the central, defining concept

Patient engagement is a critical cornerstone of patient safety and quality. NAQC has grounded its approach to this topic by recognizing the primary importance of *relationships* between engaged patients and families and their clinicians, including but not limited to nurses. The following are principles that guide NAQC in addressing care that is patient-centered:

1. There must be an active partnership among patients, their families, and the providers of their healthcare.
2. Patients are the best and ultimate source of information about their health status and retain the right to make their own decisions about care.
3. In this relationship, there are shared responsibilities and accountabilities among the patient, the family, and clinicians that make it effective.
4. While embracing partnerships, clinicians must nevertheless respect the boundaries of privacy, competent decision-making, and ethical behavior in all their encounters and transactions with patients and families. These boundaries protect recipients as well as providers of care. This relationship is grounded in confidentiality, where the patient defines the scope of the confidentiality.
5. This relationship is grounded in an appreciation of patient's rights and expands on the rights to include mutuality. Mutuality includes sharing of information, creation of consensus, and shared decision making.
6. Clinicians must recognize that the extent to which patients and family members are able to engage may vary greatly based on individual circumstances, cultural beliefs and other factors.
7. Advocacy for patients who are unable to participate fully is a fundamental nursing role. Patient advocacy is the demonstration of how all of the components of the relationship fit together.
8. Acknowledgment and appreciation of culturally, racially or ethnically diverse backgrounds is an essential part of the engagement process.
9. Health care literacy and linguistically appropriate interactions are essential for patient, family, and clinicians to understand the components of patient engagement. Providers must maintain awareness of the language needs and health care literacy level of the patient and family and respond accordingly.

FIGURE 1. Guiding principles for patient engagement. From Sofaer and Schumann (2013). Copyright 2013 by the Nursing Alliance for Quality Care. Reprinted with permission (M. J. Schumann, personal communication, January 29, 2017).

of nursing, stemming largely from ambiguity of definitions. However, this very ambiguity lends to the appropriateness of caring as a focus for the diverse and fluid practice of nursing (Cook & Peden, 2017). While several notable nursing theorists have contributed significantly to the body of knowledge regarding caring, Swanson's (1991) middle range theory of caring provides the most suitable framework for this discussion based on ease of practical application. Cook and Peden (2017) note that distinguishing features include a clear definition of the concept of caring, as well as useful descriptions of related meanings and actions, defined as *caring processes* (Swanson, 1991).

Swanson (1991) used a four-step phenomenological approach (Swanson-Kaufmann & Schonwald, 1988) to explore the meaning of caring through interviews with three groups of patients in perinatal settings: women who had miscarried, parents of infants in a newborn intensive care unit, and high social risk expectant mothers enrolled in a nurse-led public health intervention. Swanson-Kaufmann and Schonwald (1988) explored various interpretations of the phenomenological approach and identified four common practices—bracketing, analyzing, intuiting, and describing. The final phase, *describing* the phenomenon as the researcher has come to understand it through the lived experiences of participants, generated five categories of caring behaviors or actions labeled by Swanson (1991) as *knowing*, *being with*, *doing for*, *enabling*, and *maintaining belief*. Swanson (1993)

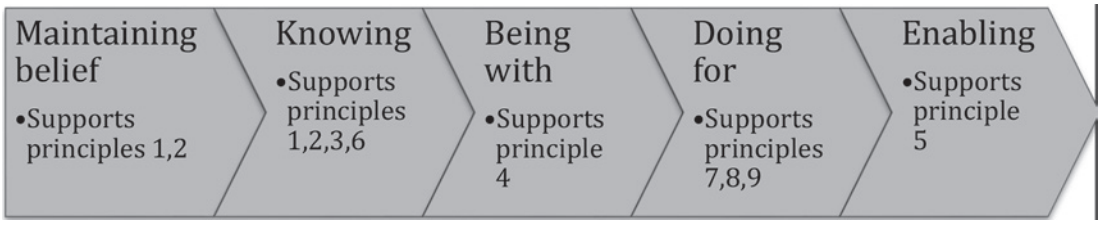

FIGURE 2. Alignment of caring processes with guiding principles for patient engagement. Caring processes from Sofaer and Schumann (2013); guiding principles from Swanson (1991).

subsequently reordered the processes in order to clarify their structural relationships (Figure 2).

