Leading Change in Health Systems: Strategies for RN-BSN Students

Leading Change in Health Systems: Strategies for RN-BSN Students

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UNIVERSITY OF WEST FLORIDA PRESSBOOKS

Contents

About the Book ix

Introduction 1

Part I. Chapter 1 Navigating Leadership

1.1 Leadership Styles 7

1.2 Emotional Intelligence 21

1.3 Spotlight Application 24

Chapter 1 References & Attribution 25

Part II. Chapter 2 Leading Effective Solutions in Organizations

2.1 Organizational Structure 31

2.2 Organizational Vision, Mission, and Values 38

2.3 Spotlight Application 43

Chapter 2 References & Attribution 45

Part III. Chapter 3 Leading Effective Teams

3.1 Roles and Responsibilities of Health Care Professionals 51

3.2 Interprofessional Communication 56

3.3 Teams and Teamwork 63
3.4 Spotlight Application 73
Chapter 3 References & Attribution 75

Part IV. Chapter 4 Leading Evidence-Informed Decision Making

4.1 Evidence-Informed Decision Making 81
4.2 Standards of Quality Care 89
4.3 Spotlight Application 98
Chapter 4 References & Attribution 100

Part V. Chapter 5 Leading Effective Change

5.1 Theoretical Approach to Change 105
5.2 Conflict Management 112
5.3 Interprofessional Collaborative Practice 128
5.4 Spotlight Application 134
Chapter 5 References & Attribution 138

Part VI. Chapter 6 Leading Effective Outcomes

6.1 Quality Improvement Process 143
6.2 Quality Improvement Measures 146
6.3 Spotlight Application 152
Chapter 6 References & Attribution 154

Part VII. Chapter 7 Leading Person-Centered Health Systems

7.1 Person-Centered Care 159
7.2 Health Care Trends and Issues 162
7.3 Spotlight Application 172
Chapter 7 References & Attribution 174

About the Contributors 179
Glossary 181
Appendices 191
Appendix A Scholarly Writing Resources 192
Appendix B Team Stepps Strategies 193
Appendix C Communication Strategies 201
Appendix D Conflict Management Strategies 218
Appendix E Person-Centered Strategies 220
Appendix F Teaching Strategies 227

About the Book

About the Book

Leading Change in Health Systems: Strategies for RN-BSN Students has been developed for practicing nurses returning to school to earn a Baccalaureate Degree in Nursing (BSN). As a lifelong learner who has pursued advanced education while working and raising a family, I understand the challenges encountered by non-traditional students in balancing multiple priorities. After teaching RN-BSN courses for many years and utilizing a wide variety of textbook resources, I recognized most textbooks focus on the novice nurse and do not address the particular needs of nurses returning to school. I have wanted to design a leadership textbook that is for non-traditional students as opposed to new graduate nurses and am grateful for the opportunity to author this textbook.

Kathy Andresen, DNP, MPH, RN, CNE University of West Florida

Intended Audience

Students

I hope you will find this resource engaging and relevant to your practice. Each chapter includes a **Spotlight Application**, which includes examples of leadership

challenges in healthcare and is designed to apply chapter concepts in an unfolding case study. **Applied Learning Activities** are included in most chapters. These activities are intended for students to apply to real world situations experienced by practicing nurses in a complex health system. **Appendices** are included at the end of this book and include strategies for integration of leadership tools in a variety of healthcare systems. Appendix A includes **Scholarly Writing Resources** that are provided for reference to professional writing style that is often a challenge for nurses unaccustomed to these particular requirements.

Nurse Educators

I hope you will find this resource helpful and consider adopting it in your courses to support RN-BSN students as they balance work, home and many other priorities. **Appendix F** includes **Teaching Strategies** that provide suggestions on integration of various tools within the book, including **Applied Learning Activities** and **Spotlight Applications.**

Special Thanks & Acknowledgement

to **Cindy Gruwell**, Asst. Librarian/Coordinator of Scholarly Communication and Health Sciences Librarian at the University of West Florida, for her patience and guidance through the process of adapting and publishing this OER book.

Attribution

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- "Nursing Management and Processional Concepts" by Chippewa Valley Technical College. Select content adapted for clarity and flow for RN-BSN students is licensed under CC BY 4.0

Next- Introduction

Introduction

This is an open educational resource with CC-BY licensing. It has been developed specifically for licensed nursing students pursuing a Baccalaureate Degree in Nursing (RN-BSN).

This book introduces concepts related to nursing leadership and management for the licensed nurse and emphasizes, collaboration within the interprofessional team, quality and evidence-based practice and person-centered care. Several online, interactive learning activities are included in each chapter that encourage application of content to patient-care situations.

In the PDF version of the book, glossary terms are in blue.

Next- Chapter 1 Navigating Leadership

PART I

CHAPTER 1 NAVIGATING LEADERSHIP

Learning Objectives

- Identify effective leadership styles in various settings
- Appraise leadership attributes that influence health outcomes

As a licensed RN, you have likely had some leadership content in your pre-licensure program and have likely engaged in a variety of leadership roles within your workplace either as a charge nurse on a temporary basis or as a nurse manager. You may currently be in a formal leadership role within your organization and have experienced informal or formal training on leadership. This chapter will explore leadership and management responsibilities of a BSN prepared nurse. Leadership styles are introduced and readers will explore their own leadership attributes.

An RN is expected to demonstrate leadership and management skills in many facets of the role. Nurses manage care for high-acuity patients as they are admitted, transferred, and discharged; coordinate care among a variety of diverse

health professionals; advocate for clients' needs; and manage limited resources with shrinking budgets (Cherry & Jacob, 2017)

An article published in the *Online Journal of Issues in Nursing* states, "With the growing complexity of healthcare practice environments and pending nurse leader retirements, the development of future nurse leaders is increasingly important (Dyess et al., 2016)

As you begin to explore leadership attributes in this book, a helpful activity is to complete your own workstyles inventory (Applied Learning Activity 1.1).

Applied Learning Activity 1.1 Work Styles Inventory

Take the short quiz below to determine your work style.

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Next: 1.1 Leadership Styles

1.1 Leadership Styles

Followership

Followership is described as the upward influence of individuals on their leaders and their teams. The actions of followers have an important influence on staff performance and patient outcomes. Being an effective follower requires individuals to contribute to the team not only by doing as they are told, but also by being aware and raising relevant concerns. Effective followers realize that they can initiate change and disagree or challenge their leaders if they feel their organization or unit is failing to promote wellness and deliver safe, value-driven, and compassionate care. Leaders who gain the trust and dedication of followers are more effective in their leadership role. Everybody has a voice and a responsibility to take ownership of the workplace culture, and good followership contributes to the establishment of high-functioning and safety-conscious teams (Dreier et al., 2019)

Team members impact patient safety by following teamwork guidelines for good followership. For example, strategies such as closed-loop communication are important tools to promote patient safety.

Leadership and Management Characteristics

Leadership and management are terms often used interchangeably, but they are two different concepts with many overlapping characteristics. **Leadership** is the art of

establishing direction and influencing and motivating others to achieve their maximum potential to accomplish tasks, objectives, or projects (Northhouse, 2004; Specchia et al., 2021). There is no universally accepted definition or theory of nursing leadership, but there is increasing clarity about how it differs from management (Scully, 2015). **Management** refers to roles that focus on tasks such as planning, organizing, prioritizing, budgeting, staffing, coordinating, and reporting (Hannaway, 1989). The overriding function of management has been described as providing order and consistency to organizations, whereas the primary function of leadership is to produce change and movement (Cherry & Jacob, 2017). View a comparison of the characteristics of management and leadership in Table 1.1a.

Table 1.1a Management and Leadership Characteristics (Northhouse, 2004)

MANAGEMENT	LEADERSHIP
Planning, Organizing, and Prioritizing • Establish agenda • Set goals and time frames • Prioritize tasks • Establish policies and procedures	**Establishing Direction** • Create a shared vision • Identify issues requiring change • Set strategies • Implement evidence-based practices
Budgeting and Staffing • Allocate resources • Hire and terminate employees • Make assignments	**Influencing Others** • Listen to team members' concerns • Communicate effectively • Advocate for clients, family members, communities, and the nursing profession • Build effective teamwork
Coordinating and Problem-Solving • Generate solutions • Develop incentives • Take corrective actions • Participate in quality improvement initiatives	**Motivating** • Inspire, energize, and empower team members • Promote professional growth

Not all nurses are managers, but all nurses are leaders because they encourage individuals to achieve their goals. The American Nurses Association (ANA) established *Leadership* as a Standard of Professional Performance for all registered nurses. Standards of Professional Performance are "authoritative statements of action and behaviors that all registered nurses, regardless of role, population, specialty, and setting, are expected to perform competently" (ANA, 2021). See the competencies of the ANA *Leadership* standard in the following box and additional content in other chapters of this book.

Competencies of ANA's Leadership Standard of Professional Performance

- Promotes effective relationships to achieve quality outcomes and a culture of safety
- Leads decision-making groups
- Engages in creating an interprofessional environment that promotes respect, trust, and integrity
- Embraces practice innovations and role performance to achieve lifelong personal and professional goals
- Communicates to lead change, influence others, and resolve conflict
- Implements evidence-based practices for safe, quality health care and health care consumer satisfaction
- Demonstrates authority, ownership, accountability, and responsibility for appropriate delegation of nursing care
- Mentors colleagues and others to embrace their knowledge, skills, and abilities
- Participates in professional activities and organizations for professional growth and influence
- Advocates for all aspects of human and environmental health in practice and policy

Leadership Theories and Styles

In the 1930s Kurt Lewin, the father of social psychology, originally identified three leadership styles: authoritarian, democratic, and laissez-faire (Carlin, 2019; Lewin et al., 1939).

Authoritarian leadership means the leader has full power. Authoritarian leaders tell team members what to do and expect team members to execute their plans. When fast decisions must be made in emergency situations, such as when a patient "codes," the authoritarian leader makes quick decisions and provides the group with direct instructions. However, there are disadvantages to authoritarian leadership. Authoritarian leaders are more likely to disregard creative ideas of other team members, causing resentment and stress (Carlin, 2019).

Democratic leadership balances decision-making responsibility between team members and the leader. Democratic leaders actively participate in discussions, but also make sure to listen to the views of others. For example, a nurse supervisor may hold a meeting regarding an increased incidence of patient falls on the unit and ask team members to share their observations regarding causes and potential solutions. The democratic leadership style often leads to positive, inclusive, and collaborative work environments that encourage team members' creativity. Under this style, the leader still retains responsibility for the final decision (Carlin, 2019).

Laissez-faire is a French word that translates to English as, "leave alone." Laissez-faire leadership gives team members total freedom to perform as they please. Laissez-faire leaders do not participate in decision-making processes and rarely offer opinions. The laissez-faire leadership style can work well if team members are highly skilled and highly motivated to perform quality work. However, without the leader's input,

conflict and a culture of blame may occur as team members disagree on roles, responsibilities, and policies. By not contributing to the decision-making process, the leader forfeits control of team performance (Carlin, 2019).

Over the decades, Lewin's original leadership styles have evolved into many styles of leadership in health care, such as passive-avoidant, transactional, transformational, servant, resonant, and authentic (Northhouse, 2004; Specchia et al., 2021). Many of these leadership styles have overlapping characteristics.

Passive-avoidant leadership is similar to laissez-faire leadership and is characterized by a leader who avoids taking responsibility and confronting others. Employees perceive the lack of control over the environment resulting from the absence of clear directives. Organizations with this type of leader have high staff turnover and low retention of employees. These types of leaders tend to react and take corrective action only after problems have become serious and often avoid making any decisions at all (Specchia et al., 2021).

Transactional leadership involves both the leader and the follower receiving something for their efforts; the leader gets the job done and the follower receives pay, recognition, rewards, or punishment based on how well they perform the tasks assigned to them (Northhouse, 2004). Staff generally work independently with no focus on cooperation among employees or commitment to the organization (Specchia et al., 2021).

Transformational leadership involves leaders motivating followers to perform beyond expectations by creating a sense of ownership in reaching a shared vision (Northhouse, 2004). It is characterized by a leader's charismatic influence over team members and includes effective communication, valued relationships, and consideration of team member input. Transformational leaders know how to convey a sense

of loyalty through shared goals, resulting in increased productivity, improved morale, and increased employees' job satisfaction (Specchia et al., 2021). They often motivate others to do more than originally intended by inspiring them to look past individual self-interest and perform to promote team and organizational interests (Specchia et al., 2021).

Servant leadership focuses on the professional growth of employees while simultaneously promoting improved quality care through a combination of interprofessional teamwork and shared decision-making. Servant leaders assist team members to achieve their personal goals by listening with empathy and committing to individual growth and community-building. They share power, put the needs of others first, and help individuals optimize performance while forsaking their own personal advancement and rewards (Specchia et al., 2021).

Learn More

Visit the Greenleaf Center site to learn more about "What is Servant Leadership?"

Resonant leaders are in tune with the emotions of those around them, use empathy, and manage their own emotions effectively. Resonant leaders build strong, trusting relationships and create a climate of optimism that inspires commitment even in the face of adversity. They create an environment where employees are highly engaged, making them willing and able to contribute with their full potential (Specchia et al., 2021).

Authentic leaders have an honest and direct approach with employees, demonstrating self-awareness, internalized moral perspective, and relationship transparency. They strive for trusting, symmetrical, and close leader–follower relationships; promote the open sharing of information; and consider others' viewpoints (Specchia et al., 2021).

Table 1.1b Characteristics of Leadership Styles

Authoritarian	Democratic	Laissez-Faire or Passive-Avoidant
• Demonstrate centralized decision-making • Use power to control others • Motivate through fear or reward • Disregard needs of group members	• Demonstrate participatory decision-making • Display multidirectional communication • Build close, personal relationships • Encourage goal attainment	• Demonstrate passive, permissive, or absent decision-making

Transactional	Transformational	Servant
• Promote both parties receiving something for efforts • Motivate with external rewards • Reward good performance and penalize low performance • Do not focus on team cooperation or commitment to the organization	• Create ownership with shared, inspiring vision • Demonstrate effective communication • Value relationships • Consider individuals' needs and abilities	• Focus on growth and well-being of team members • Share in decision-making • Develop team members to their highest potential

Resonant Leaders	Authentic Leaders
• Build strong, trusting relationships • Tune into the emotions of those around them, use empathy, and manage their own emotions effectively • Create a climate of optimism	• Use an honest and direct approach • Develop close leader–follower relationships • Promote the open sharing of information • Consider others' viewpoints

Outcomes of Various Leadership Styles

Leadership styles affect team members, patient outcomes, and the organization. A systematic review of the literature published in 2021 showed significant correlations between leadership styles and nurses' job satisfaction. Transformational leadership style had the greatest positive correlation with nurses' job satisfaction, followed by authentic, resonant, and servant leadership styles. Passive-avoidant and laissez-faire leadership styles showed a negative correlation with nurses' job satisfaction (Specchia et al., 2021). In this challenging health care environment, managers and nurse leaders must promote technical and professional competencies of their staff, but they must also act to improve staff satisfaction and morale by using appropriate leadership styles with their team (Specchia et al., 2021).

Systems Theory

Systems theory is based on the concept that systems do not

function in isolation but rather there is an interdependence that exists between their parts. Systems theory assumes that most individuals strive to do good work, but are affected by diverse influences within the system. Efficient and functional systems account for these diverse influences and improve outcomes by studying patterns and behaviors across the system (Anderson, 2016).

Many health care agencies have adopted a culture of safety based on systems theory. A **culture of safety** is an organizational culture that embraces error reporting by employees with the goal of identifying systemic causes of problems that can be addressed to improve patient safety. According to The Joint Commission, a culture of safety includes the following components (The Joint Commission, 2017):

- **Just Culture:** A culture where people feel safe raising questions and concerns and report safety events in an environment that emphasizes a nonpunitive response to errors and near misses. Clear lines are drawn by managers between human error, at-risk, and reckless employee behaviors. See Figure 1.2 (Palarski, 2020) for an illustration of Just Culture.
- **Reporting Culture:** People realize errors are inevitable and are encouraged to speak up for patient safety by reporting errors and near misses. For example, nurses complete an "incident report" according to agency policy when a medication error occurs or a client falls. Error reporting helps the agency manage risk and reduce potential liability.
- **Learning Culture:** People regularly collect information and learn from errors and successes while openly sharing data and information and applying best evidence to improve work processes and patient outcomes.

The Just Culture model categorizes human behavior into three

categories of errors. Consequences of errors are based on whether the error is a simple human error or caused by at-risk or reckless behavior (ANA, 2010):

- **Simple human error:** A simple human error occurs when an individual inadvertently does something other than what should have been done. Most medical errors are the result of human error due to poor processes, programs, education, environmental issues, or situations. These errors are managed by correcting the cause, looking at the process, and fixing the deviation. For example, a nurse appropriately checks the rights of medication administration three times, but due to the similar appearance and names of two different medications stored next to each other in the medication dispensing system, administers the incorrect medication to a patient. In this example, a root cause analysis reveals a system issue that must be modified to prevent future patient errors (e.g., change the labelling and storage of look alike-sound alike medications) (ANA, 2010).
- **At-risk behavior:** An error due to at-risk behavior occurs when a behavioral choice is made that increases risk where the risk is not recognized or is mistakenly believed to be justified. For example, a nurse scans a patient's medication with a barcode scanner prior to administration, but an error message appears on the scanner. The nurse mistakenly interprets the error to be a technology problem and proceeds to administer the medication instead of stopping the process and further investigating the error message, resulting in the wrong dosage of a medication being administered to the patient. In this case, ignoring the error message on the scanner can be considered "at-risk behavior" because the behavioral choice was considered justified by the nurse at the time (ANA, 2010).

- **Reckless behavior:** Reckless behavior is an error that occurs when an action is taken with conscious disregard for a substantial and unjustifiable risk. For example, a nurse arrives at work intoxicated and administers the wrong medication to the wrong patient. This error is considered due to reckless behavior because the decision to arrive intoxicated was made with conscious disregard for substantial risk (ANA, 2010).

These categories of errors result in different consequences to the employee based on the Just Culture model:

- If an individual commits a simple human error, managers console the individual and consider changes in training, procedures, and processes (ANA, 2010). In the "simple human error" example above, system-wide changes would be made to change the label and location of the medications to prevent future errors from occurring with the same medications.
- Individuals committing at-risk behavior are held accountable for their behavioral choices and often require coaching with incentives for less risky behaviors and situational awareness (ANA, 2010). In the "at-risk behavior" example above, when the nurse chose to ignore an error message on the barcode scanner, mandatory training on using barcode scanners and responding to errors would likely be implemented, and the manager would track the employee's correct usage of the barcode scanner for several months following training.
- If an individual demonstrates reckless behavior, remedial action and/or punitive action is taken (ANA, 2010). In the "reckless behavior" example above, the manager would report the nurse's behavior to the State Board of Nursing for disciplinary action. The SBON would likely mandate substance abuse counseling for the nurse to maintain

their nursing license. However, employment may be terminated and/or the nursing license revoked if continued patterns of reckless behavior occur.

See Table 1.1c describing classifications of errors using the Just Culture model.

Table 1.1c Classification of Errors Using the Just Culture Model

Human Error	At-Risk Behavior	Reckless Behavior
The caregiver made an error while working appropriately and focusing on the patient's best interests.	The caregiver made a potentially unsafe choice resulting from faulty or self-serving decision-making.	The caregiver knowingly violated a rule and/or made a dangerous or unsafe choice.
Investigation reveals system factors contributing to similar errors by others with similar knowledge and skills.	Investigation reveals the system supports risky action and the caregiver requires coaching.	Investigation reveals the caregiver is accountable and needs retraining.
Manage by fixing system errors in processes, procedures, training, design, or environment.	Manage by coaching the caregiver and fixing any system issues: • Remove incentives for at-risk behaviors • Create incentives for safe behaviors • Increase situational awareness	Manage by disciplining the caregiver. If the system supports reckless behavior, it requires fixing.
CONSOLE	COACH	PUNISH

Systems leadership refers to a set of skills used to catalyze, enable, and support the process of systems-level change that is encouraged by the Just Culture Model. Systems leadership is comprised of three interconnected elements (Dreier, 2019):

- **The Individual:** The skills of collaborative leadership to enable learning, trust-building, and empowered action among stakeholders who share a common goal
- **The Community:** The tactics of coalition building and advocacy to develop alignment and mobilize action among stakeholders in the system, both within and between organizations
- **The System:** An understanding of the complex systems shaping the challenge to be addressed

Applied Learning Experience 1.2 Leadership Self Assessment

- Click here to complete the quiz "*What is your Leadership Style*?"
- Review your leadership style
- Reflect on your findings

Next: 1.2 Emotional Intelligence

1.2 Emotional Intelligence

Overview

The position of either leader or follower does not hold power. Rather, it is how we respond when we are in these roles, based on our emotional intelligence, that gives power to each role. **Emotional intelligence** has been described as the "ability to monitor and discriminate among emotions and to the use the data to guide thought and action" (Goleman, 2020).

Goleman (2020), a researcher who has completed work spanning decades in the area of work performance, studied the importance of emotional intelligence in achieving personal excellence. He defines emotional intelligence in greater depth, stating that it is composed of abilities such as being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to empathize and to hope (Goleman, 2020). Goleman's model of emotional intelligence contains five skills that comprise personal and social competencies (see Table 1.2 below). The three skills of self-awareness, self-regulation, and motivation relate to the individual's personal competence. The remaining skills of empathy and social skills are classified as social competencies (Liu & Boyatzis, 2021).

Table 1.2 Emotional Intelligence Skills and Competencies (*Data Source: Table based on material from Sadri, 2012.*)

Competency	Skill Area	Description
Personal	Self-awareness	Knowing one's self
	Self-regulation	Managing one's self
	Motivation	Sentiments and passions that facilitate the attainment of goals
Social	Empathy	Understanding of others and compassion toward them
	Social skills	Expertise in inspiring others to be in agreement

Developing Emotional and Social Intelligence

As a nurse, gaining emotional and social intelligence is critical to expanding leadership capacity. Emotional Intelligence contributes to achievement of effective management in

healthcare (Prezerakos, 2018). You encounter many different types of people, both colleagues and patients. It is extremely important to be self-aware, reflect on your feelings, and think about how emotions can influence both actions and relationships (or social interactions). That is, you must learn to reflect on your clinical experiences and think of how you could have changed a situation by using self-awareness or mindsight. It is essential for nurses to improve social and emotional skills (Prezerakos, 2018). See Applied Learning Activity 1.2 to complete an assessment of your Emotional Intelligence.

Applied Learning Activity 1.2 Emotional Intelligence

- Click here to complete the ***Emotional Intelligence self-assessment test.***
- Complete this online survey: the online system calculates the results for you.
- Review your EI score.
- Reflect on your findings.

Next: 1.3 Spotlight Application

1.3 Spotlight Application

Jax is a nurse working in the emergency department at a busy Level 1 trauma center. The environment is fast-paced and there are typically a multitude of patients who require care, the unit is often short-staffed. Jax appreciates the collaboration that is reflected among members of the health care team, especially in times of stress, but has noticed that nurses are being asked to take on extra shifts. The workload demand has been especially problematic since the COVID-19 pandemic where many nurses resigned.

Jax is providing care for an 8-year-old patient who has broken her arm when there is a call that there are three Level 1 trauma patients approximately 5 minutes from the ED. The trauma surgeon reports to the ER, and multiple members of the trauma team report to the ED intake bays.

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Next- Chapter 1 References & Attribution

Chapter 1 References & Attribution

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Chapter 2 Leading Effective Solutions in Organizations

PART II

CHAPTER 2 LEADING EFFECTIVE SOLUTIONS IN ORGANIZATIONS

Learning Objectives

- Apply systems theory to health care
- Identify the relationships between organizational culture and leadership
- Analyze relationships among mission and organizational structure

As the healthcare system responds to changes in the environment, nurse leaders refine and adapt leadership tools and care processes. Leadership tools such as organizational mission, vision, and value statements, which guide both administration and patient care providers through their daily work, are routinely reviewed and modified. Nurse leaders play an important role within this complex adaptive system as they retain a focus on maintaining a strong care provider culture that supports quality care and improved patient outcomes, regardless of unending change.

This chapter addresses the relationship between nursing leadership and the larger healthcare system. Understanding this relationship requires that we look at our health care system

as a complex adaptive system with multiple relationships between different aspects of it that impact both the system and the health of the individuals within it. Health care organizations define their role and describe how they will fulfill this role within the greater system through their vision, mission, and value statements. Members of the organization look through the lens of these guiding statements and principles when making decisions. These guided decisions promote the development of an organizational culture, or common system of beliefs and behaviors for all employees. However, in complex adaptive systems, organizational culture may be influenced by factors other than the vision, mission, and values, leading to undesirable outcomes. But even in complex adaptive systems, leaders can inspire change through a focus on relational leadership and empowerment.

Next: 2.1 Organizational Structure

2.1 Organizational Structure

Systems Theory and Health Care

As nurses we know that the success of our patient-centered care interventions is dependent upon many factors. All too often, despite extensive planning and hard work, a patient care intervention fails to lead to the intended results. Factors beyond our control, and often beyond our knowledge, change the intended outcomes. This is typical of events in a complex adaptive system.

So how can we be successful leaders if we cannot predict what will happen when we attempt to guide others? Perhaps a review of the first two principles of the complex adaptive system will provide an answer to this question. The first principle, which is focused on using the **lens of complexity**, and the second principle, which describes **good enough vision**, provide us with clues on how to lead others within the complex adaptive health care system. Organizations and nurse leaders acknowledge that they cannot control change, and thus they do not try to control every aspect of organizational change. Successful health care leaders attempt to give a general sense of direction to employees, rather than focus on specific details. Next, leaders also encourage employees to develop innovative responses that best meet their individual strengths and needs and meet the healthcare system's ultimate goal of quality patient care. Leaders cannot predict all the factors that will influence the final results of change activities, but by following these principles, they know that the final response will be what

is best suited to the environment, or healthcare system, and the needs of the individual.

Learning Exercise 2.1.1

What are we talking about when we speak about systems theory in a health care organization? For a deeper understanding, watch this video titled "System Theory of Management" (7:37) by Nguyen Thanh Thi, then answer the following questions:

1. What are the three basic system types? Describe each type.
2. What type of system is a hospital?
3. What is synergy? What is entropy?

There are three fundamental concepts that, when applied to our individual organizations, can transform the way we provide health care. For additional information, watch this video titled "Systems Thinking and Complexity in Health: A Short Introduction" (5:02), then complete the following exercises:

1. Define the three fundamental concepts that can transform the way we provide health care.
2. Give an example of how each concept can make a difference to health care provision.

Organizational Culture

Organizational culture is often referred to in healthcare organizations, but there is a lack of consensus on what it actually is, how it influences behaviors and if leaders can change the culture (Watkins, 2013). In a social media platform, Watkins facilitated a discussion on perceptions of organizational culture and later published a synthesis of responses in *Harvard Business Review* (Watkins, 2013), As you can see from the variety of responses compiled in Table 2.2.1, there is not one clear consensus for a definition of organizational culture. Implications for nursing leadership include the need to be aware of cultural nuances in their own organization and that it can change based upon a number of variables (Watkins, 2013)

Table 2.1.1 What is Organizational Culture? (Watkins, 2013)

"Culture is how organizations 'do things'." — Robbie Katanga

"In large part, culture is a product of compensation." — Alec Haverstick

"Organizational culture defines a jointly shared description of an organization from within." — Bruce Perron

"Organizational culture is the sum of values and rituals which serve as 'glue' to integrate the members of the organization." — Richard Perrin

"Organizational culture is civilization in the workplace." — Alan Adler

"Culture is the organization's immune system." — Michael Watkins

"Organizational culture [is shaped by] the main culture of the society we live in, albeit with greater emphasis on particular parts of it." — Elizabeth Skringar

"It over simplifies the situation in large organizations to assume there is only one culture… and it's risky for new leaders to ignore the sub-cultures." — Rolf Winkler

"An organization [is] a living culture… that can adapt to the reality as fast as possible." — Abdi Osman Jama

Further Research

Hung, D., Chung, S., Martinez, M., & Tai-Seale, M. (2016). Effect of organizational culture on patient access, care continuity and experience of primary care. *Journal of Ambulatory Care Management, 39*(3), 242–252.

Purpose: To examine the relationships between organizational culture and patient-centered outcomes in a large medical practice.

Discussion: This American study was conducted in a large physician group practice setting of 357 physicians, 41 primary care departments, and nearly a million patients. Organizational culture was found to be significantly associated with "patient access to care, continuity of care, and reported experiences with care delivery" (Hung et al., 2016, pp. 245–246).

Application to Practice: When introducing change to an organization, it is essential to recognize the underlying organizational culture. Acknowledging and leveraging this aspect of collective behavior, while targeting specific patient-centered care goals, will lead to improved care.

Leaders know that employees frequently resist change and innovation in their workplace using the argument that "it has always been this way." Leaders play a pivotal role in inspiring change. When introducing innovation or transformation, it is important to recognize that cultural change cannot be commanded, but can only be inspired. Effective leaders understand both implicit and explicitly stated cultural norms and traditions when they introduce change into the organization. One highly valued nursing leadership and innovation is **Magnet®** (Learning Exercise 2.1.2).

Research with Magnet® hospitals in the United States reinforced the need for a health care environment that is focused on the provision of quality patient care. This necessity has also been identified in the UK. When caregivers are provided with adequate resources, support, and respect, there is evidence of increased job satisfaction and reduced patient morbidity and mortality (Aiken, Clarke, Sloane, Lake, & Cheney, 2008).

Holistic leadership approaches, which include a focus on relational leadership and staff empowerment, foster a strong and robust care provider culture within the organization. When supportive care provider cultures are present, improved health is likely to be evident for both care providers and patients. Research indicates that successful and effective nurse leaders have a positive impact upon the well-being of nurses, which converts into improved patient–client outcomes (Specchia et al., 2021)

Learning Exercise 2.1.2

Explore the Magnet® Recognition Program:
https://www.nursingworld.org/organizational-programs/magnet/about-magnet/why-become-magnet/

Reflect on the following:

- What is a Magnet® Recognition Program?
- What are 3 characteristics of Magnet® Organizations?
- How does Magnet® recognition benefit stakeholders?
- Is your organization a Magnet®-recognized organization?
    - If yes, what do you perceive as the primary benefit?
    - If not, what would it take for your organization to pursue this recognition?

Next: Organizational Vision, Mission, and Values

2.2 Organizational Vision, Mission, and Values

Relationship Between Organizational Culture and Mission, Vision & Values

Organizational culture can be described as the implicit values and beliefs that reflect the norms and traditions of an organization. An organization's vision, mission, and values statements are the foundation of organizational culture. Because individual organizations have their own vision, mission, and values statements, each organization has a different culture.

As health care continues to evolve and new models of care are introduced, nursing managers must develop innovative approaches that address change while aligning with that organization's vision, mission, and values. Leaders embrace the organization's mission, identify how individuals' work contributes to it, and ensure that outcomes advance the organization's mission and purpose. Leaders use vision, mission, and values statements for guidance when determining appropriate responses to critical events and unforeseen challenges that are common in a complex health care system. Successful organizations require employees to be committed to following these strategic guidelines during the course of their work activities. Employees who understand the relationship between their own work and the mission and purpose of the organization will contribute to a stronger health care system that excels in providing first-class patient care. The

vision, mission, and values provide a common organization-wide frame of reference for decision-making for both leaders and staff.

Organizational vision, mission, and values, established by leadership, provide the foundation for the establishment's culture. Since individual organizations have their own vision, mission, and value statements, each organization has a different culture. Not surprisingly, when there are conflicts between the mission and vision of various institutions, collaboration in providing services to the patient or consumer can also lead to disagreements (Ko et al. 2015). With the increasing emphasis upon collaboration between health care organizations, it is essential to understand how to overcome the challenges of cultural differences that may impede group efforts.

Vision, Mission, and Values & Leadership

Organizational leaders provide a sense of direction and overall guidance to their employees through the use of organizational vision, mission, and values statements. An organization's **vision statement** defines why the organization exists, describes how the organization is unique and different from similar organizations, and specifies where the leaders hope the organization is going (Sanders, 2013). The **mission** describes how the organization will fulfill its vision and establishes a common course of action for future endeavors. Finally, **values** are developed to assist with the achievement of the vision and mission and provide strategic guidelines for decision making, both internally and externally, by members of the organization (Kotalik et al., 2014). The vision, mission, and value statements are expressed in a concise and clear manner that is easily understood by all the members of the organization. The vision, mission, and values provide guidelines for every person

participating in all activities occurring within the organization and sets the tone for expectations of employees.

The United States of America's health care is an open system that is undergoing constant change while responding to the surrounding environment. Complexity science requires leaders and staff to handle this rapid change in a thoughtful manner. As health care continues to evolve and new models of care are introduced, managers need to consider innovative approaches that meet the needs of change while complying with their individual organization's vision, mission, and values. According to Porter–O'Grady and Malloch, "the language of leadership must reflect the requisites of embracing the mission, identifying how individual work effort contributes to it, and ensuring that work outcomes advance the organization's mission and purpose" (2011, p. 233). Leaders look through the lenses of the vision, mission, and values statements for guidance when determining appropriate responses to critical events and unforeseen challenges, common in a complex system. Successful organizations require each employee to be committed to following these strategic guidelines during the course of their work activities. Employees who understand the relationship between their own work and the mission and purpose of the organization will contribute to a stronger health care system that excels in providing first-class patient care. The vision, mission, and values provide a common organization-wide frame of reference for decision making for both leaders and staff (Kotalik et al., 2014).

Learning Exercise 2.2.1

Watch this video "How to Write a Mission Statement"

(4:00), presented by M3 Planning, then answer the following questions:

1. What is a mission statement?
2. What are five characteristics of a mission statement?
3. Who needs to be involved in writing a mission statement?
4. What information do you need to write a mission statement?
5. What should the process of writing a mission statement involve?

Learning Exercise 2.2.2

1.

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https://pressbooks.uwf.edu/nursingleadership/?p=306#h5p-26

2.

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.uwf.edu/nursingleadership/?p=306#h5p-28

3.

Consider the mission, vision, and values of your employer and reflect on the following questions:

- How well do your organization's vision and values align with your personal values regarding health care?
- How well does your organization's mission align with your potential Quality Improvement project?

Next: 2.3 Spotlight Application

2.3 Spotlight Application

Jamie is a nurse working on a general medical floor in a large urban teaching hospital. The typical assignment is between four and six patients depending on the acuity mix. Many of the patients are directly admitted patients or are transferred from the emergency department. Jamie has recently noticed a significant delay on weekend shifts with staff cleaning rooms and new patient admittance.

Jamie voiced concerns regarding the delays in room availability to the unit manager, Jo. Jo agreed that room turnover delays on the weekend have significantly increased in recent months and reported that they will investigate the delays further. A few weeks pass and Jo reports back that there have been staff reductions in the organization's environmental services staff on the weekend shifts. As a result, room cleaning has been delayed significantly. Jo has voiced concerns regarding the delays, but administration has been reluctant to hire additional staff. Jamie and Jo both feel strongly that investment in staff is needed.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/nursingleadership/?p=213#h5p-30

Chapter 2 References & Attribution

Chapter 2 References & Attribution

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Attribution

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Next- Chapter 3 Leading Effective Teams

PART III

CHAPTER 3 LEADING EFFECTIVE TEAMS

Learning Objectives

- Identify roles of various health care professionals
- Explore interprofessional communication strategies
- Review team attributes that impact system outcomes

All health care providers must be prepared to work together in clinical practice with a common goal of building a safer, more effective, patient-centered health care system. The World Health Organization (WHO) defines **interprofessional collaborative practice** as multiple health workers from different professional backgrounds working together with patients, families, caregivers, and communities to deliver the highest quality of care (World Health Organization, 2010).

Effective teamwork and communication have been proven to reduce medical errors, promote a safety culture, and improve patient outcomes (AHRQ, 2015). The importance of effective interprofessional collaboration has become even more important as nurses advocate to reduce health disparities related to social determinants of health (SDOH). In these

efforts, nurses work with people from a variety of professions, such as physicians, social workers, educators, policy makers, attorneys, faith leaders, government employees, community advocates, and community members. Nurses must be prepared to effectively collaborate interprofessionally in a variety of health care settings (National Academies of Sciences, Engineering, and Medicine, 2021).

The Interprofessional Education Collaborative (IPEC) has identified four core competencies for effective interprofessional collaborative practice. This chapter will review content related to these four core competencies and provide examples of effective teamwork in health systems.

The Interprofessional Education Collaborative (IPEC) established standard core competencies for effective interprofessional collaborative practice. The competencies guide the education and practice of health professionals with the necessary knowledge, skills, values, and attitudes to collaboratively work together in providing client care. See Table 3.2 for a description of the four IPEC core competencies (Interprofessional Education Collaborative, n.d.). Each of these competencies will be further discussed in the following sections of this chapter.

Table 3.1 IPEC Core Competencies

Competency 1: Values/Ethics for Interprofessional Practice Work with individuals of other professions to maintain a climate of mutual respect and shared values.
Competency 2: Roles/Responsibilities Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.
Competency 3: Interprofessional Communication Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.
Competency 4: Teams and Teamwork Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

(Interprofessional Education Collaborative, n.d.)

Next: 3.1 Roles and Responsibilities of Health Care Professionals

3.1 Roles and Responsibilities of Health Care Professionals

IPEC Competency 1: Values/Ethics for Interprofessional Practice

The coordination and delivery of safe, quality patient care demands reliable teamwork and collaboration across the organizational and community boundaries. Clients often have multiple visits across multiple providers working in different organizations. Communication failures between health care settings, departments, and team members is the leading cause of patient harm (Rosen et al., 2018). The health care system is becoming increasingly complex requiring collaboration among diverse health care team members.

The goal of good interprofessional collaboration is improved patient outcomes, as well as increased job satisfaction of health care team professionals. Patients receiving care with poor teamwork are almost five times as likely to experience complications or death. Hospitals in which staff report higher levels of teamwork have lower rates of workplace injuries and illness, fewer incidents of workplace harassment and violence, and lower turnover (Rosen et al., 2018).

Valuing and understanding the roles of team members are important steps toward establishing good interprofessional

teamwork. Another step is learning how to effectively communicate with interprofessional team members.

IPEC Competency 2: Roles/ Responsibilities

The second IPEC competency relates to the roles and responsibilities of health care professionals and states, "Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations" (Interprofessional Education Collaborative, n.d.).

See the following box for the components of this competency. It is important to understand the roles and responsibilities of the other health care team members; recognize one's limitations in skills, knowledge, and abilities; and ask for assistance when needed to provide quality, patient-centered care.

Components of IPEC's Roles/Responsibilities Competency (Interprofessional Education Collaborative, 2022.)

- Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals.
- Recognize one's limitations in skills, knowledge, and abilities.
- Engage with diverse professionals who

complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and health care needs of patients and populations.

- Explain the roles and responsibilities of other providers and the manner in which the team works together to provide care, promote health, and prevent disease.
- Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable.
- Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
- Forge interdependent relationships with other professions within and outside of the health system to improve care and advance learning.
- Engage in continuous professional and interprofessional development to enhance team performance and collaboration.
- Use unique and complementary abilities of all members of the team to optimize health and patient care.
- Describe how professionals in health and other fields can collaborate and integrate clinical care and public health interventions to optimize population health.

Nurses communicate with several individuals during their work. For example, during inpatient care, nurses may communicate with patients and their family members; pharmacists and pharmacy technicians; providers from different specialties; physical, speech, and occupational therapists; dietary aides; respiratory therapists; chaplains; social workers; case managers; nursing supervisors, charge nurses, and other staff nurses; assistive personnel; nursing students; nursing instructors; security guards; laboratory personnel; radiology and ultrasound technicians; and surgical team members. Providing holistic, quality, safe, and effective care means every team member taking care of patients must work collaboratively and understand the knowledge, skills, and scope of practice of the other team members. Table 3.4 provides examples of the roles and responsibilities of common health care team members that nurses frequently work with when providing patient care. To fully understand the roles and responsibilities of the multiple members of the complex health care delivery system, it is beneficial to spend time shadowing those within these roles.

Learn more about the roles and responsibilities of individual health care team members by completing the activity below.

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https://pressbooks.uwf.edu/nursingleadership/?p=141#h5p-29

Next: 3.2 Interprofessional Communication

3.2 Interprofessional Communication

IPEC Competency 3: Interprofessional Communication

The third IPEC competency focuses on interprofessional communication and states, "Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease" (Interprofessional Education Collaborative, 2022.). This competency also aligns with The Joint Commission's National Patient Safety Goal for improving staff communication (The Joint Commission, 2021). See the following box for the components associated with the Interprofessional Communication competency.

Components of IPEC's Interprofessional Communication Competency (Interprofessional Education Collaborative, 2022)

- Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate

discussions and interactions that enhance team function.

- Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.
- Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity, and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies.
- Listen actively and encourage ideas and opinions of other team members.
- Give timely, sensitive, constructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.
- Use respectful language appropriate for a given difficult situation, crucial conversation, or conflict.
- Recognize how one's uniqueness (experience level, expertise, culture, power, and hierarchy within the health care team) contributes to effective communication, conflict resolution, and positive interprofessional working relationships.
- Communicate the importance of teamwork in patient-centered care and population health

programs and policies.

Transmission of information among members of the health care team and facilities is ongoing and critical to quality care. However, information that is delayed, inefficient, or inadequate creates barriers for providing quality of care. Communication barriers continue to exist in health care environments due to interprofessional team members' lack of experience when interacting with other disciplines. For instance, many novice nurses enter the workforce without experiencing communication with other members of the health care team (e.g., providers, pharmacists, respiratory therapists, social workers, surgical staff, dieticians, physical therapists, etc.). Additionally, health care professionals tend to develop a professional identity based on their educational program with a distinction made between groups. This distinction can cause tension between professional groups due to diverse training and perspectives on providing quality patient care. In addition, a health care organization's environment may not be conducive to effectively sharing information with multiple staff members across multiple units.

In addition to potential educational, psychological, and organizational barriers to sharing information, there can also be general barriers that impact interprofessional communication and collaboration. See the following box for a list of these general barriers (O'Daniel & Rosenstein, 2011).