Caring in nursing is necessarily patient centered. Swanson (1991) notes that caring is a "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). The patient at the center of the care is "valued." The therapeutic practices of the nurse are grounded in a "commitment" and "responsibility" to the patient. The definition reinforces that nurse caring is relational. The relational nature of nurse caring is noted as being of primary importance by the NAQC and is highlighted in discussions of each of the concepts essential to the current discussion: caring, patient centered care, and patient engagement. A nursing definition of patient centered care includes the provision of care that incorporates the patient's context (Lusk & Fater, 2013). The patient informs nurse caring just as nursing knowledge, scientific knowledge, humanities, insight, and experience inform nursing care (Swanson, 1993).

Swanson (1993) suggests that nurse caring is "informed caring for the well-being of others" (p. 352). The relational nature of nurse caring then requires that the nurse and patient be engaged in both the sharing and receiving of information with the goal of patient well-being. Engagement indicates behavior that is by its own definition a commitment or pledge (Engagement, 2018). The NAQC suggests that nurses, as trusted professionals and skilled advocates, are bound by ethical obligation to ensure that patients and their families are heard as well as engaged in their interactions with the complex health-care system. Health-care literature and organizational strategic plans are replete with references to patient engagement, with the potential unintended consequence that this critical concept is at risk of being perceived as the latest buzzword (Maloof, 2016) or a source of work stress related to the time and tasks related to patient involvement (Arnetz, Zhdanova, & Arnetz, 2016). The NAQC guiding principles and Swanson (1991) caring processes are conceptually aligned. Delineation and discussion of this alignment may help to ensure that patient engagement is appropriately framed within health-care dialogue, as an outcome of informed caring.

Discussion

Maintaining belief "is sustaining faith in the other's capacity to get through an event or transition and face a future with meaning" (Swanson, 1991, p. 165). Nurse caring that maintains belief is a philosophical attitude that demonstrates a commitment on the part of the nurse to, despite a patient's individual circumstances, cultural beliefs, and demands, offer realistic optimism and maintain a hope filled attitude (Swanson, 1991). The ongoing fundamental belief in the capacity of the patient to persevere through challenges and create meaning supports the continued recognition by nurses of barriers facing the patient. This fundamental belief is most closely aligned with principles one and two regarding partnership with, and primacy of, the patient; and underpins the capacity of the nurse to engage in the process of knowing (Swanson, 1991, 1993).

Swanson (1993) describes the caring process of knowing as "striving to understand events as they have meaning in the life of the other" (p. 355). Knowing requires the nurse to center on and actively partner with the patient and their family in order to be fully informed about their perception of events. Swanson (1991) suggests that knowing occurs when the self of both the provider and patient are engaged. The active and ongoing partnership requires that the nurse continually seek cues from the patient through ongoing assessment and careful avoidance of assumptions (Swanson, 1991). The nurse fully engages with the self of the patient in order to appreciate the background of the patient's experience. A truly informed understanding is developed, strengthening the foundation for partnership.

Principle one highlights that the partnership among patients, their families, and their provid-

ers must be active. The NAQC notes that nurses "at the front lines" must shift their behavior to see "the world from the 'shoes' of the patient," while nurses in managerial, executive, and policy roles must 'champion' the role of the patient in decision making (Sofaer & Schumann, 2013, p. 15). Principle two notes the patient as being of primary importance. Patients are the "best and ultimate source of information…and retain the right to make their own decisions about care" (Sofaer & Schumann, 2013, p. 6). NAQC suggests that nurses shift their awareness to acknowledge the patient being at the center of care and decision making. Principle three highlights the primacy of relationship to patient engagement. Nurses are encouraged to recognize their role in supporting patients who may encounter obstacles to self-management; thereby fostering shared responsibility and accountability (Sofaer & Schumann, 2013). Principle six recognizes that "individual circumstances, cultural beliefs and other factors" (Sofaer & Schumann, 2013, p. 6) may influence varying levels of engagement. The nurse is expected to incorporate important contextual factors into the plan of care, and be aware of and respond to shifts in patient or family engagement (Sofaer & Schumann, 2013). Integration of the caring process of knowing (Swanson, 1991) offers a strong theoretical base for these principles, and provides clear methods through which nursing practice behavior can shift to more fully engage patients and their families.