General Barriers to Interprofessional Communication and Collaboration (O'Daniel & Rosenstein, 2011)

- Personal values and expectations
- Personality differences
- Organizational hierarchy
- Lack of cultural humility
- Generational differences
- Historical interprofessional and intraprofessional rivalries
- Differences in language and medical jargon
- Differences in schedules and professional routines
- Varying levels of preparation, qualifications, and status
- Differences in requirements, regulations, and norms of professional education
- Fears of diluted professional identity
- Differences in accountability and reimbursement models
- Diverse clinical responsibilities
- Increased complexity of patient care
- Emphasis on rapid decision-making

There are several national initiatives that have been developed to overcome barriers to communication among interprofessional team members. These initiatives are summarized in Table 3.2 (Weller et al., 2014).

Table 3.2 Initiatives to Overcome Barriers to

Interprofessional Communication and Collaboration (Weller et al., 2014)

Action	Description
Teach structured interprofessional communication strategies	Structured communication strategies, such as ISBARR, handoff reports, I-PASS reports, and closed-loop communication should be taught to all health professionals.
Train interprofessional teams together	Teams that work together should train together.
Train teams using simulation	Simulation creates a safe environment to practice communication strategies and increase interdisciplinary understanding.
Define cohesive interprofessional teams	Interprofessional health care teams should be defined within organizations as a cohesive whole with common goals and not just a collection of disciplines.
Create democratic teams	All members of the health care team should feel valued. Creating democratic teams (instead of establishing hierarchies) encourages open team communication.
Support teamwork with protocols and procedures	Protocols and procedures encouraging information sharing across the whole team include checklists, briefings, huddles, and debriefing. Technology and informatics should also be used to promote information sharing among team members.
Develop an organizational culture supporting health care teams	Agency leaders must establish a safety culture and emphasize the importance of effective interprofessional collaboration for achieving good patient outcomes.

Communication Strategies

Several communication strategies have been implemented nationally to ensure information is exchanged among health

care team members in a structured, concise, and accurate manner to promote safe patient care. Examples of these initiatives are ISBARR, handoff reports, closed-loop communication, and I-PASS. Documentation that promotes sharing information interprofessionally to promote continuity of care is also essential. These strategies are reviewed in Appendix C.

Nurses may already be using these strategies in their health system. However, a key responsibility of nursing leaders is to ensure that communication tools are used effectively. Nurses are encouraged to review the barriers and strategies to determine the efficacy of communication within their own health system. Assessing one's own communication style is helpful in identifying potential strategies for enhanced communication. See Applied Learning Activity 3.2 Communication Style Inventory below.

Applied Learning Activity 3.2 Communication Style Inventory

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Next: 3.3 Teams and Teamwork

Appendix C

3.3 Teams and Teamwork

IPEC Competency 4: Teams and Teamwork

Now that we have reviewed the first three IPEC competencies related to valuing team members , understanding team members' roles and responsibilities and interprofessional communication, let's discuss strategies that promote effective teamwork. The fourth IPEC competency states, "Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable" (Interprofessional Education Collaborative, n.d.). See the following box for the components of this IPEC competency.

Components of IPEC's Teams and Teamwork Competency (Interprofessional Education Collaborative, 2022.)

- Describe the process of team development and the roles and practices of effective teams.
- Develop consensus on the ethical principles to guide all aspects of teamwork.

- Engage health and other professionals in shared patient-centered and population-focused problem-solving.
- Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting patient and community values and priorities/ preferences for care.
- Apply leadership practices that support collaborative practice and team effectiveness.
- Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise among health and other professionals and with patients, families, and community members.
- Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.
- Reflect on individual and team performance for individual, as well as team, performance improvement.
- Use process improvement to increase effectiveness of interprofessional teamwork and team-based services, programs, and policies.
- Use available evidence to inform effective teamwork and team-based practices.
- Perform effectively on teams and in different team roles in a variety of settings.

Developing effective teams is critical for providing health care

that is patient-centered, safe, timely, effective, efficient, and equitable (Interprofessional Education Collaborative Expert Panel, 2011).

Nurses collaborate with the interprofessional team by not only assigning and coordinating tasks, but also by promoting solid teamwork in a positive environment. A nursing leader, such as a charge nurse, identifies gaps in workflow, recognizes when task overload is occurring, and promotes the adaptability of the team to respond to evolving patient conditions. Qualities of a successful team are described in the following box (O'Daniel & Rosenstein, 2011).

Qualities of A Successful Team (O'Daniel & Rosenstein, 2011)

- Promote a respectful atmosphere
- Define clear roles and responsibilities for team members
- Regularly and routinely share information
- Encourage open communication
- Implement a culture of safety
- Provide clear directions
- Share responsibility for team success
- Balance team member participation based on the current situation
- Acknowledge and manage conflict
- Enforce accountability among all team members
- Communicate the decision-making process
- Facilitate access to needed resources
- Evaluate team outcomes and adjust as

needed

STEP Tool

STEP is a tool for monitoring the delivery of health care

STEP Tool (AHRQ, 2020)

Status of Patients: "What is going on with your patients?"

- Patient History
- Vital Signs
- Medications
- Physical Exam
- Plan of Care
- Psychosocial Issues

Team Members: "What is going on with you and your team?"(See the "I'M SAFE Checklist" below.)

- Fatigue
- Workload
- Task Performance
- Skill
- Stress

Environment: Knowing Your Resources

- Facility Information
- Administrative Information
- Human Resources
- Triage Acuity
- Equipment

Progression Towards Goal:

- Status of the Team's Patients
- Established Goals of the Team
- Tasks/Actions of the Team
- Appropriateness of the Plan – Are Modifications Needed?

Cross Monitoring

As the STEP tool is implemented, the team leader continues to cross monitor to reduce the incidence of errors. Cross monitoring includes the following (AHRQ, 2020):

- Monitoring the actions of other team members.
- Providing a safety net within the team.
- Ensuring that mistakes or oversights are caught quickly and easily.
- Supporting each other as needed.

I’M SAFE Checklist

The **I’M SAFE** mnemonic is a tool used to assess one’s own safety status, as well as that of other team members in their ability to provide safe patient care. See the I’M SAFE Checklist in the following box (AHRQ, 2020). If a team member feels their ability to provide safe care is diminished because of one of these factors, they should notify the charge nurse or other nursing supervisor. In a similar manner, if a nurse notices that another member of the team is impaired or providing care in an unsafe manner, it is an ethical imperative to protect clients and report their concerns according to agency policy (AHRQ, 2020).

I’m SAFE Checklist (AHRQ, 2020)

- **I:** Illness
- **M:** Medication
- **S:** Stress
- **A:** Alcohol and Drugs
- **F:** Fatigue
- **E:** Eating and Elimination

Read an example of a nursing team leader performing situation monitoring using the STEP tool in the following box.

Example of Situation Monitoring

Two emergent situations occur simultaneously on a busy medical-surgical hospital unit as one patient codes and another develops a postoperative hemorrhage. Connie, the charge nurse, is performing situation monitoring by continually scanning and assessing the status of all patients on the unit and directing additional assistance where it is needed. Each nursing team member maintains situation awareness by being aware of what is happening on the unit, in addition to caring for the patients they have been assigned. Connie creates a shared mental model by ensuring all team members are aware of their evolving responsibilities as the situation changes.

Connie directs additional assistance to the emergent patients while also ensuring appropriate coverage for the other patients on the unit to ensure all patients receive safe and effective care. For example, as the "code" is called, Connie directs two additional nurses and two additional assistive personnel to assist with the emergent patients while the other nurses and assistive personnel are directed to "cover" the remaining patients, answer call lights, and assist patients to the bathroom to prevent falls. Additionally, Connie is aware that after performing a few rounds of CPR for the coding patient, the assistive personnel must be switched with another team member to maintain effective chest compressions. As the situation progresses,

Connie evaluates the status of all patients and makes adjustments to the plan as needed.

Mutual Support

Mutual support is the fourth skill of the TeamSTEPPS® framework and defined as the "ability to anticipate and support team members' needs through accurate knowledge about their responsibilities and workload" (AHRQ, 2020). Mutual support includes providing task assistance, giving feedback, and advocating for patient safety by using assertive statements to correct a safety concern. Managing conflict is also a component of supporting team members' needs.

Task Assistance

Helping other team members with tasks builds a strong team. Task assistance includes the following components (AHRQ, 2020):

- Team members protect each other from work-overload situations.
- Effective teams place all offers and requests for assistance in the context of patient safety.
- Team members foster a climate where it is expected that assistance will be actively sought and offered.

Example of Task Assistance

In the previous example, one patient on the unit was coding while another was experiencing a postoperative hemorrhage. After the emergent care was provided and the hemorrhaging patient was stabilized, Sue, the nurse caring for the hemorrhaging patient, finds many scheduled medications for her other patients are past due. Sue reaches out to Sam, another nurse on the team, and requests assistance. Sam agrees to administer a scheduled IV antibiotic to a stable third patient so Sue can administer oral medications to her remaining patients. Sam knows that on an upcoming shift, he may need to request assistance from Sue when unexpected situations occur. In this manner, team members foster a climate where assistance is actively sought and offered to maintain patient safety.

Feedback

Feedback is provided to a team member for the purpose of improving team performance. Effective feedback should follow these parameters (AHRQ, 2020):

- *Timely:* Provided soon after the target behavior has occurred.
- *Respectful:* Focused on behaviors, not personal attributes.
- *Specific:* Related to a specific task or behavior that

requires correction or improvement.

- *Directed towards improvement:* Suggestions are made for future improvement.
- *Considerate:* Team members' feelings should be considered and privacy provided. Negative information should be delivered with fairness and respect

Strategies for effective communication are found in Appendix C.

Next: 3.4 Spotlight Application

Supplemental Resources Appendix C

3.4 Spotlight Application

Jamie normally works the overnight shift on a general medical floor and was floated to an orthopedic unit for the night shift due to increased patient census on that unit. Jamie has worked for the organization for 15 years and was working with four new RNs that recently completed orientation on the orthopedic unit. Jamie was assigned to be the charge nurse on this unit for this shift. Jamie was not happy about this assignment and was concerned about adequate staffing. In addition to the other 4 RNs, the patient care team for the night shift included 3 patient-care technicians (PCT) . One was newly hired in the health system and still orientating, but the other PCTs had worked on this unit for over 5 years.

Jamie focused on creating an effective team and ensuring effective communication. A few hours into the shift, Jamie noticed that one of the RNs was delegating patient care tasks that were outside the scope of practice for the PCT and should not be delegated by the RN. When Jamie asked the RN and PCT about this delegation, PCT had been doing this for "years" and had indicated that they were always trusted to perform these particular tasks.

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Chapter 4 Leading

Evidence-Informed Decision Making

Supplemental Resources Appendix B Team Stepps Strategies

PART IV

CHAPTER 4 LEADING EVIDENCE-INFORMED DECISION MAKING

Learning Objectives

- Recognize value of evidence in leadership decisions
- Identify standards of quality

Florence Nightingale was a pioneer in the evaluation of quality nursing care. She identified the role of a nurse within the health care team and measured patient outcomes to support the value of a nurse. Over the years nursing theorists and governing agencies have continued the evaluation work of Florence Nightingale by collecting data, using statistics, and creating reports to ensure the best quality care is being delivered to all patients.

A common question by nurses and other health care stakeholders is, "What is the definition of quality health care?" A second question is, "How is quality measured and evaluated in health care to determine if standards are met?" A third related question is, "How do nurses incorporate research and evidence-based practices into their nursing practice?" This chapter will review how quality nursing care is defined,

measured, and evaluated and how nurses implement evidence-based practices into their daily nursing practice.

Next: 4.1 Evidence-Informed Decision Making

4.1 Evidence-Informed Decision Making

Evidence-Informed Leadership

This section will discuss how leaders influence those around them to make evidence-informed decisions and deliver evidence-informed care. Evidence-informed care is associated with positive outcomes for patients, such as lower rates of injury and mortality, and less burnout and turnover for nurses. Within health care settings, leaders influence organizational culture by promoting the use of evidence and critical thinking. Their quest for evidence-informed excellence is often challenged by competing concerns, such as finances, which can put patients and nurses at risk. Brave leaders are those who seek out evidence and use the best available evidence to guide them.

Let's begin with a review of evidence-informed practice, also known as evidence-based practice. Whether you are a student, a practicing nurse, or a nurse leader with formal authority within a health care setting, you are expected to use evidence to inform your decisions and your actions.

Nurses and nurse leaders need to know where to locate different types of evidence; they need to determine whether or not it is trustworthy evidence (i.e., valid, reliable); and they need to know how to use it in their practice—whether caring for patients or leading within a health care setting. Schools of nursing, in their undergraduate and graduate programs, include critical thinking and assessment and use of evidence as important learner competencies.

Learning Experience 4.1.1

Watch the following YouTube video:

1. "What is Evidence-Based Practice?" with Ann Dabrow Woods (3:27)

In the video, Dabrow states that the Joanna Briggs Institute is a great source for health care evidence. Look at the Institute's website. Resources like this are vital to evidence-informed nurse leaders.

Regardless of whether you are a newer nurse or are a leader in a formal role (e.g., unit manager, facility director, chief nursing officer), your decisions need to be informed by evidence. And yet, as emphasized in the video, only a small proportion (20 per cent) of the decisions made in health care are based on evidence. Furthermore, Dabrow Woods states, "It takes 15 to 20 years to get evidence into practice." What is going on?

After watching the video and considering the previous question, answer the following questions:

- What should organizational leaders do to promote evidence-informed practice?
- What should individual nurses do to optimize use of evidence in their practice?

For successful innovation uptake and use, there are three basic clusters of influence that need to be addressed by leaders at

all levels of a health care organization: perceptions of the innovation, composition of staff, and contextual information.

Perceptions of the Innovation

The first cluster is perceptions of the innovation. Leaders need to thoughtfully consider how to introduce a new policy or protocol or a new piece of technology or medicine: first impressions count. Leaders need to consider five characteristics of an innovation by asking the following questions before introducing that innovation to their staff:

1. Will staff perceive the innovation as a benefit to them?
2. Does the innovation fit with staff's current needs? (e.g., Will the innovation enhance care delivery?)
3. Is the innovation easy to understand? Is it simple to do? Complexity (e.g., multiple parts, steps) slows down innovation. Simplicity promotes "spread."
4. Is it possible to do a small-scale pilot? Trialability improves the rate of innovation.
5. Is it possible for staff to observe the innovation in progress, to learn about it and answer any questions or concerns they may have? Observability and trialability often work well together.

Leaders, therefore, need to plan in advance for how they will influence staff's first impressions of an innovation. Change is frightening to people; we typically resist proposed changes because change often involves extra effort, resources, and time. With the busyness in our lives, we need to know, from leaders, that they are making evidence-informed decisions about proposed changes. Why should we change the status quo?

Learning Exercise 4.1.2

Read Dr. Donald Berwick's 2003 paper titled "Disseminating Innovations in Health Care." This classic paper discusses why innovation, or positive change, is difficult to integrate within health care settings.

According to innovation experts such as Dr. Donald Berwick, "failure to use available science is costly and harmful; it leads to overuse of unhelpful care, underuse of effective care, and errors in execution" (2003, p. 1969). For nurses and doctors, our errors can cost injury and even loss of life. Dr. Berwick asks the following set of questions:

- Why is the gap between knowledge and practice so large?
- Why do clinical care systems not incorporate the findings of clinical science or copy "best known" practices reliably, quickly, and even gratefully into their daily work simply as a matter of course? (p. 1969)

Composition of Staff

The second cluster of influence that leaders need to think about is the composition of their staff. Leaders cannot impose innovation on their own; they need the right staff helping them out. Without the right complement of helpers, their attempts

at innovation will fail. Take a look at Figure 2 in the Berwick paper (2003, p. 1972). For innovation to succeed, you need: innovators, early adopters, and an early majority.

Innovators are the source of proposed positive changes. They are those individuals within an organization that read scientific journals, attend conferences, and keep informed about best practices. They are well connected with sources of evidence outside the organization, and they bring ideas back to the organization.

Early adopters are well connected within the organization. They are the leaders who have influence and authority. They can make things happen, given their formal power within the organization. These leaders believe in the value of innovation, and they support their innovators. As one example, an early adopter leader provides release time and financial support for a nurse educator to attend a conference on medical-surgical practice innovations. The nurse educator brings back great ideas and presents them to the leadership and staff.

Once an early adopter leader recognizes the potential of an innovation, the leader gets to work, planning for how to present the innovation to staff (i.e., how to make the first impression). The leader proposes a pilot and asks for staff volunteers to help. Those staff who step forward to trial the innovation make up the early majority. In many instances, the early majority consists of new graduate nurses who are eager to try something new.

If the pilot has been successful, the rest of the staff—who have observed the positive outcomes from the pilot—will readily adopt the innovation. These staff comprise the late majority. And lastly, there are some staff, the laggards, who remain resistant to change. Leaders should listen to their concerns, but ultimately, if some staff members are uncomfortable with the change, it may be time for them to look for another unit or place of employment.

The laggards typically represent only a small number of staff (16%), and yet leaders often get sidetracked trying to convince

them to change. The fact is that they may never change. Leaders, therefore, should focus their energies on the initial 20 per cent of staff at the beginning of the innovation curve (i.e., innovators, early adopters, early majority) who need leadership support: they are the critical mass for positive change.

Contextual Information

The third cluster of influence consists of contextual factors that facilitate or impede innovation within the organization. The leadership and the organizational culture both have major influence over innovation spread. You need evidence-informed leaders (i.e., early adopters) throughout the organization who: (1) promote staff interactions, discussions, and networking across the organization (remember observability?); (2) trust and enable their staff to adapt new ideas to their needs; (3) invest essential resources, supports, and time in innovation; and (4) "walk the talk" or champion the innovations themselves. As Dr. Berwick (2003) wrote about Captain James Cook, an early explorer and innovator and early adopter: "James Cook had to eat his own sauerkraut, and health care leaders who want to spread change must change themselves first" (p. 1974).

Learning Exercise 4.1.3

Answer the following questions:

1. What kind of leaders would you like to work

with? Why?

2. What kind of organization would you like to work in? Why?

Leaders are essential for creating an open, transparent culture of learning, where everyone is expected to use the evidence to ensure best practice and best possible delivery of care to patients. Leaders are essential for modeling the way for others and providing the necessary information, resources, and supports so that all nurses and other staff have the means to provide quality, safe care to patients. Leaders are essential for promoting a culture of continuous learning, openness, and transparency toward sharing and using evidence to make a difference—what is known as a learning organization.

All members of an organization, staff and leaders alike, are expected to contribute to a learning organization culture.

Research Supports a Healthy Organization

Research on organizations from all different sectors (including industry, business, and health care) has shown that organizations that promote practices associated with learning organizations have significantly better outcomes, such as improved quality, efficiency, and effectiveness. Organizations and their leadership, therefore, are making wise investments when they support cultures that promote continuous learning (Robbins, Garman, Song, & McAlearney, 2012).

Position statements are typically evidence-based documents that can be found on websites of professional organizations,

regulatory colleges, unions, and the government. Although these documents are often referenced and fact-checked, they may also include guiding principles that reflect their organization's mission, vision, and values. It's important for nurses, therefore, to seek guidance from organizations that reflect professional nursing standards and codes of ethics. For practicing nurses, these documents are great resources, which also provide an introduction to the professional principles that define who we are as nurses.

Evidence-informed leaders are early adopters who seek out the best available evidence and promote evidence-informed practices among their staff. These leaders provide the structures and the processes necessary to spread the use of evidence and innovation throughout their organizations. Evidence-informed leaders do not only seek out the best available evidence, but they use it to drive their decisions—that is to say, they "walk the talk." Moreover, evidence-informed leaders promote learning organization cultures of transparency and continuous learning.

Leaders influence how others interpret and share evidence, depending on other leadership attributes they possess. As discussed throughout this book, it takes other leadership attributes, such as authenticity, moral integrity, and effective use of power, to make a great leader.

Next: 4.2 Standards of Quality Care

4.2 Standards of Quality Care

Quality is defined in a variety of ways that impact nursing practice.

American Nurses Association Definition of Quality

The American Nurses Association (ANA) defines **quality** as, "The degree to which nursing services for health care consumers, families, groups, communities, and populations increase the likelihood of desirable outcomes and are consistent with evolving nursing knowledge" (ANA, 2021). The phrases in this definition focus on three aspects of quality: services (nursing interventions), desirable outcomes, and consistency with evolving nursing knowledge (evidence-based practice). Alignment of nursing interventions with current evidence-based practice is a key component for quality care (Stevens, 2013). Evidence-based practice (EBP) will be further discussed later in this chapter.

Quality of Practice is one of the ANA's Standards of Professional Performance. **ANA Standards of Professional Performance** are "authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting are expected to perform competently." See the competencies for the ANA's *Quality of Practice* Standard of Professional Performance in the following box (ANA, 2021).

Competencies of ANA's Quality of Practice Standard of Professional Performance (ANA, 2021)

- Ensures that nursing practice is safe, effective, efficient, equitable, timely, and person-centered.
- Incorporates evidence into nursing practice to improve outcomes.
- Uses creativity and innovation to enhance nursing care.
- Recommends strategies to improve nursing care quality.
- Collects data to monitor the quality of nursing practice.
- Contributes to efforts to improve health care efficiency.
- Provides critical review and evaluation of policies, procedures, and guidelines to improve the quality of health care.
- Engages in formal and informal peer review processes of the interprofessional team.
- Participates in quality improvement initiatives.
- Collaborates with the interprofessional team to implement quality improvement plans and interventions.
- Documents nursing practice in a manner that supports quality and performance improvement initiatives.
- Recognizes the value of professional and specialty certification.

Learning Exercise 4.2.1

Answer the following reflective questions about the *Quality of Practice*:

1. What *Quality of Practice* competencies have you already demonstrated during your nursing practice?
2. What *Quality of Practice* competencies are you most interested in mastering?
3. What questions do you have about the ANA's *Quality of Practice* competencies? Where could you find answers to those questions (e.g., instructors, preceptors, health care team members, guidelines, or core measures)?

Framework of Quality Health Care

A definition of quality that has historically guided the measurement of quality initiatives in health care systems is based on the framework for improvement originally created by the Institute of Medicine (IOM). The IOM name changed to the National Academy of Medicine in 2015. The IOM framework includes the following six criteria for defining quality health care (Agency for Healthcare Research & Quality, 2015; Institute of Medicine Committee on Quality of Health Care in America, 2001):

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (i.e., avoiding underuse and misuse).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who provide care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

This framework continues to guide quality improvement initiatives across America's health care system. The evidence-based practice (EBP) movement began with the public acknowledgement of unacceptable patient outcomes resulting from a gap between research findings and actual health care practices. For EBP to be successfully adopted and sustained, it must be adopted by nurses and other health care team members, system leaders, and policy makers. Regulations and recognitions are also necessary to promote the adoption of EBP. For example, the Magnet Recognition Program promotes nursing as a leader in catalyzing adoption of EBP and using it as a marker of excellence (Stevens, 2013).

Reimbursement Models

Quality health care is also defined by value-based reimbursement models used by Medicare, Medicaid, and private insurance companies paying for health services. Value-based payment reimbursement models use financial incentives to reward quality health care and positive patient outcomes. For example, Medicare no longer reimburses hospitals to treat patients who acquire certain preventable conditions during their hospital stay, such as pressure injuries or urinary tract infections associated with use of catheters (James, 2012). These reimbursement models directly impact the evidence-based care nurses provide at the bedside and the associated documentation of assessments, interventions, and nursing care plans to ensure quality performance criteria are met.

CMS Quality Initiatives

The Centers for Medicare & Medicaid Services (CMS) establishes quality initiatives that focus on several key quality measures of health care. These quality measures provide a comprehensive understanding and evaluation of the care an organization delivers, as well as patients' responses to the care provided. These quality measures evaluate many areas of health care, including the following (CMS.gov, 2020):

- Health outcomes
- Clinical processes
- Patient safety
- Efficient use of health care resources
- Care coordination

- Patient engagement in their own care
- Patient perceptions of their care

These measures of quality focus on providing the care the patient needs when the patient needs it, in an affordable, safe, effective manner. It also means engaging and involving the patient so they take ownership in managing their care at home.

Learn More

Visit the CMS *What is a Quality Measure* webpage.

Accreditation

Accreditation is a review process that determines if an agency is meeting the defined standards of quality determined by the accrediting body. The main accrediting organizations for health care are as follows:

- The Joint Commission
- National Committee for Quality Assurance
- American Medical Accreditation Program
- American Accreditation Healthcare Commission

The standards of quality vary depending on the accrediting organization, but they all share common goals to improve efficiency, equity, and delivery of high-quality care. Two terms commonly associated with accreditation that are directly

related to quality nursing care are core measures and patient safety goals.

Core Measures

Core measures are national standards of care and treatment processes for common conditions. These processes are proven to reduce complications and lead to better patient outcomes. Core measure compliance reports show how often a hospital successfully provides recommended treatment for certain medical conditions. In the United States, hospitals must report their compliance with core measures to The Joint Commission, CMS, and other agencies (John Hopkins Medicine, n.d.).

In November 2003, The Joint Commission and CMS began work to align common core measures so they are identical. This work resulted in the creation of one common set of measures known as the *Specifications Manual for National Hospital Inpatient Quality Measures*. These core measures are used by both organizations to improve the health care delivery process. Examples of core measures include guidelines regarding immunizations, tobacco treatment, substance use, hip and knee replacements, cardiac care, strokes, treatment of high blood pressure, and the use of high-risk medications in the elderly. Nurses must be aware of core measures and ensure the care they provide aligns with these recommendations (The Joint Commission, n.d.).

Learn More

Read more about the National Hospital Inpatient Quality Measures.

Patient Safety Goals

Patient safety goals are guidelines specific to organizations accredited by The Joint Commission that focus on health care safety problems and ways to solve them. The National Patient Safety Goals (NPSG) were first established in 2003 and are updated annually to address areas of national concern related to patient safety, as well as to promote high-quality care. The NPSG provide guidance for specific health care settings, including hospitals, ambulatory clinics, behavioral health, critical access hospitals, home care, laboratory, skilled nursing care, and surgery.

The following goals are some examples of NPSG for hospitals (The Joint Commission, 2022):

- Identify patients correctly
- Improve staff communication
- Use medicines safely
- Use alarms safely
- Prevent infection
- Identify patient safety risks
- Prevent mistakes in surgery

Nurses must be aware of the current NPSG for their health care setting, implement appropriate interventions, and document their assessments and interventions. Documentation in the

electronic medical record is primarily used as evidence that an organization is meeting these goals.

Learn More

Read the current agency-specific National Patient Safety Goals.

Next: 4.3 Spotlight Application

4.3 Spotlight Application

Jax and Jamie are colleagues that work on two different units in the same health system, but knew each other from nursing school. While having lunch one day, they shared frustrations over the staffing shortages on their units, the number of nurses that have left since the COVID-19 pandemic and their growing dissatisfaction with the lack of response from administrators.

While Jamie notices that there are staffing shortages beyond nursing staff, they both agree that staffing shortages are impacting patient care throughout the health system. They both feel that the administration is not paying close enough attention to nursing concerns and are ready to take action. They have decided to put together a proposal to present to the administration to make some changes. They plan to present their proposal to the *Innovations Committee*, which is an interprofessional committee composed of department heads across the system.

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Next Chapter 5 Leading Effective Change

PART V

CHAPTER 5 LEADING EFFECTIVE CHANGE

Learning Objectives

- Explore theories utilized to lead change
- Select effective conflict management approaches
- Identify interprofessional collaborative practice methods

Change is constant in the health care environment. **Change** is defined as the process of altering or replacing existing knowledge, skills, attitudes, systems, policies, or procedures (Ana & Hendricks-Jackson, 2017). The outcomes of change must be consistent with an organization's mission, vision, and values. Although change is a dynamic process that requires alterations in behavior and can cause conflict and resistance, change can also stimulate positive behaviors and attitudes and improve organizational outcomes and employee performance. Change can result from identified problems or from the incorporation of new knowledge, technology, management, or leadership. Problems may be identified from many sources, such as quality improvement initiatives, employee performance evaluations, or accreditation survey results (Ana & Hendricks-Jackson, 2017).

Nurse leaders must deal with the fears and concerns

triggered by change. They should recognize that change may not be easy and may be met with enthusiasm by some and resistance by others. Leaders should identify individuals who will be enthusiastic about the change (referred to as “early adopters”), as well as those who will be resisters (referred to as “laggards”). Early adopters should be involved to build momentum, and the concerns of resisters should be considered to identify barriers. Data should be collected, analyzed, and communicated so the need for change (and its projected consequences) can be clearly articulated. Managers should articulate the reasons for change, the way(s) the change will affect employees, the way(s) the change will benefit the organization, and the desired outcomes of the change process (Ana & Hendricks-Jackson, 2017). See Figure 5.1 (Amman Wahab Nizamani, n.d.) for an illustration of communicating upcoming change.

Next: 5.1 Theoretical Approach to Change

5.1 Theoretical Approach to Change

Change Theories

There are several change theories that nurse leaders may adopt when implementing change. Two traditional change theories are known as Lewin's Unfreeze-Change-Refreeze Model and Lippitt's Seven-Step Change Theory (Ana & Hendricks-Jackson, 2017).

Lewin's Change Model

Kurt Lewin, the father of social psychology, introduced the classic three-step model of change known as Unfreeze-Change-Refreeze Model that requires prior learning to be rejected and replaced. Lewin's model has three major concepts: driving forces, restraining forces, and equilibrium. Driving forces are those that push in a direction and cause change to occur. They facilitate change because they push the person in a desired direction. They cause a shift in the equilibrium towards change. Restraining forces are those forces that counter the driving forces. They hinder change because they push the person in the opposite direction. They cause a shift in the equilibrium that opposes change. Equilibrium is a state of being where driving forces equal restraining forces, and no change occurs. It can be raised or lowered by changes that occur between the driving and

restraining forces (Ana & Hendricks-Jackson, 2017; Nursing Theory, n.d.)).

- **Step 1: Unfreeze the status quo.** Unfreezing is the process of altering behavior to agitate the equilibrium of the current state. This step is necessary if resistance is to be overcome and conformity achieved. Unfreezing can be achieved by increasing the driving forces that direct behavior away from the existing situation or status quo while decreasing the restraining forces that negatively affect the movement from the existing equilibrium. Nurse leaders can initiate activities that can assist in the unfreezing step, such as motivating participants by preparing them for change, building trust and recognition for the need to change, and encouraging active participation in recognizing problems and brainstorming solutions within a group (Kritsonis, 2005).
- **Step 2: Change.** Change is the process of moving to a new equilibrium. Nurse leaders can implement actions that assist in movement to a new equilibrium by persuading employees to agree that the status quo is not beneficial to them; encouraging them to view the problem from a fresh perspective; working together to search for new, relevant information; and connecting the views of the group to well-respected, powerful leaders who also support the change (Kritsonis, 2005).
- **Step 3: Refreeze.** Refreezing refers to attaining equilibrium with the newly desired behaviors. This step must take place after the change has been implemented for it to be sustained over time. If this step does not occur, it is very likely the change will be short-lived and employees will revert to the old equilibrium. Refreezing integrates new values into community values and traditions. Nursing leaders can reinforce new patterns of behavior and institutionalize them by adopting new

policies and procedures (Kritsonis, 2005).

Example Using Lewin's Change Theory

Sue, a new nurse working in a medical-surgical unit, identifies that bedside handoff reports are not currently being used during shift reports.

Step 1: Unfreeze: Sue recognizes a change is needed for improved patient safety and discusses the concern with Jason, the nurse manager. Current evidence-based practice is shared regarding bedside handoff reports between shifts for patient safety (AHRQ, n.d.). Jason initiates activities such as scheduling unit meetings to discuss evidence-based practice and the need to incorporate bedside handoff reports.

Step 2: Change: Jason gains support from the Director of Nursing to implement organizational change and plans staff education about bedside report checklists and the manner in which they are performed.

Step 3: Refreeze: Jason adopts bedside handoff reports in a new unit policy and monitors staff for effectiveness.

Lippitt's Seven-Step Change Theory

Lippitt's Seven-Step Change Theory expands on Lewin's change theory by focusing on the role of the change agent.

A **change agent** is anyone who has the skill and power to stimulate, facilitate, and coordinate the change effort. Change agents can be internal, such as nurse managers or employees appointed to oversee the change process, or external, such as an outside consulting firm. External change agents are not bound by organizational culture, politics, or traditions, so they bring a different perspective to the situation and challenge the status quo. However, this can also be a disadvantage because external change agents lack an understanding of the agency's history, operating procedures, and personnel (Lunenburg, 2010). The seven-step model includes the following steps (Ana & Hendricks-Jackson, 2017):

- **Step 1: Diagnose the problem.** Examine possible consequences, determine who will be affected by the change, identify essential management personnel who will be responsible for fixing the problem, collect data from those who will be affected by the change, and ensure those affected by the change will be committed to its success.
- **Step 2: Evaluate motivation and capability for change.** Identify financial and human resources capacity and organizational structure.
- **Step 3: Assess the change agent's motivation and resources, experience, stamina, and dedication.**
- **Step 4: Select progressive change objectives.** Define the change process and develop action plans and accompanying strategies.
- **Step 5: Explain the role of the change agent to all employees and ensure the expectations are clear.**
- **Step 6: Maintain change.** Facilitate feedback, enhance communication, and coordinate the effects of change.
- **Step 7: Gradually terminate the helping relationship of the change agent.**

Example Using Lippitt's Seven-Step Change Theory

Refer to the previous example of using Lewin's change theory on a medical-surgical unit to implement bedside handoff reporting. Jason, the nurse manager, expands on the Unfreeze-Change-Refreeze Model by implementing additional steps based on Lippitt's Seven-Step Change Theory:

- Jason collects data from team members affected by the changes and ensures their commitment to success.
- Early adopters are identified as change agents on the unit who are committed to improving patient safety by implementing evidence-based practices such as bedside handoff reporting.
- Action plans (including staff education and mentoring), timelines, and expectations are clearly communicated to team members as progressive change objectives. Early adopters are trained as "super-users" to provide staff education and mentor other nurses in using bedside handoff checklists across all shifts.
- Jason facilitates feedback and encourages two-way communication about challenges as change is implemented on the unit. Positive reinforcement is provided as team members effectively incorporate change.
- Bedside handoff reporting is implemented as a unit policy, and all team members are

held accountable for performing accurate bedside handoff reporting.

Learn More

Read more about additional change theories in the Current Theories of Change Management pdf.

Watch the video "Lewin's 3-Stage Model of Change: Unfreezing, Changing & Refreezing" (8:06) by Education-Portal.com for more about Lewin's change model.

Watch the video "Rogers Diffusion of Innovation" (3:15) by Kendal Pho, Yuri Dorovskikh, and Natalia Lara (Digital Pixels) for more about Rogers' theory of innovation.

Change Management

Change management is the process of making changes in a deliberate, planned, and systematic manner (Ana & Hendricks-Jackson, 2017). It is important for nurse leaders and nurse managers to remember a few key points about change management (Ana & Hendricks-Jackson, 2017):

- Employees will react differently to change, no matter how important or advantageous the change is purported to be.
- Basic needs will influence reaction to change, such as the need to be part of the change process, the need to be able to express oneself openly and honestly, and the need to feel that one has some control over the impact of change.
- Change often results in a feeling of loss due to changes in established routines. Employees may react with shock, anger, and resistance, but ideally will eventually accept and adopt change.
- Change must be managed realistically, without false hopes and expectations, yet with enthusiasm for the future. Employees should be provided information honestly and allowed to ask questions and express concerns.

Next: 5.2 Conflict Management

5.2 Conflict Management

The Theory of Conflict

Conflict is inevitable, especially for leaders. Effective nurse leaders invest time understanding the causes of conflict and learn how to manage and resolve it. The first step to managing conflict is to reflect on your own experiences and understand your personal approach to conflict. After learning their own preferred style, effective leaders learn to understand the styles of others and adapt their approaches accordingly. They observe and practice de-escalating situations and coaching people toward resolution. Fortunately, managing conflict is not something to be feared; rather, it is something that can be learned and practiced. It just takes time.

The model of conflict resolution presented has been used by informal and formal nurse leaders in a variety of health care environments. This section describes the model and helps the reader understand conflict and the five different approaches to managing conflict. Each approach is then applied to hypothetical nursing situations or environments, to help the reader see the practical use of the theory in nursing. A review of the evidence concludes the chapter.

For centuries, people accepted adversarial disputes and harsh conflict as a by-product of human nature. This acceptance caused people to analyze only how conflict could be resolved, that is, how they could make it go away. In the past decade or two, many people have started to also ask, “Why is conflict resolved in that way?” and, “Might there be a better way?”

If we are to make progress toward better conflict resolution, it is imperative that we understand why conflicts arise and how people traditionally have reacted to conflict situations. When we are able to analyze more clearly the causes of disputes, we will be able to determine better what processes need to be implemented to produce a more positive outcome to the conflict.

Four Major Types of Conflict

In order to analyze how to transform destructive conflict into a dispute with a positive outcome, let us begin by exploring the four major types of conflict (categorized by cause): data conflicts, relationship conflicts, value conflicts, and structural conflicts.

Data Conflicts

Data conflicts occur when people lack the information necessary to make wise decisions, are misinformed, disagree over which data are relevant, interpret information differently, or have competing assessment procedures. This type of conflict is usually the simplest to overcome, by adopting a process to ensure both parties perceive the data in the same way.

Relationship Conflicts

These problems often result in what have been called unrealistic or unnecessary conflicts since they may occur even

when objective pre-conditions for conflict, such as limited resources or mutually exclusive goals, are not present. They occur due to the presence of strong emotion (e.g., jealousy, mistrust, hatred) and are created from perceptions, poor communication, stereotypes, and so on. Relationship conflicts often fuel disputes, causing them to escalate.

Value Conflicts

This type of conflict is caused by perceived or actual incompatible value systems. Values are beliefs people use to give meaning to life and to explain what is good, bad, right, or wrong. Value conflicts occur only when people attempt to force one's set of values on another or lay claim to exclusive value systems, which do not allow for divergent beliefs.

Structural Conflicts

Structural conflicts are caused by oppressive patterns of human relationships. These patterns are often shaped by forces external to the people in dispute. Often, the disputants have no reason to be in conflict other than the structural problem that is imposed on their relationship. Often, these conflicts can be overcome by identifying the structural problem and working to change it. Acceptance of the status quo can perpetuate structural conflict.

It is important to understand what type of conflict (data, value, relationship, or structural) you are dealing with before you can effectively work toward a resolution. The solution for each type of conflict will be different and must suit the type of conflict you are addressing. For example, it would be unlikely that you would resolve a relationship problem with a data solution.

Data and structural conflicts have external sources of conflict and are typically easier to resolve; this is done by changing something in the external environment. Conversely, relationship and value conflicts relate to internal sources of conflict and can be much more difficult to resolve. Understanding relationship and value conflicts requires a deep internal awareness and empathy for others. Resolving relationship and value conflicts may significantly challenge an individual's personal perspectives, which generally makes the process more difficult. Typically, when we are under stress or in an escalated conflict we reach for data or structural solutions to resolve the conflict as these solutions require less time and effort.

Dealing with Conflict—Different Approaches

Every individual or group manages conflict differently. In the 1970s, consultants Kenneth W. Thomas and Ralph H. Kilmann developed a tool for analyzing the approaches to conflict resolution. This tool is called the Thomas-Kilmann Conflict Mode Instrument (TKI) (Kilmann Diagnostics, 2017).

Thomas and Kilmann suggest that in a conflict situation, a person's behavior can be assessed on two factors:

1. **Commitment to goals or assertiveness**—the extent to which an individual (or a group) attempts to satisfy his or her own concerns or goals.
2. **Commitment to relationships or cooperation**—the extent to which an individual (or a group) attempts to satisfy the concerns of the other party, and the importance of the relationship with the other party.

Thomas and Kilmann use these factors to explain the five different approaches to dealing with conflict: avoiding, competing, accommodating, compromising, and collaborating. There is an appropriate time to use each approach in dealing with conflict. While most people will use different methods in various circumstances, we all tend to have a more dominant approach that feels most comfortable. One approach is not necessarily better than another and all approaches can be learned and utilized. To most effectively deal with conflict, it is important to analyze the situation and determine which approach is most appropriate.

Let's take a closer look at each approach and when to use it.

Avoiding

An avoidance approach demonstrates a low commitment to both goals and relationships. This is the most common method of dealing with conflict, especially by people who view conflict negatively.

Types of avoidance include:

- Physical and/or mental withdrawal
- Blaming or minimizing
- Denial that a problem exists or changing the subject
- Postponement to a more appropriate time
- Use of emotions (tears, anger, etc.)

What may result from avoidance:

- The dispute is not resolved, or may build up and eventually explode
- Frustration over the dispute may lead to complaining, discontentment, or talking back
- Stress spreads to other parties (e.g., coworkers, family)

Application to Nursing – Avoidance

When might avoidance be an appropriate approach to conflict in a hospital or clinic setting?

In a hospital or clinical setting, there may be times when it is appropriate to avoid conflict. For example, on a particularly busy day in the emergency room, when a patient in life-threatening condition has just been received, the attending doctor may bark directions at the assisting nurses to get equipment. The nurses may feel offended by the doctor's actions; however, it may be appropriate for the nurses to avoid the conflict at that moment given the emergency situation. The nurse, if he or she felt it was inappropriate behavior by the doctor, could then deal with the conflict after the patient has been stabilized.

When might avoidance be an inappropriate approach to conflict in a hospital or clinic setting?

Avoiding the conflict may be inappropriate if that same doctor continues to bark directions at the nursing staff in non-emergency situations, such as during debrief of a surgery, or when communicating non-emergency instructions. When the nurses and doctor have to continue a working relationship, avoiding the continuing conflict will no longer be appropriate.

Competing

A competing approach to conflict demonstrates a high commitment to goals and a low commitment to relationships. Individuals who use the competing approach pursue their own goals at the other party's expense. People taking this approach will use whatever power is necessary to win. It may display as defending a position, interest, or value that you believe to be correct. Competing approaches are often supported by structures (courts, legislatures, sales quotas, etc.) and can be initiated by the actions of one party. Competition may be appropriate or inappropriate (as defined by the expectations of the relationship).