The caring process being with (Swanson, 1991) speaks eloquently to the relational nature of caring. Swanson (1991) describes being with as "being emotionally present to the other" (p. 163). The nurse offers not only physical presence, but also emotional presence through attentive listening, meaningful sharing, and thoughtful responding (Swanson, 1993). The process of being with conveys the message to the patient that they matter, that their experiences matter, and that the nurse is willing and able to endure with them (Swanson, 1993). This enduring commitment conveys the message to the patient they are not alone (Swanson, 1993) and builds a trusting therapeutic relationship. The patient can understand through the actions of the nurse that they are in fact the ultimate source of information about themselves and the valuable decision maker. Despite the close relationship, the nurse is reminded to respect the fine line between professional caring behaviors and those that may burden the patient by intruding on their privacy, decision making, and ethical perspective. The patient's reality is not and should not become the nurse's reality (Swanson, 1993). In addition to supporting the first three principles, being with is clearly aligned with principle four regarding boundaries and confidentiality.

Principle four reinforces that boundaries to protect patients, their families, and providers must be respected (Sofaer & Schumann, 2013). While a valued partnership and shared responsibility should be maintained, privacy, competent decision making, and ethical behavior are necessary for the protection of the relationship (Sofaer & Schumann, 2013). Essential to an understanding of respect for boundaries and protection of the patient–provider relationship is confidentiality. NAQC indicates that the scope of confidentiality should be defined by the patient (Sofaer & Schumann, 2013). The *Code of Ethics for Nurses* (ANA, 2015) calls nurses to both be aware of and act in accordance with respect for professional boundaries and confidentiality essential to the foundation of trust upon which patient–provider relationships are based. Conveyance of a message of responsible presence is an essential component of the caring process being with (Swanson, 1991, 1993).

Swanson (1991) defines doing for as "doing for the other what he or she would do for themselves if it were at all possible" (p. 164). The nurse is focused on actions to preserve the patient's wholeness and dignity. Doing for balances working with the patient to facilitate their journey with performing skillfully on their behalf if they cannot do so on their own (Swanson, 1991, 1993). The dignity of the patient is preserved as the relational nature of the interaction is protective of the patient's perspective.

Principle seven underscores the primacy of advocacy. NAQC notes that advocacy is fundamental to the nurse–patient relationship (Sofaer & Schumann, 2013). Patient advocacy is defined as "the demonstration of how all of the components of the relationship fit together" (Sofaer & Schumann, 2013, p. 6). Nurses are expected to be aware of their role in supporting patients whose perspectives are not being recognized or honored. The caring process of doing for supports this relational advocacy. The nurse acknowledges and affirms the patient's perspective by providing care in a way that is consistent with the patient's context.

Principle eight draws on concepts highlighted in earlier principles and inherent in NAQC perspective. Nurses must have an "acknowledgement and appreciation of culturally, racially and ethnically diverse backgrounds…" (Sofaer &

Schumann, 2013, p. 6) in order to fully engage with the patient. This principle thus draws on the suggestions of principle 6 which encourages nurses to consider cultural context as well as on the fundamental assumption that the patient and their perspective is of primary importance to the nurse–patient relationship and to patient engagement. NAQC suggests that nurses can maximize their contributions to patient engagement by being aware of cultural context and effectively integrating native language and tradition into practice.

Principle nine further reinforces the importance of advocacy by addressing the value of health literacy and linguistically appropriate interactions to the engagement process (Sofaer & Schumann, 2013). Nurses must remain aware of the patient's language needs and health-care literacy level in order to appropriately foster engagement and respond to patient need. Language needs and literacy levels may impact the authenticity of informed consent. NAQC reminds nurses that advocacy and ensuring informed consent through the provision of information tailored to meet the language and literacy level of the patient is an important responsibility of nursing practice (Sofaer & Schumann, 2013). Principles seven, eight, and nine are theoretically grounded in Swanson (1991) caring process doing for.