Types of competition include:

- Power of authority, position, or majority
- Power of persuasion
- Pressure techniques (e.g., threats, force, intimidation)
- Disguising the issue

What may result from competition:

- The conflict may escalate or the other party may withdraw
- Reduces the quality and durability of agreement
- Assumes no reciprocating power will come from the other side; people tend to reach for whatever power they have when threatened
- Increases the likelihood of future problems between parties
- Restricts communication and decreases trust

Application to Nursing – Competing

When might a competing approach to conflict be appropriate in a hospital or clinic setting?

A completing approach to conflict may be appropriate in a hospital or clinic setting if you recognize that another nurse has made an error in how much medication to administer to a patient. You recognize this mistake prior to the nurse entering the patient's room so you approach the nurse, take the medication out of his or her hands, and place the correct dosage. The goal of patient safety outweighs the commitment to the relationship with that nurse in this case.

When might a competing approach to conflict be inappropriate in a hospital or clinic setting?

It would be inappropriate to continue to be competitive when you debrief with the nurse about the dangers of medication errors and the system of double checking dosage amounts. The goal at this point is to enhance the learning of that nurse as well as to build trust in your relationship as colleagues. A different approach is needed.

Accommodating

Accommodating demonstrates a low commitment to goals and high commitment to relationship. This approach is the opposite of competing. It occurs when a person ignores or overrides their own concerns to satisfy the concerns of the other party. An accommodating approach is used to establish

reciprocal adaptations or adjustments. This could be a hopeful outcome for those who take an accommodating approach, but when the other party does not reciprocate, conflict can result. Others may view those who use the accommodating approach heavily as "that is the way they are" and don't need anything in return. Accommodators typically will not ask for anything in return. Accommodators tend to get resentful when a reciprocal relationship isn't established. Once resentment grows, people who rely on the accommodating approach often shift to a competing approach because they are tired of being "used." This leads to confusion and conflict.

Types of accommodation:

- Playing down the conflict to maintain surface harmony
- Self-sacrifice
- Yielding to the other point of view

What may result from accommodation:

- Builds relationships that will allow you to be more effective in future problem solving
- Increases the chances that the other party may be more accommodating to your needs in the future
- Does not improve communication

Application to Nursing – Accommodation

When might accommodation be an appropriate approach to conflict in a hospital or clinic setting?

It may be appropriate to use an accommodating

approach when, for example, one of the nurses on your shift has a particularly difficult patient who is taking up a lot of time and effort. Seeing that the nurse is having difficulty, you take on some of her or his tasks. This increases your workload for a period of time, but it allows your colleague the time needed to deal with the difficult patient.

When might accommodation be an inappropriate approach to conflict in a hospital or clinic setting?

This approach may no longer be appropriate if that same nurse expects you to continue to cover his or her tasks after the situation with the difficult patient has been resolved.

Compromising

A compromising approach strikes a balance between a commitment to goals and a commitment to relationships. The objective of a compromising approach is a quick solution that will work for both parties. Usually it involves both parties giving up something and meeting in the middle. Compromising is often used in labor negotiations, as typically there are multiple issues to resolve in a short period of time.

Types of compromising:

- Splitting the difference
- Exchanging concessions
- Finding middle ground

What may result from compromising:

- Both parties may feel they lost the battle and feel the need to get even next time.
- No relationship is established although it should also not cause relationship to deteriorate.
- Danger of stalemate
- Does not explore the issue in any depth

Application to Nursing – Compromise

When might compromise be an appropriate approach to conflict in a hospital or clinic setting?

You are currently on shift with another nurse that does the bare minimum and rarely likes to help his or her colleagues out. It is two hours since lunch and one of your hyperglycemic patients have not received their lunch tray. You approach your colleague and ask him or her to go look for the tray while you draw blood from a patient for them. The other nurse agrees as he or she has been having difficulty with the patient that needs a blood draw.

When might a compromise be an inappropriate approach to conflict in a hospital or clinic setting?

It would be inappropriate to continue to ask the nurse to do tasks for you that are less appealing than the tasks you take on.

Collaborating

Collaborating is an approach that demonstrates a high commitment to goals and also a high commitment to relationships. This approach is used in an attempt to meet concerns of all parties. Trust and willingness for risk is required for this approach to be effective.

Types of collaboration:

- Maximizing use of fixed resources
- Working to increase resources
- Listening and communicating to promote understanding of interests and values
- Learning from each other's insight

What may result from collaboration:

- Builds relationships and improves potential for future problem solving
- Promotes creative solutions

Application to Nursing – Collaborating

When might collaboration be an appropriate approach to conflict in a hospital or clinic setting?

It may be appropriate to use collaboration in a hospital or clinic setting when discussing vacation cover off with team members at a team meeting. During a team meeting, time is available to discuss and

focus on what is important for each member of the team.

When might collaboration be an inappropriate approach to conflict in a hospital or clinic setting?

Collaboration would be inappropriate in a discussion of a new policy that has been put in place if the team has little influence in making adjustments.

What Does Each Approach Need?

There are times when others may take an approach that is not helpful to the situation. However, the only person that you can control in a conflict is yourself. It is important to be flexible and shift your approach according to the situation and the other people with whom you are working. When someone else is taking an approach that is not beneficial to the situation, it is critical to understand what needs underlie the decision to take that approach. Here are a few examples:

- **Avoiders** may need to feel physically and emotionally safe. When dealing with avoiders, try taking the time to assure them that they are going to be heard and listened to.
- **Competitors** may need to feel that something will be accomplished in order to meet their goals. When dealing with competitors, say for example, "We will work out a solution; it may take some time for us to get there."
- **Compromisers** may need to know that they will get something later. When dealing with compromisers, say for example, "We will go to this movie tonight, and next week you can pick." (Be true to your word.)

- **Accommodators** may need to know that no matter what happens during the conversation, your relationship will remain intact. When dealing with accommodators, say for example, "This will not affect our relationship or how we work together."
- **Collaborators** may need to know what you want before they are comfortable sharing their needs. When dealing with collaborators, say for example, "I need this, this, and this. . . . What do you need?"

All approaches to conflict can be appropriate at some times, and there are times when they can be overused. It is important to take the time to consider which approach would be most beneficial to the situation in question. Taking the wrong approach can escalate conflict, damage relationships, and reduce your ability to effectively meet goals. The right approach will build trust in relationships, accomplish goals, and de-escalate conflict.

Everyone has the capacity to use each approach to conflict and to shift from his or her natural style as needed. We react with our most dominant style when we are under stress, but other styles can be learned and applied with practice and self-awareness. When dealing with others who may not have developed their capacity to shift from their preferred style of conflict, it is important to listen for their underlying needs. By understanding the needs that exist beneath the surface of the conflict, you can work with the other person toward a common goal.

Applied Learning Activity 5.2 Conflict Management Style

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/nursingleadership/?p=56#h5p-17

Take the self-assessment above to determine your conflict management style. Keep in mind that one style of conflict management is not necessarily better than another; each style has pros and cons, and each can be useful depending on the situation.

This assessment is intended to help you identify your typical response to conflict, with the goal that when you encounter future conflicts, you will be aware of not only your instinctive reaction, but also the pros and cons of that reaction for the specific situation.

Furthermore, you will also be aware of the other styles of conflict management that you could draw on to resolve the situation, if one of the other styles is more appropriate for the current situation.

An interactive H5P element has been excluded from this version of the text. You can view it online here: https://pressbooks.uwf.edu/nursingleadership/?p=56#h5p-21

Next: 5.3 Interprofessional Collaborative Practice

Supplemental Resources Appendix D Conflict Management Strategies

5.3 Interprofessional Collaborative Practice

Previous sections of this book discussed IPEC competencies required for effective interprofessional collaboration and methods for managing conflict. In addition to demonstrating these competencies, nurses also have many other responsibilities related to interprofessional collaborative practice. Nurses plan and participate in interdisciplinary care conferences; assign, delegate, and supervise nursing team members; educate clients and staff; act as client advocates; make client referrals; ensure continuity of care; and contribute to the evaluation of patient outcomes. These responsibilities of the nurse are further described in the following subsections.

Planning and Participating in Interdisciplinary Care Conferences

The nurse identifies clients who would benefit from interdisciplinary care conferences. **Interdisciplinary care conferences** are meetings where interprofessional team members professionally collaborate, share their expertise, and plan collaborative interventions to meet client needs. As the interprofessional team member likely to spend the most time at the client's bedside, nurses are key members for advocating for client needs during interdisciplinary care conferences. The nurse utilizes effective communication techniques by expressing and advocating for client needs, listening attentively to suggestions of other team members, formulating

a collaborative plan of care, and documenting it in the client's nursing care plan.

Learning Exercise 5.3.1

Watch this video titled "IPC Case Scenario for Mr. Jones Part 1" (7:09) by Interprofessional Professionalism Collaborative illustrating an interdisciplinary care conference as a patient's plan of care is designed and implemented.

Reflections(Interprofessional Professionalism Collaborative, 2019)**:**

1. As you watch the video, notice how the professionals from different health disciplines communicate and interact with each other to formulate the plan of care for a patient and how the care is continued through multidisciplinary involvement.
2. Assess interprofessional collaborative practice of the health care team using the Interprofessional Professionalism Assessment Tool.

Educating Clients and Staff

Nurses provide patient education, train staff, and serve as a staff resource. For example, an RN serves as a resource to

assistive personnel (AP) floating to their unit. The RN provides a general orientation of the unit, explains the pertinent needs of the clients as they pertain to the AP's assigned tasks, and shares how the staff interact and communicate within the unit. The RN ensures the AP understands the orientation information, is competent in their assigned/delegated tasks, and utilizes the RN as a resource throughout the shift.

Acting As a Client Advocate

Nurses advocate for client needs with family members, interprofessional team members, health care administrators, and, in some cases, health insurance companies and policy makers. Nurses protect and defend the rights and interests of their clients and ensure their safety, especially if the client is unable to advocate for themselves. For example, clients who are unconscious, developmentally disabled, illiterate, or experiencing confusion often require assertive advocacy with the interprofessional team to effectively meet their needs and preferences (Gerber, 2018).

Making Client Referrals

Nurses assess clients, determine their needs, and make referrals based on potential or actual problem(s). If the assessed needs of the client cannot be met by the collaborative nursing interventions, the nurse seeks out other resources to fulfill the client's needs. For example, nurses often advocate for referrals to community resources such as home health care, support groups, social services, respite care, emergency shelters, transportation, elder day care, and parenting groups.

After needed referrals are identified, the nurse obtains necessary provider orders and completes applicable referral forms. This information is shared confidentially with the client and the referral resource.

Ensuring Continuity of Care

Nurses serve a vital role for maintaining **continuity of care** and making any client transition of care smooth and unfragmented. Continuity of care is defined as "the use of information on past events and personal circumstances to make current care appropriate for each individual" (Kim, 2017). Transitions of care include admission to a facility, transfer from one unit to another within the same facility, transfer from one facility to another, or discharge to their home or a long-term care facility. For example, a transfer occurs when a client is moved from a medical unit bed to the intensive care unit.

There is high risk for medical errors during transitions of care. Nurses help make transitions seamless with good handoff reports and documentation while effectively collaborating with the interprofessional team. Read about preventing medication errors during transitions of care in the following box.

Preventing Medication Errors During Transitions
(World Health Organization, n.d.)

Key strategies for improving medication safety during transitions of care include the following:

- Implementing formal structured processes

for medication reconciliation at all transition points of care. Steps of effective medication reconciliation are to build the best possible medication history by interviewing the patient and verifying with at least one reliable information source, reconciling and updating the medication list, and communicating with the patient and future health care providers about changes in their medications.

- Partnering with clients, families, caregivers, and health care professionals to agree on treatment plans, ensuring clients are equipped to manage their medications safely, and ensuring clients have an up-to-date medication list.
- Where necessary, prioritize clients at high risk of medication-related harm for enhanced support such as post-discharge contact by a nurse.

Reporting New Information and Changing Conditions

The nurse is often responsible for reporting new information to the interprofessional team regarding inpatients, such as newly reported laboratory or diagnostic results or changes in a patient's condition. Here are some examples of a nurse reporting and following up on issues:

- A client receiving BiPAP therapy has worsening oxygen saturation levels and respiratory status. The nurse reports these changes to the respiratory therapist, who reassesses and adjusts the positive pressure settings as needed.
- An inpatient receiving furosemide has new abnormal potassium levels. The nurse reports the newly reported lab results to the provider.
- A client receiving an antibiotic for the first time develops a rash and shortness of breath. The nurse reports the client's adverse reaction to the prescribing provider and the pharmacist and ensures the allergy is noted in the client's chart.
- A family member shares a recent change in a client's living arrangements that is concerning. The nurse reports updates to the social worker to assist in making alternative living arrangements.

Contributing to the Evaluation of Client Outcomes

In today's complex health care system, data regarding patient outcomes is constantly documented and analyzed. This data drives management decisions and is also reported to insurance companies as a component of "pay for performance" reimbursement processes. The nurse is directly involved in this data by establishing expected outcomes customized to the client, evaluating these outcomes, and documenting data supporting outcomes related to collaborative nursing interventions.

Next: 5.4 Spotlight Application

5.4 Spotlight Application

Scenario 1

Sue and Sam are both nurses working the same shift. Sue is responsible for patients in Rooms 1–6, and Sam is responsible for patients in Rooms 7–12. Over the course of their shift, both nurses routinely visit their patients' rooms to take vitals and deliver medication.

On one of his rounds, Sam attends to his patient in Room 8. He reads the chart and notices Sue's initials signaling that she had already checked on this patient. A bit confused, he continues on to his next patient. After another hour goes by, Sam returns to Room 8 and again notices Sue's initials on the chart. Sam is concerned that Sue thinks he is incompetent, since she keeps checking up on his work. He decides to approach Sue and see what is going on.

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/nursingleadership/?p=162#h5p-32

Scenario 2

A nursing team is having a routine meeting. Tanya is a senior nurse in the unit with over ten years' experience on this specific unit. Stephen is new to the unit with fewer than three years' experience in nursing. Tanya has been asked to present information to the team about effective time management on the unit. During Tanya's presentation, Stephen rolls his eyes and talks to other members of the team. Tanya pauses to ask if Stephen has anything to add. Stephen replies, "No, I just don't know why we need to talk about this again." Tanya chooses to avoid engaging with Stephen further and finishes her presentation. Stephen continues to be disruptive throughout the presentation.

After the meeting concludes, Tanya approaches Stephen and asks why he was being disruptive. Stephen replies, "I just think we all know what the procedure is because we just learned it all during orientation training. Maybe if you don't remember the training, you should take it again." Tanya is shocked by his reply and quickly composes herself. She states, "Stephen, I have worked on this unit for over ten years. I was asked to present that information because there are current issues going on among the staff. Next time please respect my authority and listen to those who come before you."

An interactive H5P element has been excluded from this version of the text. You can view it online here:
https://pressbooks.uwf.edu/nursingleadership/?p=162#h5p-33

Scenario 3

Connie, the charge nurse for her unit in a medical-surgical hospital, is a respected member of the team. She has been working on this unit for a number of years and is seen by the other nurses as the "go to" person for questions and guidance. Connie is always thorough with patients and demonstrates excellence and quality in her work. Dr. Smith is a well-respected member of the medical profession and an expert in his field of medicine. He has a reputation for excellent bedside manner and is thorough in his approach with patients.

Connie is four hours into her 12-hour shift when she is approached by Dr. Smith. He asks, "Connie, why has the patient in Room 2 not received his blood pressure medication over the past few days? I was not notified about this!"

Connie, trying to find a quick solution, replies, "I didn't know that patient had been missing medication. I'll go check on it and get back to you."

Dr. Smith is persistent, saying, "I know this patient and should have been informed about the withholding of medication and the reasons why."

Connie, again attempting to find a resolution, states, "Well, there must be some communication about this change-"

"There isn't!" Dr. Smith interrupts.

Connie becomes upset and decides to leave the conversation after declaring, "Fine, if you know everything, then you figure it out; you're the one with the medical degree, aren't you?" She storms off.

Connie makes her way to the nurses' station and vents about the frustrating encounter to the other nurses there. Meanwhile, Dr. Smith has made his way to the doctor's lounge and tells his side of the story to his fellow doctors. A few hours later, Connie and Dr. Smith have each spoken to several people about the interaction, and as their shift continues they find

more and more reasons to attack the other's character. By the end of the day, Connie has filed a complaint against Dr. Smith, and Dr. Smith has filed his own against Connie.

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https://pressbooks.uwf.edu/nursingleadership/?p=162#h5p-34

Learn More

Visit the TeamSTEPPS® Instructor Manual: Specialty Scenarios for multiple AHRQ scenarios requiring application of TeamSTEPPS® to patient scenarios.

Chapter 5 References & Attribution

Chapter 5 References & Attribution

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Next- Chapter 6 Leading Effective

Outcomes

PART VI

CHAPTER 6 LEADING EFFECTIVE OUTCOMES

Learning Objectives

- Explore methods of continuous quality improvement processes
- Differentiate between process and outcome evaluation methods

As practicing nurses, you are likely accustomed to applying quality improvement processes within your workplace with individual patients or clients. Depending upon your work setting, you may be using these method for groups or populations. The idea of applying these methods is part of the nursing process. As a nurse leader, it is essential to think about outcomes in a tangible manner.

Outcomes are driven by a wide array of stakeholders from national or regional requirements to the individual stakeholders that are direct recipients of your services. Whatever the reason for collecting data, it is important to use that data to improve outcomes. In healthcare settings, often one method of of outcome data is insufficient, multiple outcome methods are used to measure improvement (Verhagen et al., 2022).

In this chapter, you will be exploring the quality improvement

process. One of the most, if not the most, important aspect of leading a quality improvement project is selecting appropriate outcome measures. Outcome measures are used to inform stakeholders of the project progression. If your project successfully achieves optimal outcomes, you will be able to expand the project and likely acquire additional resources. If, however, you achieve suboptimal outcomes, there will be minimal motivation from stakeholders to provide further support. The need to measure your progress during the process is essential and not limit your measurement to the end, as it will be too late to make adjustments to your plan.

Next: 6.1 Quality Improvement Process

6.1 Quality Improvement Process

Quality Improvement

Quality Improvement (QI) is a systematic process using measurable data to improve health care services and the overall health status of patients (Study.com, n.d.). QI is one of the competencies of the Quality and Safety Education (QSEN) project and defined as, "using data to monitor the outcomes of care processes and using improvement methods to design and test changes to continuously improve the quality and safety of health care systems" (QSEN Institute, n.d.).

The overall goal of the QI process is to improve the quality and safety of health care. The process of quality improvement is very similar to the Nursing Process, but its purpose is to answer these three main questions

- What are we trying to accomplish?
- How will we know if a change is an improvement?
- What changes can we make that will result in an improvement?

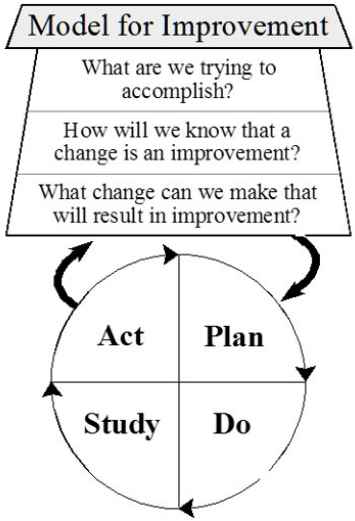

Figure 6.1 Quality Improvement Process (Cliffnorman, 2018)

See Figure 6.1 (Cliffnorman, 2018.) for an illustration of the Quality Improvement Process.

To answer these questions, QI is a continuous process in which a project is planned, interventions are implemented, data is collected, results are studied, and outcomes are evaluated. The process is repeated after additional planning. During the QI process, four key steps are used to evaluate current patient care and determine if changes are needed. These components are referred to as Plan, Do, Study, and Act:

- **Plan:** The first step in the QI process is to identify what you will be testing or focusing on and what will be measured. Similar to the Nursing Process where subjective and objective data are collected, the nurse determines what data will be needed during the QI process. The nurse also determines a timeline for the QI project, such as one year, including a specific framework for when data is collected and when it will be reviewed. For example, fall rates will decrease 10% in one year.
- **Do:** After the plan is determined, the nurse works with a health care team to implement the project and ensure data collection occurs.
- **Study:** During this phase, the nurse works with the health care team to review and analyze the data that was collected and determine if the outcomes were achieved or not.
- **Act:** In the fourth step of the QI process, the team discusses the outcomes. In this step the team identifies barriers, strengths, and weaknesses and then decides if additional changes are needed in nursing practice. The QI process is continuous, so the QI team uses outcome findings to continue the process of Plan, Do, Study, and Act to ensure safe, quality patient care.

It is important to note that quality improvement is different

from nursing research. QI evaluates processes in place and determines if changes are needed, whereas the goal of research is to identify new innovations in nursing practice (Agency for Healthcare Research and Quality, 2013).

Next: 6.2 Quality Improvement Measures

6.2 Quality Improvement Measures

Measuring Outcomes

An important aspect of quality improvement is the use of measures, also referred to as metrics, to identify the level of change on specific elements of the project. The Institute for Healthcare Improvement(IHI) provides a white paper on Whole System Measures (Martin et al., 2007). The IHI white paper identifies a system of existing metrics that impact quality in a health system. These metrics are unique to each health system and should be considered as the leader selects measures for their specific project. Depending upon the scope of the project, multiple measures are utilized.