Enabling includes therapeutic actions implemented for the purpose of facilitating the patient's ability to grow in order to develop and sustain their well being (Swanson, 1991, 1993). Swanson (1991) defines enabling as "facilitating the other's passage through life transitions and unfamiliar events" (p. 164). Essential to an understanding of enabling is the important balance between professional responsibilities and the nurturing and allowance of space and time for patient growth (Swanson, 1993). Through the process of enabling, the nurse fosters the capacity of the patient and family to act upon the desire for change and to assume responsibility and accountability for actions to improve health. The nurse's role in facilitating the transition of the patient from passive recipient of care to informed and engaged partner in care includes: coaching and explaining, supporting the patient and allowing them to generate alternatives, offering feedback while encouraging the patient to think through information provided, and validating the patient's experience while providing thoughtful feedback (Swanson, 1993). Swanson (1993) describes a therapeutic process by which the nurse is a provider of expert knowledge for the purpose of sharing informing rather than directing the patient. The patient, with caring encouragement, is able to think through their concerns, refocus their attention on the issues most important to them, and ask questions. The circular description of the nurse–patient relationship, essential to the caring process of enabling, reveals the mutuality essential to patient engagement and shared decision making.

Principle five underscores the value of this mutuality in the nurse–patient relationship. NAQC notes that "mutuality includes sharing of information, creation of consensus, and shared decision making" (Sofaer & Schumann, 2013, p. 6). Nurses are encouraged to be aware of their work with the patient rather than for or on behalf of the patient, while actively listening to and seeking feedback from the patient. Inclusion of the patient during rounds and shift report encourages mutuality. Swanson (1993) provides a strong theoretical foundation for the integration of mutuality in practice as a therapeutic action consistent with the principles of enabling (Swanson, 1991).

NAQC acknowledges that not all patients and families engage or choose to engage at the same level. Nurse caring, according to Swanson (1993), is informed. Information is gathered in a thoughtful and personal way through the development of a trusting nurse–patient relationship. This fundamental understanding of the patient as valuable provider of knowledge and partner in decision-making stems from the caring process of maintaining belief (Swanson, 1993). The caring process of knowing (Swanson, 1991), through informed understanding, again and offers support for nurse recognition and acceptance of differing levels of patient engagement related to contextual factors. Levels of understanding, ability, and willingness only become available to the nurse through an intentional presence with the patient. When a nurse becomes both physically and emotionally present, they are implementing the caring process of being with (Swanson, 1993). Applying the fullness of shared information to nursing practice reveals itself in both doing for and enabling which are described as therapeutic actions (Swanson, 1993). Doing for calls upon the nurse to protect and preserve the dignity (Swanson, 1991) of the patient and to perform competently and skillfully (Swanson, 1991) on their behalf. Enabling (Swanson, 1991) is an interactive processing of the circumstances of the patient's situation. Enabling asks the nurse to support the patient while further explaining and clarifying areas of misunderstanding. Both doing for and enabling are achieved through knowledge

of the patient's abilities and level of understanding.

The suggested alignment is not intended to imply exclusive relationships between certain caring processes and NAQC principles. Swanson (1993) notes that the processes overlap, and clearly a case may be made for other dimensions of alignment. The intent is to demonstrate, by highlighting predominant threads or commonalities, the relationship of nursing's core value of caring to patient engagement.

Implications

The prior discussion underscores the complex, nonlinear nature of patient engagement, and the value of informed nurse caring as a path to promoting engagement. The premise of the discussion holds significant implications for professional nurses in all roles, as stewards of core nursing values. Stewardship is defined as "the careful and responsible management of something entrusted to one's care" (Stewardship, 2018). In nursing, the concept of stewardship speaks to the obligation of nurses in various roles to safeguard, uphold, and promote the core values of the profession (Milton, 2014; Murphy & Roberts, 2008). Nurse stewards act to ensure that care is genuinely patient centered and focused on optimal patient outcomes. Effective patient engagement may be viewed as one broad optimal outcome among the many that may be influenced by informed nurse caring.

Recognition alone of nursing's obligation to uphold patient-centered caring as a path to engagement is not sufficient to ensure implementation in practice. While direct care nurses may acknowledge caring as a core value, they may view themselves as ill equipped to fully integrate caring practices in light of constraints within the healthcare environment.The NAQC proposes a detailed logic model with strategies designed to position nurses for maximal impact on patient engagement (Sofaer & Schumann, 2013). Implicitly acknowledged within the strategies are numerous challenges to successful implementation, including, but not limited to, knowledge deficits regarding specific engagement skills; potential lack of commitment to patient involvement on the part of practicing nurses; and time and other resource constraints (Sofaer & Schumann, 2013). It is essential to understand and address these challenges in both practice and academic settings, with the full support and involvement of nurse leaders and researchers.

In the practice setting, direct care nurses may lack competency in relevant foundational skills, addressed later in this discussion. Further, they may face competing priorities on a daily basis as they struggle to reconcile the role of caregiver with that of employee (Jones, 2010). It is important to acknowledge that the caring actions and processes that foster engagement cannot be reduced to a series of tasks, with check marks entered in haste to enhance patient flow. This observation is not intended to diminish the value of checklists in the provision of patient care, but rather to highlight that they often fail to capture the nuances and complexities associated with meaningful completion. For example, a checkmark verifying completion of the teach-back process does not reflect nursing knowledge of the patient as a unique individual, or patient motivation and intent to follow through with the recommended actions.

The preceding challenge is magnified for new graduate RNs transitioning to their first clinical positions. New graduates often find themselves in unfamiliar situations, and in roles that are vastly more complex than those they rehearsed during their clinical rotations. Novice nurses are characteristically task-focused (Benner, 1984), posing the risk that they may quickly resort to a "check the box" mentality, lacking the ability to recognize the underlying implications of each task. This may be further exacerbated in settings where the unit culture does not genuinely support patient-centered care, or in settings where unit and organizational nurse leaders do not "walk the talk" (Kramer et al., 2009, p. 77) in authentic promotion of patient-centered work environments. Opportunities exist for academic and clinical educators to play critical roles in the development of knowledge, skills, and attitudes (KSAs) necessary to promote patient engagement in practice.

The NAQC notes the importance of fundamental KSAs in key areas such as therapeutic communication, health literacy, health promotion, cultural competence, and patient advocacy (Sofaer & Schumann, 2013). Competencies in these and other relevant skills are integrated throughout the various standards and guidelines that provide the framework for entry-level professional nursing education, including the *Essentials of Baccalaureate Education for Professional Nursing Practice* (American Association of Colleges of Nursing, 2008), the *Quality and Safety Education for Nurses* competencies (Cronenwett et al., 2007), and *Nurse of the Future* competencies (Massachusetts Department of Higher Education Nursing Initiative, 2016). While

these competencies are to varying degrees interdependent, therapeutic communication is widely regarded as foundational to effective nursing practice, and has been identified by the National Council of State Boards of Nursing (NCSBN) as an integrated process in the NCLEX-RN exam (NCSBN, 2016). Further, the importance of therapeutic communication in its many forms is threaded throughout the processes of the middle range theory of caring (Swanson, 1991).

Despite the essential nature of therapeutic communication skills such as listening, use of plain language, and the use of collaborative styles such as motivational interviewing (Sofaer & Schumann, 2013), limited evidence exists regarding specific skills taught in pre-licensure programs (Grant & Jenkins, 2014). An opportunity exists to ensure that pre-licensure curricula include specific, evidence-based communication skills demonstrated to promote patient engagement. In addition, a focus on the premise of this discussion—that patient engagement approaches are aligned with fundamental expressions of caring—may help to foster positive attitudes regarding these approaches, and ensure that students commit to integrating them in practice.