IHI identifies three types of measures that are used in for improvement efforts. They include outcomes measures, process, measures and balancing measures (IHI, n.d.).

For this textbook, we are focusing on Outcome and Process measures examples from the IHI. **Process** measures can be considered indicators that are measured at specific intervals of the project. Process measures are vital for success of a project as they can inform leaders of the need to change the direction throughout the project, as opposed to waiting until the end of a change project.

Process Measures (IHI, 2019)

Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

- For diabetes: Percentage of patients whose hemoglobin A1c level was measured twice in the past year
- For access: Average daily clinician hours available for appointments
- For critical care: Percentage of patients with intentional rounding completed on schedule

Outcome measures are those that indicate change at the end of a specified period of time.

Outcome Measures (IHI, 2019)

How does the system impact the values of patients, their health and wellbeing? What are impacts on other stakeholders such as payers, employees, or the community?

- For diabetes: Average hemoglobin A1c level for population of patients with diabetes
- For access: Number of days to 3rd next available appointment
- For critical care: Intensive Care Unit (ICU)

percent unadjusted mortality
- For medication systems: Adverse drug events per 1,000 doses

Use of existing measures is ideal so change can be tracked over a period of time. This box shares some examples of existing measures. Additional measures are described in further detail in the pages below.

Examples of Existing Measures (IHI, 2019)

- Patient/client satisfaction surveys
- Length of stay
- Adverse events
- Staff turnover rates
- Staff-to-patient ratio
- Infection rates
- Employee satisfaction surveys

Utilization Review

Health care agencies are reimbursed from Medicare, Medicaid, and private insurance based on their quality performance measures. A **utilization review** is an investigation of health care services performed by doctors, nurses, and other health care

team members to ensure money is not wasted covering unnecessary or inefficient expenditures for proper treatment. Utilization review also allows organizations to objectively measure how their health care services and resources are being used to best meet their patients' needs. Information from patients' medical records is analyzed, along with patient demographics, to evaluate resource allocation, efficiency, and quality of health promotion initiatives (Institute of Medicine, 1989).

Using Informatics to Promote Quality

Utilization review relies on the collection of meaningful data from health records to determine if quality metrics are being met. **Informatics** refers to using information and technology to communicate, manage knowledge, mitigate error, and support decision-making (QSEN, n.d.). Informatics allows members of the health care team to share, store, and analyze health-related information. Nurses have an important role in informatics. **Nursing informatics** is the science and practice of integrating nursing knowledge with information and communication technologies to promote the health of people, families, and communities worldwide (AMIA, n.d.). It is a nursing specialty with certification available from the ANCC.

These are several benefits of using informatics in health care (Otokiti, 2019):

- **Improvement of Patient Safety:** Informatics allows for up-to-date information sharing by both the patient and members of the health care team. Using informatics can help to reduce the occurrence of medication errors, as well as monitor patient side effects and overall health status. For example, barcode scanning has reduced medication

errors by ensuring the correct dose is administered to the correct patient at the correct time.

- **Reduction of Delays in Care:** Some health care informatics systems allow for direct communication between health care team members and patients. The ability to ask and answer questions without needing to schedule an office appointment promotes the ability for care to be delivered efficiently in a cost-effective manner.
- **Reduction of Waste:** The use of informatics to share information between care team members reduces waste associated with duplication of tests or exams when more than one provider is on the care team. Additionally, patients can request their records be shared with health providers from other health organizations, which reduces duplication and unnecessary spending across the nation.
- **Promotion of Patient-Centered Care:** Many informatics systems have "patient portal" options where the patient and/or designated personnel are able to be active participants in the care planning and health promotion processes. Informatics offers an inclusive environment for patients to communicate and share directly with their care team regardless of physical location and timing.
- **Support of Quality Improvement:** The continuous process of quality improvement requires the ability to collect and analyze data in a systematic and reliable manner. Using informatics provides members of the health care team a secure place to store data, as well as the ability to review in a timely manner.

Quality Indicators

The National Database of Nursing Quality Indicators (NDNQI) was developed as a national nursing database used to evaluate

quality in nursing care. This database was purchased by Press Ganey in 2014. In collaboration with the American Nursing Association (ANA), the original NDNQI database established nurse-sensitive quality indicators such as these (Montalvo, 2007):

- Nursing Care Hours Per Patient Day
- Hospital-Acquired Pressure Injuries
- RN Job Satisfaction

Nurses use quality indicators to support practice changes with evidence directly related to improved patient outcomes.

Learn More

Read about current quality measures promoting clinical excellence at the Press Ganey website.

Next: 6.3 Spotlight Application

6.3 Spotlight Application

As mentioned in the**Chapter 4 Spotlight Application**, Jax and Jamie have both identified staffing shortages are impacting patient care on their respective units within their health system. They both feel that the administration is not paying close enough attention to nursing concerns and are ready to take action. They have decided to put together a proposal to present to the administration to make some changes. They will present their proposal to the Innovations Committee, which is an interprofessional committee composed of department heads across the system.

Part of their proposal for staff retention includes measuring outcomes and they decide to include both Process and Outcome Measures in their proposal to demonstrate the impact of staffing on the indicators below.

- Patient/client satisfaction surveys
- Length of stay
- Adverse events
- Staff turnover rates
- Staff-to-patient ratio
- Infection rates
- Employee satisfaction surveys

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Next Chapter 6 References & Attribution

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7.1 Person-Centered Care

PART VII

CHAPTER 7 LEADING PERSON-CENTERED HEALTH SYSTEMS

Learning Objectives

- Explore leadership concepts with quality improvement principles in the provision of patient/client centered care
- Identify health care trends and issues that impact stakeholder outcomes

What do you think of when you hear the word “advocacy”? Nurses act as advocates for their clients (e.g., individuals, families, communities, or populations) by protecting their “patient rights” and voicing their needs. Nurses have a long history of acting as client advocates. Early nurses advocated for professional nurses’ value and knowledge and fought for implementation of best practices, safety measures, and other quality improvements. Florence Nightingale advocated for practice changes that improved environmental conditions in health care and reduced life-threatening infections by using data to support her recommendations. Lillian Wald worked to establish public health nursing and improve the lives of immigrant communities.

More recently, nurses led the establishment of Nurse Practice Acts in each state and pushed for multistate licensing via the Nurse Licensure Compact (NLC). The American Nurses Association (ANA) declared 2018 as the "Year of Advocacy" to highlight the importance of advocacy in the nurse's role. Nurses continue to advocate for building healthier communities as demonstrated in the *Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* report (National Academies of Sciences, Engineering, and Medicine, 2021).

In this chapter, we will review how every nurse is responsible for client advocacy and examine the powerful influence nurses can have on local, state, and federal health care policies that affect the nation's health and the profession of nursing.

Learn More

Read the *Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* at Future of Nursing: Campaign for Action.

Next: 7.1 Person-Centered Care

7.1 Person-Centered Care

Person-Centered Care

Patient-centered care, also known as person-centered care, has become an increasingly popular term in healthcare over the last decade. This is not a new concept for nurses, as our core commitment to patients is to provide the best care possible. The concept of patient-centered care has been in the literature since the mid-20th century (Parse, 2019). In 1960, the patient-centered approach was considered "a trend in modern nursing practice . . . gradually replacing the procedure-centered approach . . . as the prime concern of the nurse" (Hofling, 1960).

However, the term has grown in popularity in an attempt to meet the challenges in healthcare. This philosophy in creating a larger focus on patterning with patients stems from coordinated care efforts in managing multiple chronic conditions, or co-morbidities. While person-centered care is a philosophy that is embraced by health systems, a consistent manner of quantifying this approach has not been identified (Bokhour et al., 2018).

Figure 7.1 Person-Centered Care

Person-Centered Leadership

As nurse leaders, person- centered care can and should extend beyond the "patient" but should also include all stakeholders, including those that are impacted by policy and leadership decisions. In a systems-based leadership approach, person-centered collaboration includes a wide array of stakeholder expertise and commitment (Jobe et al., 2020).

Healthcare workforce shortages have a tremendous impact on the patient experience. IN a recent article shared by

Planetree International (March 2023) *entitled "What Makes Health care Workers Stay in Their Jobs? Culture and Caring."* A foundation of patient-centered care and positive work culture impacts staff retention (Lampe, 2023). Effective nurse leaders can impact a positive work culture and ultimately, staff retention.

An essential reminder of keeping the "persons" in mind when planning will go a long way to achieving optimal outcomes (Learning Exercise 7.1.1).

Learning Exercise 7.1.1

Questions to consider when leading person-centered decisions:

- Who are our primary stakeholders?
- Who will benefit from this decision?
- Who will need to be included in this discussion?
- Why are we making this change?
- Is there another way to complete this?
- What are our priorities?

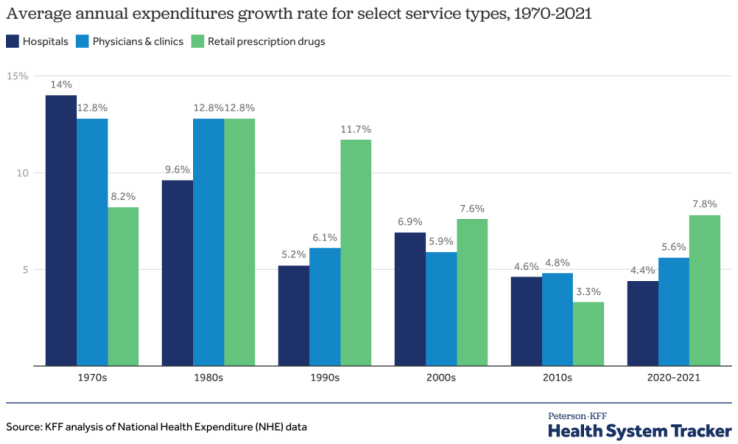
Next: 7.2 Health Care Trends and Issues

Supplemental Resources Appendix E Person-Centered Strategies

7.2 Health Care Trends and Issues

The Cost of Care

The cost of health care in the United States is higher than any other country in the world and has a significant financial impact on our economy (CMS.gov, 2020). U.S. health care spending grew 4.6 percent in 2019, reaching $3.8 trillion or $11,582 per person. Health care spending accounts for 17.7 percent of our Gross Domestic Product (GDP), the total value of goods produced and services provided annually (CMS, 2020). See Figure 7.2 (Telesford et al., 2023) for a graph of health care cost as a percentage of GDP in the United States compared to other countries around the world.



7.2 Average Annual Expenditures Growth Rate for Select Service Types, 1970-2021 (Peterson-KFF, 2023)

Despite spending more money on health care than other high-income countries, the United States has some of the poorest health outcomes, such as the lowest life expectancy, the highest infant mortality rate, and a higher prevalence of chronic diseases (Bush, 2018). The increasing costs of health care also have several negative impacts on society, employers, and individuals, including the following effects (Schreck, 2020):

- When the government spends more on health care, the national debt increases and funds available for other programs decrease.
- When people spend more on health care, they have less money to spend on other items.
- When health insurance is paid by employers, employees are paid less.
- When employers spend more on health care, the costs of their products and services increase. Jobs may be moved to countries with lower health care costs.
- An increasing number of people cannot afford health care insurance. When people without health care insurance receive health care, they often cannot pay for it. As a result of unpaid bills, this care is indirectly paid for by other people paying increased insurance premiums and taxes.
- People without health care insurance may not seek preventative care and develop a more costly, serious medical disorder that could have been prevented.
- Medical bills that are not covered by health insurance can cause bankruptcy.

There are several national trends affecting the cost of health care and related impacts, including the aging population, increased costs of medical technology, increased prescription medication cost, the Affordable Care Act, and social determinants of health.

Aging Population

According to the Agency for Healthcare Research and Quality (AHRQ), the United States has a growing number of older adults (age 65 years or older) who are living longer than previous generations. It is anticipated that older adults will make up more than 20 percent of the U.S. population by 2030 (AHRQ, n.d.). See Figure 7.3 (U.S. Census Bureau, n.d.) for an illustration of the aging population from the U.S. Census Bureau. This change in demographics will result in increased national health care costs because older adults typically experience more chronic conditions than younger populations, requiring expensive specialty and long-term care (AHRQ, n.d.).

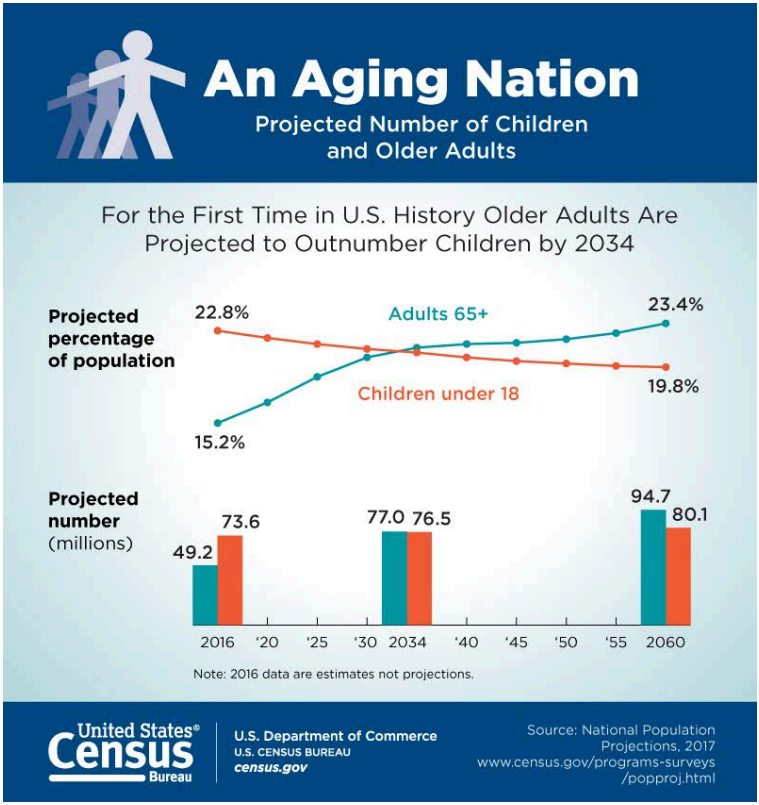


Figure 7.3 Aging Population in the United States (US Census Bureau, 2017)

Increased Costs of Medical Technology

Highly visible medical technologies, such as organ transplantation, diagnostic imaging systems, and biotechnology products, attract both praise and blame. Evolving medical technologies may save lives and improve a client's health status, but they are also viewed as a dominant cause of continued escalation of medical costs. Research

suggests that medical technology accounts for about 10 to 40 percent of the increase in health care expenditures over time (Neumann et al., 1991). These costs also lead to further ethical dilemmas as decisions regarding what scarce resources are provided to which patients are made.

Medical technologies, especially new ones, must justify their costs in a climate of competing claims on limited resources. Resource allocation follows American society's objective of cost effectiveness: if a new technology improves health outcomes at a lower cost than existing technologies, it should be adopted; otherwise, it should not (Neumann et al., 1991).

Increased Prescription Medication Costs

Retail prices for commonly-used prescription medications continue to increase twice as much as inflation, contributing to increased health care costs and making these life-sustaining medicines potentially unaffordable to many Americans. According to a recent AARP *Rx Price Watch* report, in 2020 prices for 260 commonly used medications increased 2.9 percent while the general rate of inflation was 1.3 percent (Bunis, 2021). For example, the cost of Symbicort, a medication used to treat asthma and COPD, increased 46 percent, from $2,940 to $4,282 (Bunis, 2021).

Although the majority of Americans have either public or private insurance that helps them pay for medications, increased medication prices result in higher health insurance premiums and higher taxpayer costs for the Medicare and Medicaid programs. Some insurance companies only cover approved formulary medications. As a result, national organizations like the American Association of Retired Persons (AARP) advocate for national policy changes, such as allowing

Medicare to negotiate the prices of prescription medications with drug companies and allowing private insurance plans to have access to those lower prices (Bunis, 2021).

Many consumers find themselves tasked with the difficult decision of purchasing expensive medication or going without prescribed medication to pay for their families' housing and food. Nurses often become involved in case management activities when assisting clients to obtain medications they cannot afford. Nursing case management activities are discussed later in this chapter.

Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), also known as the **Affordable Care Act (ACA)** or Obamacare, was signed into law in 2010. The purpose of this legislation was to increase consumers' access to health care coverage and protect them from insurance practices that restricted care or significantly increased the cost of care. The ACA mandated health insurance coverage for employers and individuals. Employers were mandated to provide health care coverage based on the number of their employees, and individuals who were not covered through employer insurance plans were mandated to seek coverage through a newly created Marketplace. The Marketplace provides a central, website that offers three standard health insurance coverage levels to facilitate comparison by consumers. As a result of the ACA and associated Medicaid expansion, 32 million people had health care coverage in 2021 (HealthCare.gov, n.d.; U.S. Department of Health and Human Services, n.d.).

Learn More

Read about the Affordable Care Act at HHS.gov.

View the U.S. Department of Health and Human Services' YouTube video, "5 Things About The Affordable Care Act (ACA)".

Key Provisions of the ACA

The ACA includes the following key provisions (HHS.gov, n.d.):

- Insurers can no longer deny coverage or care for preexisting conditions like diabetes, asthma, and cancer.
- Young adults may remain on their parents' insurance plans until they are 26 (even if they are married, financially independent, or not living with their parents).
- Health insurance plans cannot place annual or lifetime limits on coverage, except for nonessential exceptions, such as cosmetic procedures.
- Many preventive services must be provided, such as:
  - Well-child visits, flu shots, and other common vaccines
  - Screening tests for blood pressure and diabetes
  - Diagnostic screening tests, such mammograms and colonoscopies
  - Counseling services related to mental health and substance use

The ACA also provides an avenue for consumers to appeal

insurance companies' denials for care or payment of services and restricts situations in which an insurance carrier may cancel a policy.

Challenges to the ACA

Although the ACA has significantly increased the number of Americans with health insurance coverage, it continues to be debated. Debates focus on increased taxes, increased insurance premiums, and some people's belief that mandated coverage is governmental intrusion on an individual's rights. The Affordable Care Act has been challenged three times without success. In 2012 the U. S. Supreme Court upheld mandated coverage as a constitutional exercise of Congress' taxing powers because it could be interpreted as an individual's choice to maintain health insurance or pay a tax. However, in 2017 Congress set the penalty for failing to comply with the mandate at zero dollars after multiple attempts to repeal and replace the ACA. In June 2021 the U.S. Supreme Court rejected a third major challenge regarding the constitutionality of the ACA. In a 7-to-2 decision, the U.S. Supreme Court upheld the ACA based on the judgment that the states who brought forth the case did not prove damage to citizens because the fines for not having health coverage had been eliminated since the original legislation was passed (K&L Gates LLP, 2021).

What to Expect Next

Given the Supreme Court's recent decision regarding the ACA, it is expected the current administration will continue to advocate for the ACA and work towards making ACA tax credits permanent. Congress is also actively debating other legislative

proposals to reduce health care costs, such as medication pricing reform and expanding Medicare eligibility age and benefits (K&L Gates LLP, 2021).

Social Determinants of Health

Social Determinants of Health (SDOH) are the conditions in the environments where people live, learn, work, and play that affect a wide range of outcomes. SDOH include health care access and quality, neighborhood and environment, social and community context, economic stability, and education access and quality. These conditions have a major impact on people's health and well-being, ultimately affecting national health care costs (Healthy People 2030, n.d.).

SDOH directly impact individuals' health behaviors, their access to routine health care, and development of chronic disease. Yet, the United States spends a significantly lower percentage of its gross domestic product (GDP) on social services as compared to similar countries with better health outcomes (Bush, 2018).

Healthy People 2030, established by the U.S. Department of Health and Human Services, identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being over the next decade by addressing SDOH. One of Healthy People 2030's goals states, "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all" (Healthy People 2030, n.d.). Nurses act in many ways to address these priorities as they advocate for individuals, families, and communities.

Learn More

Read more about efforts addressing SDOH for improved economic stability and health care access in Healthy People 2030.

Next: 7.3 Spotlight Application

7.3 Spotlight Application

Jamie and Jax are putting the final touches on their proposed staffing retention proposal to present to the Innovations Committee, which is an interprofessional committee composed of department heads across the system. They have heard from nursing colleagues about growing dissatisfaction and tension in the health system between nursing staff and physicians**(See Spotlight Application 5)**. They are aware that these conflicts are impacting the quality of care within the health system. While their proposal is not specifically related to person-centered care, they recognize that these types of issues could impact the overall viability of their proposal.

Jamie and Jax decide to engage stakeholders in identifying system-wide solutions that exemplify person-centered care. They decide to include a Person-Centered Care Consultant in their proposal to help address the growing tensions.

They have heard of Planetree International as a leader in person-centered care and decide to explore their website for potential consulting support.

- **https://planetree.org/how-we-help/#consulting**

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https://pressbooks.uwf.edu/nursingleadership/?p=426#h5p-38

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Chapter 7 References & Attribution

Chapter 7 References & Attribution

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About the Contributors
Glossary
Appendices

About the Contributors

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Dr. Andresen is an Assistant Clinical Professor at the University of West Florida (UWF) in Pensacola, Florida. Dr. Andresen teaches courses at the graduate and undergraduate levels in nursing leadership, evidence-based practice and community/ public health. Prior to teaching at UWF, Dr. Andresen taught full-time at another teaching institution in the Midwest, serving as Department Chair and providing leadership in several different roles.