In the practice setting, preceptors and clinical nurse educators have the potential to play a critical role in helping new nurses to recognize the many ways in which caring processes translate to clinical practice, and to identify strategies to honor and advocate for informed caring as a core value. Encouraging self-reflection (Olsen, 2014) as a consistent practice is an example of one approach to assist both new and experienced nurses to maintain a connection with the underlying nuances of practice not reflected in a checklist. A simple call to reflect upon how one demonstrated caring in a given situation, and how those actions or behaviors might have impacted the patient, conveys the message that caring matters. In addition, preceptors and educators should reinforce the relational aspects of various tasks and responsibilities, to ensure understanding of the goals for meaningful completion. Further, Murphy and Roberts (2008) note that clinical nurse educators have the potential to play a critical role in helping direct care nurses to develop the skills needed to advocate for essential core values.

Finally, it is important to acknowledge the relevance of the concept of time and the temporal nature of the caring processes (Swanson, 1991) to this discussion. The notion of time to care is highly context-, patient-, and nurse-dependent (Jones, 2010); and therefore difficult to quantify. Jones (2010) explores the meaning of physical, psychological, and sociological time and the relationship of each dimension to patient and nurse perceptions of care. Physical clock time is easily defined and measured, and often used as the basis for benchmarks, staffing ratios, and productivity metrics (Jones, 2010). Limited studies on allocation of physical nursing time suggest that emotional care and support are often given low priority and left unfinished, in order to meet basic patient safety, physiologic, treatment and procedure needs (Jones, 2016).

Psychological time is highly subjective, based on nurse and patient perceptions not only of what constitutes a nursing care encounter, but also how they experience that care. In a study by Davis (2005), the concept of presence appeared repeatedly throughout patient descriptions of good nursing care. Jones (2010) suggests that the concept of psychological time may be more relevant to the nurse–patient relationship than clock time alone. While it is clear that nurses must be afforded adequate clock time to interact with patients as individuals—time to care and time to engage—it is also important to recognize the degree to which the quality of those interactions matters. Finally, it is important for nurses to be aware of how the sociological norms of a unit or facility—for example, change-of-shift routines—may influence their allocation of time, and strive to minimize the extent to which these norms intrude on the nurse–patient relationship. Time as an essential resource in pursuit of patient engagement, together with the aforementioned challenges regarding KSAs, holds significant implications for nurses in leadership roles.

Nurse leaders are accountable to serve as stewards of core values based on their potential to influence organizational environments and resources that support patient-centered nursing care (Murphy & Roberts, 2008). Various competencies throughout those established by the American Organization of Nurse Executives (AONE) for nurse leaders practicing in management (AONE, 2015a) and executive (AONE, 2015b) roles speak to the leadership KSAs essential to effective advocacy for core values. The importance of evidence-based practice and the role of nurse leaders in communicating the value of nursing practice to organizational governing boards are explicitly addressed within the nurse executive competencies (AONE, 2015b). It follows that current, relevant evidence is essential for effective advocacy.

An immediate need exists for evidence to support organizational structures and resources that facilitate nurse caring as essential to engagement. In many practice settings, countless protocols, checklists, and bundles have been implemented to ensure nursing completion of critical tasks identified as essential to patient safety, quality of care, and regulatory compliance. As noted earlier, it is important to recognize that task completion should not serve as a de facto measure of patient engagement. When viewed within the context of a caring practice, there are few, if any, useful measures that demonstrate relationships between nursing interventions and patient engagement. In addition, limited evidence exists regarding nurses' allocation of work time in various settings (Westbrook, Duffield, Li, & Creswick, 2011). There is a significant need for nursing research that explores the relationships between caring practices that have historically been devalued, valid measures of patient engagement, and discrete clinical and financial outcomes.

Conclusion

The middle range theory of caring (Swanson, 1991, 1993) has the potential to lend depth, clarity, and direction to the dialogue regarding the role of nurses in patient engagement. Consideration of the alignment between informed nurse caring and patient engagement suggests a path for expression of nursing's core values in clinical practice, strengthening the potential to make patient engagement "the rule rather than the exception in every healthcare encounter" (Sofaer & Schumann, 2013, pp. 8–9). As stewards of core professional values, it is incumbent upon nurses to join in focused and coordinated efforts to generate meaningful evidence, build capacity, and advocate for resources and processes that enable nurses to foster patient engagement.

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