Dr. Andresen considers herself a life-long learner and has earned numerous degrees in nursing after starting her career as a Licensed Practical Nurse (LPN). Her pursuit of additional education was supported by many mentors throughout her career, all who have encouraged her to make a difference. She holds a Doctorate in Nursing Practice (DNP) from Rush University in Chicago, IL , Master of Science in Nursing from the University of Iowa, IA City, a Bachelor of Science in Health Arts from the University of St. Francis in Joliet, IL and and Associate Degree in Nursing from Scott Community College, Bettendorf, IA. Acter completing her DNP, Dr. Andresen completed a Master of Public Health from St. Ambrose University, Davenport, IA.

Dr. Andresen has a passion for public health and has practiced nursing care in a variety of community based settings. Her primary expertise is community-based nursing care within school settings, where she has served as a consultant in regional, state and national roles working to inform policy based upon best practices for school nurses. Her

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Charli Swanson

Charli Swanson is a student at UWF in the Instructional Design & Technology program. She enjoys the combination of structure and creativity in the design of educational materials and hopes to continue working to make education equitable, accessible, and engaging. Charli contributed to the design and organization of this resource.

Glossary

Accreditation: A review process to determine if an agency meets the defined standards of quality determined by the accrediting body.

Acuity-based staffing: A patient assignment model that takes into account the level of patient care required based on the severity of a patient's illness or condition.

Admission: Refers to an initial visit or contact with a client.

Advocacy: The act or process of pleading for, supporting, or recommending a cause of course of action for individuals, groups, organizations, communities, society, or policy issues.

Affordable Care Act (ACA): Legislation enacted in 2010 to increase consumers' access to health care coverage and protect them from insurance practices that restrict care or significantly increase the cost of care.

ANA Standards of Professional Practice: Authoritative statements of the actions and behaviors that all registered nurses, regardless of role, population, specialty, and setting are expected to perform competently.

Brief: A short session to share a plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and contingencies.

Budget: An estimate of revenue and expenses over a specified period of time, usually over a year.

Capital budgets: Budgets used to plan investments and upgrades to tangible assets that lose or gain value over time. Capital is something that can be touched, such as buildings or computers.

Change: The process of altering or replacing existing knowledge, skills, attitudes, systems, policies, or procedures.

Change agent: Anyone who has the skill and power to stimulate, facilitate, and coordinate the change effort.

Closed-loop communication: A communication strategy used to ensure that information conveyed by the sender is heard by the receiver and completed.

Collective bargaining: Negotiation of wages and other conditions of employment by an organized body of employees.

Continuity of care: The use of information on past events and personal circumstances to make current care appropriate for each individual.

Conflict: Competitive or opposing action of incompatibles : antagonistic state or action (as of divergent ideas, interests, or persons)

Co-pay: A flat fee the consumer pays at the time of receiving a health care service as a part of their health care plan.

Core measures: National standards of care and treatment processes for common conditions. These processes are proven to reduce complications and lead to better patient outcomes.

Cultural diversity: A term used to describe cultural differences among clients, family members, and health care team members.

Cultural humility: A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process.[1]

Culture of safety: Organizational culture that embraces error reporting by employees with the goal of identifying systemic causes of problems that can be addressed to improve patient safety. Just Culture is a component of a culture of safety.

CUS statements: Assertive statements that are well-recognized by all staff across a health care agency as implementation of the two-challenge rule. These assertive

1. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

statements are “I am Concerned – I am Uncomfortable – This is a Safety issue!”

Debrief: An informal information exchange session designed to improve team performance and effectiveness through reinforcement of positive behaviors and reflecting on lessons learned after a significant event occurs.

Deductible: The amount of money a consumer pays for health care before their insurance plan pays anything. These amounts generally apply per person per calendar year.

DESC: A tool used to help resolve conflict. DESC is a mnemonic that stands for Describe the specific situation or behavior and provide concrete data, Express how the situation makes you feel/what your concerns are using “I” messages, Suggest other alternatives and seek agreement, and Consequences are stated in terms of impact on established team goals while striving for consensus.

Discharge: The completion of care and services in a health care facility and the client is sent home (or to another health care facility).

Economics: The study of how society makes decisions about its limited resources.

Evidence-Based Practice (EBP): A lifelong problem-solving approach that integrates the best evidence from well-designed research studies and evidence-based theories; clinical expertise and evidence from assessment of the health care consumer’s history and condition, as well as health care resources; and patient, family, group, community, and population preferences and values.

Feedback: Information is provided to a team member for the purpose of improving team performance. Feedback should be timely, respectful, specific, directed towards improvement, and considerate.

Floating: An agency strategy that asks nurses to temporarily work on a different unit to help cover a short-staffed shift.

Followership: The upward influence of individuals on their leaders and their teams.

Grievance process: A process for resolving disagreements between employees and management.

Handoff reports: A transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the patient's care.

Huddle: A brief meeting during a shift to reestablish situational awareness, reinforce plans already in place, and adjust the teamwork plan as needed.

I'M SAFE: A tool used to assess one's own safety status, as well as that of other team members in their ability to provide safe patient care. It is a mnemonic standing for personal safety risks as a result of Illness, Medication, Stress, Alcohol and Drugs, Fatigue, and Eating and Elimination.

Informatics: Using information and technology to communicate, manage knowledge, mitigate error, and support decision-making.

Interdisciplinary care conferences: Meetings where interprofessional team members professionally collaborate, share their expertise, and plan collaborative interventions to meet client needs.

Interprofessional collaborative practice: Multiple health workers from different professional backgrounds working together with patients, families, caregivers, and communities to deliver the highest quality of care.

I-PASS: A mnemonic used as a structured communication tool among interprofessional team members. I-PASS stands for Illness severity, Patient summary, Action list, Situation awareness, and Synthesis by the receiver.

ISBARR: A mnemonic for the components of Introduction,

Situation, Background, Assessment, Request/ Recommendations, and Repeat back.

Just Culture: A culture where people feel safe raising questions and concerns and report safety events in an environment that emphasizes a nonpunitive response to errors and near misses. Clear lines are drawn between human error, at-risk, and reckless employee behaviors.

Leadership: The art of establishing direction and influencing and motivating others to achieve their maximum potential to accomplish tasks, objectives, or projects.

Magnet® Recognition Program: An organizational credential that recognizes quality patient outcomes, nursing excellence, and innovations in professional nursing practice.

Management: Roles that focus on tasks such as planning, organizing, prioritizing, budgeting, staffing, coordinating, and reporting.

Mandatory overtime: A requirement by agencies for nurses to stay and care for patients beyond their scheduled shift when short staffing occurs.

Medicaid: A joint federal and state program covering groups of eligible individuals, such as low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI). States may choose to cover additional groups, such as individuals receiving home and community-based services and children in foster care who are not otherwise eligible.

Medicare: A federal health insurance program used by people aged 65 and older, younger individuals with permanent disabilities, and people with end-stage renal disease requiring dialysis or a kidney transplant.

Meta-analysis: A type of nursing research (also referred to as a "systematic review") that compares the results of independent research studies asking similar research questions. This research often collects both quantitative and

qualitative data to provide a well-rounded evaluation by providing both objective and subjective outcomes.

Mission statement: An organization's statement that describes how the organization will fulfill its vision and establishes a common course of action for future endeavors.

Mutual support: The ability to anticipate and support team members' needs through accurate knowledge about their responsibilities and workload.

Nursing informatics: The science and practice integrating nursing, its information and knowledge, with information and communication technologies to promote the health of people, families, and communities worldwide.

Nursing research: The systematic inquiry designed to develop knowledge about issues of importance to the nursing profession.

Off with benefits: An agency staffing strategy when a nurse is not needed for their scheduled shift. The nurse does not typically receive an hourly wage and is not expected to report to work, but they still accrue benefits such as insurance and paid time off.

On call: An agency staffing strategy when a nurse is not immediately needed for their scheduled shift. They may have options to stay at work and complete work-related education or stay home.

Operating budgets: Budgets including personnel costs and annual facility operating costs.

Organizational culture: The implicit values and beliefs that reflect the norms and traditions of an organization. An organization's vision, mission, and values statements are the foundation of organizational culture.

Patient-centered care: The patient is the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs..

Patient safety goals: Guidelines specific to organizations

accredited by The Joint Commission that focus on problems in health care safety and ways to solve them.

Pay for Performance: A reimbursement model, also known as value-based payment, that attaches financial incentives based on the performance of health care agencies and providers.

Peer-reviewed: Scholarly journal articles that have been reviewed independently by at least two other academic experts in the same field as the author(s) to ensure accuracy and quality.

Primary source: An original study or report of an experiment or clinical problem. The evidence is typically written and published by the individual(s) conducting the research and includes a literature review, description of the research design, statistical analysis of the data, and discussion regarding the implications of the results.

Resource stewardship: Using appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, financially responsible, and used judiciously.

Quality: The degree to which nursing services for health care consumers, families, groups, communities, and populations increase the likelihood of desirable outcomes and are consistent with evolving nursing knowledge.

Quality Improvement (QI): Using data to monitor the outcomes of care processes and using improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

Qualitative research: A type of study that provides subjective data, often focusing on the perception or experience of the participants. Data is collected through observations and open-ended questions and often referred to as experimental data. Data is interpreted by developing themes in participants' views and observations.

Quantitative research: A type of study that provides objective data by using number values to explain outcomes.

Researchers can use statistical analysis to determine strength of the findings, as well as identify correlations.

Shared governance: A shared leadership model between management and employees working together to achieve common goals.

Shared mental model: The actions of a team leader that ensure all team members have situation awareness and are "on the same page" as situations evolve on the unit.

Secondary source: Evidence is written by an author who gathers existing data provided from research completed by another individual. This type of source analyzes and reports on findings from other research projects and may interpret findings or draw conclusions. In nursing research these sources are typically published as a systematic review and meta-analysis.

Situation awareness: The awareness of a team member knowing what is going on around them.

Situation monitoring: The process of continually scanning and assessing the situation to gain and maintain an understanding of what is going on around you.

Social Determinants of Health (SDOH): Conditions in the places where people live, learn, work, and play, such as unstable housing, low income areas, unsafe neighborhoods, or substandard education that affect a wide range of health risks and outcomes.

STEP tool: A situation monitoring tool used to know what is going on with you, your patients, your team, and your environment. STEP stands for Status of the patients, Team members, Environment, and Progress Toward Goal.

Systems leadership: A set of skills used to catalyze, enable, and support the process of systems-level change that focuses on the individual, the community, and the system.

Systems theory: The concept that systems do not function in isolation but rather there is an interdependence that exists between their parts. Systems theory assumes that most

individuals strive to do good work, but are affected by diverse influences within the system.

Team nursing: A common staffing pattern that uses a combination of Registered Nurses (RNs), Licensed Practical/Vocational Nurses (LPN/VNs), and Assistive Personnel (AP) to care for a group of patients.

TeamSTEPPS®: An evidence-based framework used to optimize team performance across the health care system. It is a mnemonic standing for Team Strategies and Tools to Enhance Performance and Patient Safety.

Teamwork and collaboration: Functioning effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.[

Two-challenge rule: A strategy for advocating for patient safety that includes a team member assertively voicing their concern at least two times to ensure that it has been heard by the decision-maker.

Utilization review: An investigation by insurance agencies and other health care funders on services performed by doctors, nurses, and other health care team members to ensure money is not wasted covering things that are unnecessary for proper treatment or are inefficient. This review also allows organizations to objectively measure how effectively health care services and resources are being used to best meet their patients' needs.

Values statement: The organization's established values that support its vision and mission and provide strategic guidelines for decision-making, both internally and externally, by members of the organization.

Vision statement: An organization's statement that defines why the organization exists, describes how the organization is unique and different from similar organizations, and specifies what the organization is striving to be.

Whistleblower: A person who exposes any kind of

information or activity that is deemed illegal, unethical, or not correct within an organization.

Appendices

Appendix A Scholarly Writing Resources
Appendix B Team Stepps Strategies
Appendix C Communication Strategies
Appendix D Conflict Management Strategies
Appendix E Person-Centered Strategies
Appendix F Teaching Strategies

Appendix A Scholarly Writing Resources

This set of resources is for the student seeking guidance on various writing expectations often encountered in educational pursuits.

- Writing for Success Open access resource for various writing styles
- **APA Formatting Guide** https://owl.excelsior.edu/citation-and-documentation/apa-style/apa-formatting-guide/

Appendix B Team Stepps Strategies

TeamSTEPPS®

TeamSTEPPS® is an evidence-based framework used to optimize team performance across the health care system. It is a mnemonic standing for Team Strategies and Tools to Enhance Performance and Patient Safety. The Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD) developed the TeamSTEPPS® framework as a national initiative to improve patient safety by improving teamwork skills and communication.[1]

Learn More

View this video about the TeamSTEPPS® framework[2]:

1. AHRQ. (2019, June). *TeamSTEPPS 2.0.* https://www.ahrq.gov/teamstepps/instructor/index.html
2. AHRQ Patient Safety. (2015, April 29). *TeamSTEPPS overview*. [Video]. YouTube. All rights reserved. https://youtu.be/p4n9xPRtSuU

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.uwf.edu/nursingleadership/?p=567#oembed-1

TeamSTEPPS® is based on establishing team structure and four teamwork skills: communication, leadership, situation monitoring, and mutual support. The components of this model are described in the following sections.

Team Structure

A nursing leader establishes team structure by assigning or identifying team members' roles and responsibilities, holding team members accountable, and including clients and families as part of the team.

Communication

Communication is the first skill of the TeamSTEPPS® framework. As previously discussed, it is defined as a "structured process by which information is clearly and accurately exchanged among team members." All team

members should use these skills to ensure accurate interprofessional communication:

- Provide brief, clear, specific, and timely information to other team members.
- Seek information from all available sources.
- Use ISBARR and handoff techniques to communicate effectively with team members.
- Use closed-loop communication to verify information is communicated, understood, and completed.
- Document appropriately to facilitate continuity of care across interprofessional team members.

Leadership

Leadership is the second skill of the TeamSTEPPS® framework. As previously discussed, it is defined as the "ability to maximize the activities of team members by ensuring that team actions are understood, changes in information are shared, and team members have the necessary resources." An example of a nursing team leader in an inpatient setting is the charge nurse.

Effective team leaders demonstrate the following responsibilities[3]:

- Organize the team.
- Identify and articulate clear goals (i.e., share the plan).
- Assign tasks and responsibilities.
- Monitor and modify the plan and communicate changes.
- Review the team's performance and provide feedback

3. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

when needed.
- Manage and allocate resources.
- Facilitate information sharing.
- Encourage team members to assist one another.
- Facilitate conflict resolution in a learning environment.
- Model effective teamwork.

Three major leadership tasks include sharing a plan, monitoring and modifying the plan according to situations that occur, and reviewing team performance. Tools to perform these tasks are discussed in the following subsections.

Sharing the Plan

Nursing team leaders identify and articulate clear goals to the team at the start of the shift during inpatient care using a "brief." The **brief** is a short session to share a plan, discuss team formation, assign roles and responsibilities, establish expectations and climate, and anticipate outcomes and contingencies. See a Brief Checklist in the following box with questions based on TeamSTEPPS®.[4]

Brief Checklist

4. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

During the brief, the team should address the following questions:[5]

- Who is on the team?
- Do all members understand and agree upon goals?
- Are roles and responsibilities understood?
- What is our plan of care?
- What are staff and provider's availability throughout the shift?
- How is workload shared among team members?
- Who are the sickest clients on the unit?
- Which clients have a high fall risk or require 1:1?
- Do any clients have behavioral issues requiring consistent approaches by the team?
- What resources are available?

Monitoring and Modifying the Plan

Throughout the shift, it is often necessary for the nurse leader to modify the initial plan as patient situations change on the unit. A **huddle** is a brief meeting before and/or during a shift to establish situational awareness, reinforce plans already in

5. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

place, and adjust the teamwork plan as needed. Read more about situational awareness in the "Situation Monitoring" subsection below.

Reviewing the Team's Performance

When a significant or emergent event occurs during a shift, such as a "code," it is important to later review the team's performance and reflect on lessons learned by holding a "debrief" session. A **debrief** is an informal information exchange session designed to improve team performance and effectiveness through reinforcement of positive behaviors and reflection on lessons learned.[6] See the following box for a Debrief Checklist.

Debrief Checklist[7]

The team should address the following questions during a debrief:

- Was communication clear?
- Were roles and responsibilities understood?

6. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html
7. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

- Was situation awareness maintained?
- Was workload distribution equitable?
- Was task assistance requested or offered?
- Were errors made or avoided?
- Were resources available?
- What went well?
- What should be improved?

Situation Monitoring

Situation monitoring is the third skill of the TeamSTEPPS® framework and is defined as the "process of actively scanning and assessing situational elements to gain information or understanding, or to maintain awareness to support team functioning." **Situation monitoring** refers to the process of continually scanning and assessing the situation to gain and maintain an understanding of what is going on around you. **Situation awareness** refers to a team member knowing what is going on around them. The team leader creates a **shared mental model** to ensure all team members have situation awareness and know what is going on as situations evolve. The STEP tool is used by team leaders to assist with situation monitoring.[8]

8. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

STEP

The **STEP tool** is a situation monitoring tool used to know what is going on with you, your patients, your team, and your environment. **STEP** stands for **S**tatus of the patients, **T**eam members, **E**nvironment, and **P**rogress toward goal. See an illustration of STEP in Figure 7.7.[9] The components of the STEP tool are described in the following box.[10]

9. "stepfig1.jpg" by unknown author is licensed under Public Domain. Access for free at https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html
10. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

Appendix C Communication Strategies

Advocating for Safety with Assertive Statements

When a team member perceives a potential patient safety concern, they should assertively communicate with the decision-maker to protect patient safety. This strategy holds true for ALL team members, no matter their position within the hierarchy of the health care environment. The message should be communicated to the decision-maker in a firm and respectful manner using the following steps[1]:

- Make an opening.
- State the concern.
- State the problem (real or perceived).
- Offer a solution.
- Reach agreement on next steps.

1. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

Examples of Using Assertive Statements to Promote Patient Safety

A nurse notices that a team member did not properly wash their hands during patient care. Feedback is provided immediately in a private area after the team member left the patient room: *"I noticed you didn't wash your hands when you entered the patient's room. Can you help me understand why that didn't occur?" (Wait for an answer.) "Performing hand hygiene is essential for protecting our patients from infection. It is also hospital policy and we are audited for compliance to this policy. Let me know if you have any questions and I will check back with you later in the shift." (Monitor the team member for appropriate hand hygiene for the remainder of the shift.)*

Two-Challenge Rule

When an assertive statement is ignored by the decision-maker, the team member should assertively voice their concern at least two times to ensure that it has been heard by the decision-maker. This strategy is referred to as the **two-challenge rule**. When this rule is adopted as a policy by a health care organization, it empowers all team members to pause care if they sense or discover an essential safety breach.

The decision-maker being challenged is expected to acknowledge the concern has been heard.[2]

CUS Assertive Statements

During emergent situations, when stress levels are high or when situations are charged with emotion, the decision-maker may not "hear" the message being communicated, even when the two-challenge rule is implemented. It is helpful for agencies to establish assertive statements that are well-recognized by all staff as implementation of the two-challenge rule. These assertive statements are referred to as the CUS mnemonic: "I am **C**oncerned – I am **U**ncomfortable – This is a **S**afety issue!"[3]

Using these scripted messages may effectively catch the attention of the decision-maker. However, if the safety issue still isn't addressed after the second statement or the use of "CUS" assertive statements, the team member should take a stronger course of action and utilize the agency's chain of command. For the two-challenge rule and CUS assertive statements to be effective within an agency, administrators must support a culture of safety and emphasize the importance of these initiatives to promote patient safety.

Read an example of a nurse using assertive statements in the following box.

2. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html
3. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

Assertive Statement Example

A nurse observes a new physician resident preparing to insert a central line at a patient's bedside. The nurse notes the resident has inadvertently contaminated the right sterile glove prior to insertion.

Nurse: "Dr. Smith, I noticed that you contaminated your sterile gloves when preparing the sterile field for central line insertion. I will get a new set of sterile gloves for you."

Dr. Smith: (Ignores nurse and continues procedure.)

Nurse: "Dr. Smith, please pause the procedure. I noticed that you contaminated your right sterile glove by touching outside the sterile field. I will get a new set of sterile gloves for you."

Dr. Smith: "My gloves are fine." (Prepares to initiate insertion.)

Nurse: "Dr. Smith – I am concerned! I am uncomfortable! This is a safety issue!"

Dr. Smith: (Stops procedure, looks up, and listens to the nurse.) "I'll wait for that second pair of gloves."

Learn More

View a detailed video webinar describing the TeamSTEPPS® principles.[4]

ISBARR

A common format used by health care team members to exchange client information is **ISBARR**, a mnemonic for the components of **I**ntroduction, **S**ituation, **B**ackground, **A**ssessment, **R**equest/Recommendations, and **R**epeat back.[5,6]

- **Introduction:** Introduce your name, role, and the agency from which you are calling.
- **Situation:** Provide the client's name and location, the reason you are calling, recent vital signs, and the status of the client.
- **Background:** Provide pertinent background information about the client such as admitting medical diagnoses, code status, recent relevant lab or diagnostic results, and allergies.

4. AHRQ Patient Safety. (2017, July 26). *Introduction to the fundamentals of TeamSTEPPS® concepts and tools.* [Video]. YouTube. Video in the Public Domain. https://youtu.be/fxlRtpzsUug
5. Institute for Healthcare Improvement (n.d.). *ISBAR trip tick.* http://www.ihi.org/resources/Pages/Tools/ISBARTripTick.aspx
6. Grbach, W., Vincent, L., & Struth, D. (2008). *Curriculum developer for simulation education.* QSEN Institute. https://qsen.org/reformulating-sbar-to-i-sbar-r/

- **Assessment:** Share abnormal assessment findings and your evaluation of the current client situation.
- **Request/Recommendations:** State what you would like the provider to do, such as reassess the client, order a lab/diagnostic test, prescribe/change medication, etc.
- **Repeat back:** If you are receiving new orders from a provider, repeat them to confirm accuracy. Be sure to document communication with the provider in the client's chart.

Nursing Considerations

Before using ISBARR to call a provider regarding a changing client condition or concern, it is important for nurses to prepare and gather appropriate information. See the following box for considerations when calling the provider.

Communication Guidelines for Nurses[7]

- Have I assessed this client before I call?
- Have I reviewed the current orders?
- Are there related standing orders or protocols?
- Have I read the most recent provider and

7. Studer Group. (2007). *Patient safety toolkit – Practical tactics that improve both patient safety and patient perceptions of care*. Studer Group.

nursing progress notes?

- Have I discussed concerns with my charge nurse, if necessary?
- When ready to call, have the following information on hand:
    - Admitting diagnosis and date of admission
    - Code status
    - Allergies
    - Most recent vital signs
    - Most recent lab results
    - Current meds and IV fluids
    - If receiving oxygen therapy, current device and L/min
- Before calling, reflect on what you expect to happen as a result of this call and if you have any recommendations or specific requests.
- Repeat back any new orders to confirm them.
- Immediately after the call, document with whom you spoke, the exact time of the call, and a summary of the information shared and received.

Read an example of an ISBARR report in the following box.

Sample ISBARR Report From a Nurse to a Health Care Provider

I: "Hello Dr. Smith, this is Jane Smith, RN from the Med-Surg unit."

S: "I am calling to tell you about Ms. White in Room 210, who is experiencing an increase in pain, as well as redness at her incision site. Her recent vital signs were BP 160/95, heart rate 90, respiratory rate 22, O2 sat 96% on room air, and temperature 38 degrees Celsius. She is stable but her pain is worsening."

B: "Ms. White is a 65-year-old female, admitted yesterday post hip surgical replacement. She has been rating her pain at 3 or 4 out of 10 since surgery with her scheduled medication, but now she is rating the pain as a 7, with no relief from her scheduled medication of Vicodin 5/325 mg administered an hour ago. She is scheduled for physical therapy later this morning and is stating she won't be able to participate because of the pain this morning."

A: "I just assessed the surgical site and her dressing was clean, dry, and intact, but there is 4 cm redness surrounding the incision, and it is warm and tender to the touch. There is moderate serosanguinous drainage. Her lungs are clear and her heart rate is regular. She has no allergies. I think she has developed a wound infection."

R: "I am calling to request an order for a CBC and increased dose of pain medication."

R: "I am repeating back the order to confirm that you are ordering a STAT CBC and an increase of her Vicodin to 10/325 mg."

Handoff Reports

Handoff reports are defined by The Joint Commission as "a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another, or from one team of caregivers to another, for the purpose of ensuring the continuity and safety of the patient's care."[8] In 2017 The Joint Commission issued a sentinel alert about inadequate handoff communication that has resulted in patient harm such as wrong-site surgeries, delays in treatment, falls, and medication errors.[9]

8. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012). Transforming pediatric GME. *Pediatrics, 129*(2), 201-204. https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf
9. The Joint Commission. (n.d.). *Sentinel event alert 58: Inadequate hand-off reports*. https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/

The Joint Commission encourages the standardization of critical content to be communicated by interprofessional team members during a handoff report both verbally (preferably face to face) and in written form. Critical content to communicate to the receiver in a handoff report includes the following components[10]:

- Sender contact information
- Illness assessment, including severity
- Patient summary, including events leading up to illness or admission, hospital course, ongoing assessment, and plan of care
- To-do action list
- Contingency plans
- Allergy list
- Code status
- Medication list
- Recent laboratory tests
- Recent vital signs

Several strategies for improving handoff communication have been implemented nationally, such as the Bedside Handoff Report Checklist, closed-loop communication, and I-PASS.

Learn More

10. The Joint Commission. (n.d.). *Sentinel event alert 58: Inadequate hand-off reports*. https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/

View a video example of bedside handoff reporting.

Closed-Loop Communication

The **closed-loop communication** strategy is used to ensure that information conveyed by the sender is heard by the receiver and completed. Closed-loop communication is especially important during emergency situations when verbal orders are being provided as treatments are immediately implemented.

1. The sender initiates the message.
2. The receiver accepts the message and repeats back the message to confirm it (i.e., "Cross-Check").
3. The sender confirms the message.
4. The receiver notified the sender the task was completed (i.e., "Check-Back").

See an example of closed-loop communication during an emergent situation in the following box.

Closed-Loop Communication Example

Doctor: "Administer 25 mg Benadryl IV push STAT."

Nurse: "Give 25 mg Benadryl IV push STAT?"

Doctor: "That's correct."

Nurse: "Benadryl 25 mg IV push given at 1125."

I-PASS

I-PASS is a mnemonic used to provide structured communication among interprofessional team members. I-PASS stands for the following components[11]:

I: Illness severity
P: Patient summary
A: Action list
S: Situation awareness and contingency plans
S: Synthesis by receiver (i.e., closed-loop communication)

See a sample I-PASS Handoff in Table 7.5b.[12]

Table C.1Sample I-PASS Verbal Handoff[13]

11. The Joint Commission. (n.d.). *Sentinel event alert 58: Inadequate hand-off reports.* https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-58-inadequate-hand-off-communication/
12. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012). Transforming pediatric GME. *Pediatrics, 129*(2), 201-204. https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf
13. Starmer, A. J., Spector, N. D., Srivastava, R., Allen, A. D., Landrigan, C. P., Sectish, T. C., & I-Pass Study Group. (2012).

Transforming pediatric GME. *Pediatrics, 129*(2), 201-204.
https://www.ipassinstitute.com/hubfs/I-PASS-mnemonic.pdf

Table C.1 Sample I-PASS Verbal Handoff

I	**Illness Severity**	This is our sickest patient on the unit, and he's a full code.
P	**Patient Summary**	AJ is a 4-year-old boy admitted with hypoxia and respiratory distress secondary to left lower lobe pneumonia. He presented with cough and high fevers for two days before admission, and on the day of admission to the emergency department, he had worsening respiratory distress. In the emergency department, he was found to have a sodium level of 130 mg/dL likely due to volume depletion. He received a fluid bolus, and oxygen administration was started at 2.5 L/min per nasal cannula. He is on ceftriaxone.
A	**Action List**	Assess him at midnight to ensure his vital signs are stable. Check to determine if his blood culture is positive tonight.
S	**Situations Awareness & Contingency Planning**	If his respiratory distress worsens, get another chest radiograph to determine if he is developing an effusion.
S	**Synthesis by Receiver**	Ok, so AJ is a 4-year-old admitted with hypoxia and respiratory distress secondary to a left lower lobe pneumonia receiving ceftriaxone, oxygen, and fluids. I will assess him at midnight to ensure he is stable and check on his blood culture. If his respiratory status worsens, I will repeat a radiograph to look for an effusion.

Documentation

Accurate, timely, concise, and thorough documentation by interprofessional team members ensures continuity of care for their clients. It is well-known by health care team members that in a court of law the rule of thumb is, "If it wasn't documented, it wasn't done." Any type of documentation in the electronic health record (EHR) is considered a legal document. Abbreviations should be avoided in legal documentation and some abbreviations are prohibited.

Learn More

Read the current list of error-prone abbreviations by the Institute of Safe Medication Practices. These abbreviations should never be used when communicating medical information verbally, electronically, and/or in handwritten applications. Abbreviations included on The Joint Commission's "Do Not Use" list are identified with a double asterisk (**) and must be included on an organization's "Do Not Use" list.

Nursing staff access the electronic health record (EHR) to help ensure accuracy in medication administration and document the medication administration to help ensure patient safety.

The electronic health record (EHR) contains the following important information:

- **History and Physical (H&P):** A history and physical (H&P) is a specific type of documentation created by the health care provider when the client is admitted to the facility. An H&P includes important information about the client's current status, medical history, and the treatment plan in a concise format that is helpful for the nurse to review. Information typically includes the reason for admission, health history, surgical history, allergies, current medications, physical examination findings, medical diagnoses, and the treatment plan.
- **Provider orders:** This section includes the prescriptions, or medical orders, that the nurse must legally implement or appropriately communicate according to agency policy if not implemented.
- **Medication Administration Records (MARs):** Medications are charted through electronic medication administration records (MARs). These records interface the medication orders from providers with pharmacists and are also the location where nurses document medications administered.
- **Treatment Administration Records (TARs):** In many facilities, treatments are documented on a treatment administration record.

- **Laboratory results:** This section includes results from blood work and other tests performed in the lab.
- **Diagnostic test results:** This section includes results from diagnostic tests ordered by the provider such as X-rays, ultrasounds, etc.
- **Progress notes:** This section contains notes created by nurses, providers, and other interprofessional team members regarding client care. It is helpful for the nurse to review daily progress notes by all team members to ensure continuity of care.
- **Nursing care plans:** Nursing care plans are created by registered nurses (RNs). Documentation of individualized nursing care plans is legally required in long-term care facilities by the Centers for Medicare and Medicaid Services (CMS) and in hospitals by The Joint Commission. Nursing care plans are individualized to meet the specific and unique needs of each client. They contain expected outcomes and planned interventions to be completed by nurses and other members of the interprofessional team. As part of the nursing process, nurses routinely evaluate the client's progress toward meeting the expected outcomes and modify the nursing care plan as needed.

Appendix D Conflict Management Strategies

Managing Conflict

Conflict is not uncommon on interprofessional teams, especially when there are diverse perspectives from multiple staff regarding patient care. Nurse leaders must be prepared to manage conflict to support the needs of their team members.

When conflict occurs, the **DESC tool** can be used to help resolve conflict by using "I statements." DESC is a mnemonic that stands for the following[1]:

- **D:** Describe the specific situation or behavior; provide concrete data.
- **E:** Express how the situation makes you feel/what your concerns are using "I" statements.
- **S:** Suggest other alternatives and seek agreement.
- **C:** Consequences stated in terms of impact on established team goals while striving for consensus.

The DESC tool should be implemented in a private area with a focus on WHAT is right, not WHO is right. Read an example of a nurse using the DESC tool in the following box.

1. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

Example of Using the DESC Tool[2]

Situation: A physician became angry at a nurse who was inserting a patient's Foley catheter and yelled at the nurse in front of the patient and other team members. The nurse later addressed the physician in a private area outside the patient's room using the DESC tool and "I statements":

D: "I noticed you got angry at me when I inserted the patient's Foley catheter."

E: "I'm concerned how you addressed that issue in front of the patient and three other staff members. It made me feel bad in front of the patient and my colleagues."

S: "In the future, if you have an issue with how I do things, please pull me aside privately to discuss your concern."

C: "Our organization has a policy for managing communication challenges among team members if we can't agree on this alternative."

2. AHRQ. (2020, January). *Pocket guide: TeamSTEPPS*. https://www.ahrq.gov/teamstepps/instructor/essentials/pocketguide.html

Appendix E Person-Centered Strategies

Interprofessional Person-Centered Competencies

The first IPEC competency is related to values and ethics and states, "Work with individuals of other professions to maintain a climate of mutual respect and shared values."[1] See the box below for the components related to this competency. Notice how these interprofessional competencies are very similar to the Standards of Professional Performance established by the American Nurses Association related to *Ethics, Advocacy, Respectful and Equitable Practice, Communication*, and *Collaboration*.[2]

1. Interprofessional Education Collaborative. *IPEC core competencies.* https://www.ipecollaborative.org/ipec-core-competencies
2. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Components of IPEC's Values/Ethics for Interprofessional Practice Competency[3]

- Place interests of clients and populations at the center of interprofessional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span.
- Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.
- Embrace the cultural diversity and individual differences that characterize patients, populations, and the health team.
- Respect the unique cultures, values, roles/responsibilities, and expertise of other health professions and the impact these factors can have on health outcomes.
- Work in cooperation with those who receive care, those who provide care, and others who contribute to or support the delivery of prevention and health services and programs.
- Develop a trusting relationship with patients, families, and other team members.
- Demonstrate high standards of ethical conduct and quality of care in contributions to

3. Interprofessional Education Collaborative. *IPEC core competencies.* https://www.ipecollaborative.org/ipec-core-competencies

team-based care.

- Manage ethical dilemmas specific to interprofessional patient/population-centered care situations.
- Act with honesty and integrity in relationships with patients, families, communities, and other team members.
- Maintain competence in one's own profession appropriate to scope of practice.

Nursing, medical, and other health professional programs typically educate students in "silos" with few opportunities to collaboratively work together in the classroom or in clinical settings. However, after being hired for their first job, these graduates are thrown into complex clinical situations and expected to function as part of the team. One of the first steps in learning how to function as part of an effective interprofessional team is to value each health care professional's contribution to quality, patient-centered care. Mutual respect and trust are foundational to effective interprofessional working relationships for collaborative care delivery across the health professions. Collaborative care also honors the diversity reflected in the individual expertise each profession brings to care delivery.[4]

4. Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report on an expert panel.* Interprofessional Education Collaborative. https://ipec.memberclicks.net/assets/2011-Original.pdf

Cultural diversity is a term used to describe cultural differences among clients, family members, and health care team members. While it is useful to be aware of specific traits of a culture, it is just as important to understand that each individual is unique, and there are always variations in beliefs among individuals within a culture. Nurses should, therefore, refrain from making assumptions about the values and beliefs of members of specific cultural groups.[5] Instead, a better approach is recognizing that culture is not a static, uniform characteristic but instead realizing there is diversity within every culture and in every person. The American Nurses Association (ANA) defines **cultural humility** as, "A humble and respectful attitude toward individuals of other cultures that pushes one to challenge their own cultural biases, realize they cannot possibly know everything about other cultures, and approach learning about other cultures as a lifelong goal and process."[6] It is imperative for nurses to integrate culturally responsive care into their nursing practice and interprofessional collaborative practice.

Learn More

5. Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report on an expert panel.* Interprofessional Education Collaborative. https://ipec.memberclicks.net/assets/2011-Original.pdf
6. American Nurses Association. (2021). *Nursing: Scope and standards of practice* (4th ed.). American Nurses Association.

Read more about cultural diversity, cultural humility, and integrating culturally responsive care in the "Diverse Patients" chapter of Open RN *Nursing Fundamentals*.

Nurses value the expertise of interprofessional team members and integrate this expertise when providing patient-centered care. Some examples of valuing and integrating the expertise of interprofessional team members include the following:

- A nurse is caring for a patient admitted with chronic heart failure to a medical-surgical unit. During the shift the patient's breathing becomes more labored and the patient states, "My breathing feels worse today." The nurse ensures the patient's head of bed is elevated, oxygen is applied according to the provider orders, and the appropriate scheduled and PRN medications are administered, but the patient continues to complain of dyspnea. The nurse calls the respiratory therapist and requests a STAT consult. The respiratory therapist assesses the patient and recommends implementation of BiPAP therapy. The provider is notified and an order for BiPAP is received. The patient reports later in the shift the dyspnea is resolved with the BiPAP therapy.
- A nurse is working in the Emergency Department when an adolescent patient arrives via ambulance experiencing a severe asthma attack. The paramedic provides a handoff report with the patient's current vital signs, medications administered, and intravenous (IV) access established. The paramedic also provides information about the home environment, including information about vaping products and a cat in the adolescent's bedroom. The nurse

thanks the paramedic for sharing these observations and plans to use information about the home environment to provide patient education about asthma triggers and tobacco cessation after the patient has been stabilized.

- A nurse is working in a long-term care environment with several assistive personnel (AP) who work closely with the residents providing personal cares and have excellent knowledge regarding their baseline status. Today, after helping Mrs. Smith with her morning bath, one of the APs tells the nurse, "Mrs. Smith doesn't seem like herself today. She was very tired and kept falling asleep while I was talking to her, which is not her normal behavior." The nurse immediately assesses Mrs. Smith and confirms her somnolescence and confirms her vital signs are within her normal range. The nurse reviews Mrs. Smith's chart and notices that a new prescription for furosemide was started last month but no potassium supplements were ordered. The nurse notifies the provider of the patient's change in status and receives an order for lab work including an electrolyte panel. The results indicate that Mrs. Smith's potassium level has dropped to an abnormal level, which is the likely cause of her fatigue and somnolescence. The provider is notified, and an order is received for a potassium supplement. The nurse thanks the AP for recognizing and reporting Mrs. Smith's change in status and successfully preventing a poor patient outcome such as a life-threatening cardiac dysrhythmia.

View the "How does interprofessional

collaboration impact care: The patient's perspective?" video on YouTube regarding patients' perspectives about the importance of interprofessional collaboration.

Read Ten Lessons in Collaboration. Although this is an older publication, it provides ten lessons to consider in collaborative relationships and practice. The discussion reflects many components of collaboration that have been integral to nursing practice in interprofessional teamwork and leadership.

Reflective Questions

1. What is the difference between patient-centered care and disease-centered care?
2. Why is it important for health professionals to collaborate?

Appendix F Teaching Strategies

Teaching Strategies

This appendix is provided to offer users of this book to integrate various tools to support learners in engaging in the material and applying findings to real world situations. It is assumed that most of the students using this book are employed in healthcare; therefore most of the activities apply to healthcare system enhancement opportunities.

Applied Learning Activities

Most chapters include Applied Learning Activities. These activities are intended for students to apply to real world situations experienced by practicing nurses in a complex health system.

- **Suggested teaching strategy**: Have students complete the activity and to students to complete submit a screen shot or image to post within a Learning Management System (LMS). Use reflective methods to determine students perceptions of individual assessments (for example, leadership style) and how they can use that information to develop a plan for career growth.

Spotlight Applications

All chapters include a Spotlight Application. These are unfolding case studies that are associated with the chapter content. Each contains an activity designed to support application to the chapter's content.

- **Suggested teaching strategy**: Use some of these case studies for discussion in class or online. Have students compare and contrast the experiences of the persons described in the case studies with their own work experiences.

Institute for Healthcare Improvement (IHI)

The Institute for Healthcare Improvement[1] has multiple resources available to leverage change in health systems. Users must register to use these resources and adhere to the Terms of Use. Below are examples of how some of the IHI resources can be utilized to support concepts outlined in this book. Note that this book is not intended to teach the comprehensive method of Quality Improvement, but it provides a snapshot of change concepts needed to lead change in health systems. These suggested application activities represent a small portion of the IHI resources available; readers are encouraged to visit https://www.ihi.org/ for a comprehensive review.

Chapter 1 Navigating Leadership

- "[QI Team Member Work Styles Inventory Worksheet].

1. https://www.ihi.org/

Boston, Massachusetts: Institute for Healthcare Improvement; [2019]. (Available on www.IHI.org)"

- **Suggested teaching strategy**: Have students complete this worksheet to identify their own as well as team member workstyles and potential contributions to a Quality Improvement proposal in their workplace.

Chapter 2 Leading Effective Solutions in Organizations

- "[Aim Statement Worksheet]. Boston, Massachusetts: Institute for Healthcare Improvement; [2019]. (Available on www.IHI.org)"
- **Suggested teaching strategy**: Have students complete this worksheet to draft an Aim Statement that can be used for a Quality Improvement proposal in their workplace..

Chapter 3 Leading Effective Teams

- "[Quality Improvement Team Member Matrix Worksheet]. Boston, Massachusetts: Institute for Healthcare Improvement; [2019]. (Available on www.IHI.org)"
- **Suggested teaching strategy:** Have students identify team members that will contribute to a Quality Improvement proposal in their workplace..

Chapter 5 Leading Effective Change

- "[Quality Improvement Project Change Concepts Worksheet]. Boston, Massachusetts: Institute for Healthcare Improvement; [2019]. (Available on www.IHI.org)"
- **Suggested teaching strategy:** Have students complete this worksheet to identify change concepts that will

contribute to a Quality Improvement proposal in their workplace..

Chapter 6 Leading Effective Outcomes

- "[Cause and Effect Diagram]. Boston, Massachusetts: Institute for Healthcare Improvement; [2017]. (Available on www.IHI.org)"
- **Suggested teaching strategy:** Have students complete this diagram to identify the cause and effect of a specified problem in their workplace. This is helpful in identifying potential solutions to the problem that will lead to a Quality Improvement proposal in their workplace.

Writing Support

Students returning to school may need additional writing support in some areas. Refer students to **Appendix A Scholarly Writing Resources** for support in APA and other writing resources.